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Demographically Aging Society in the Health Care System in Poland

Summary: The notion of the „long-term health care” according to the OECD is a complex political issue that covers the whole range of services for the reliant people, who need help in performing the basic, every-day activities for a long period of time. Such a type of health care is most often needed by the people from the older group of age, who are most vulnerable to the prolonged chronic diseases that cause physical or mental disability (see: [3]). The aim of the following article is presentation of changes in the health protection system and its provision over the elderly in Poland. The study presents the description of the care provided for the elderly by including the citizens in the long-term health care service.

The features characteristic for the long-term health care in individual voivodeships underwent horizontal analysis and the descriptive analysis of the changes is presented.

Keywords: health, health care system, long-term health care.

Introduction

The elderly are more often participating in the social structure in every European country. The percentage of the elderly in the European Union increased by 3,6 point within 1991–2011. The median of the EU member’s age in 2011 was 41,2 years and it rose by 5,8 years within 1991–2011. (see: [10]).

The process that influences the acceleration of the society aging in Poland is the rising tendency of life prolongation for both, men and women. In 2012, the life expectancy for men was 72,7 years and for women 81 years. The number of births diminished. The biggest population loss was noted in 2006 and it was 32 000 of people. The percentage of people 65 and more years old also indicates the growing aging process of Poles, which in 2011 rose in comparison to 1991 by 3,3 percentage point. In Poland, between 1991 and 2011 the median of age rose by 5,5 years. The process of society aging can also be observed when evaluating the indicator of the demographic load, that rose in Poland from 15,4% in 1990 to 19,0% in 2011, i.e. by 3,6 percentage points.

When one analyses the problem of aging in Poland, one uses not only the most popular traditional measurement methods, but also those that were described by Anita Abramowska-Kmon, the so called alternative measurement methods that take into consideration the changing conditions of mortality and refer to the time left to people who are in different health conditions. It is noticeable that there is a growing demographic process of the society's aging, which forces the member countries of the UE to work on the new health protection system for the elderly people and those who are not independent by ensuring the citizens the long-term, high level health care provision (see: [1]).

The notion of the „long-term health care” according to the OECD is a complex political issue that covers the whole range of services for the reliant people, who need help in performing the basic, every-day activities for a long period of time. Such a type of health care is most often needed by the people from the older group of age, who are most vulnerable to the prolonged chronic diseases that cause physical or mental disability (see: [3]).

Whereas, accordingly to the Ministry of Health “the long-term care is a long-dated, constant, professional nursing and rehabilitation, as well as continuation of pharmacological and dietary treatment. This care is implemented at the residential health care facilities and at a patient's Home”. Kozierekiewicz, A. and Szczerbińska, K. emphasise in their report concerning the “long-term care in Poland that the long-term care concerns people who are chronically and severely ill, whose health state does not require treatment at the hospital ward, however, it leads to the state of severe deficiency in self-care” (see: [2]).

The aim of the following article is presentation of changes in the health protection system and its provision over the elderly in Poland. The study presents the description of the care provided for the elderly by including the citizens in the long-term health care service.

The features characteristic for the long-term health care in individual voivodeships underwent horizontal analysis and the descriptive analysis of the changes is presented.

1. Public health care system in Poland

The health care system is constituted by elements that are connected logically and functionally, in order to cooperate in a way that ensures success, thus, realization of its main goal. According to Poździoch, S. “[...] the health system (the health protection system) includes not only the health care system, i.e. the actions taken by the health service, but also a whole social set activities connected with the health protection” [6].

In the postwar Poland, public health care system was developed, and it included the hospitals, the medical facilities and the sanatoriums. Every citizen

should have an access to them. The health care in socialist Poland was free and the costs were covered by the public funds. The central organization of the system was to make control and management easier. The cooperative medical and private dental practices functioned next to the state health service. The partial payment for the drugs was established at 30% of their cost for the insured, and 10% of the cost for the people afflicted with one of the social diseases. **The retired people and the chronically ill were exempt from paying fees.** The health care system was based on the assumption that the state is responsible for the health of the young and elderly citizens. Such an attitude had protected the elderly, however, one can point out many causes of the lack of efficiency of that health care system. The health provisions were treated jointly with other social benefits. They were planned without taking into account any risk factors. The rate was flat, expressed in the percentage rate over the payment fund. It was a mandatory service provided by the budget. Financing of the health care institutions had nothing to do with the number, quality or the type of provided services. The main criteria for allocation of the financial resources for a consecutive year was the previous year subsidiary, the inflation level, and the guarantee of the medical center existence. Such an attitude resulted in gradual, real diminution of the resources provided for the health care in the 1980's. In the discussed period, the increase of the treatment cost took place, and it was caused by the prolongation of the average life expectancy of women and men, the development of civilization, scientific discoveries, setting new treatment methods and production of new medicines, but also new diseases. The waste caused by the elderly, who had a free access to use the medical resources and services, but did not actually need them.

2. The health care system in the 1990's

The political and economical changes that took place in Poland in the period of transition to the market economy required some radical changes also in the health care sphere. Since 1990, every leading team announced such a reorganization. In order to improve the financial state of health care, payments were introduced for drugs and sanatoriums that were open mostly to the elderly, which was contradictory to the resolutions of the Constitution. These were, however, only the palliatives in the public fund crisis, a situation of a constant lack of money necessary to guarantee the basic services. In 1990, the Project of the National Health Program was proposed that aimed at maintenance of the elements of the system that has already been decomposed. It guaranteed the equality of the right of every individual citizen, access to the doctor's direct help in emergency situations, continuity of the medical services and promotion of the idea of responsibility for the state of health of each individual citizen. Even though, the system

provided the common health service, it was excessively centralized, too specialized and there were no mechanisms extorting the reduction of the costs. In 1990 the central administration handed the property, financial resources and management authorities to the local and regional governments (mainly within the basic care range). Gradually, one could notice the regional diversity, division and faulty distribution of the resources, that was accompanied by the unofficial increase of the fees for the health care services to those that provided them. The patients started to evaluate the quality of the care offered by the system as a low one, followed by the general rise of the social dissatisfaction (see: [8], [9]). In 1991, there was an Act on the health care facilities that abolished the state's monopoly over the health service sector – the institutions of health care could be established and financed by different operators.

In such a situation, the best but also the most costly solution for the society, was the establishment of the health insurance system.

In May 1992, the Parliament took a decision that obliged the government to prepare specific projects of introducing common and obligatory health insurance in Poland. There were few propositions and the argument between supporters and opponents of the project started to become a severe one. The National Insurance Fund was extracted from the state administration and equipped with legal personality. In 1993, in the Ministry of Health and Welfare appointed a team which was supposed to prepare the assumptions and the project of the act on the common health insurance. In 1994, the Ministry of Health and Welfare introduced the program of the Strategy for Health that aimed at improvement of the health condition of the society, assurance of the free access to the medical services, increase of the efficiency and quality of the services by application of the decentralized system of the basic health care and assurance of the constant sources for financing and control of the expenses. The institution of a “family doctor” was introduced – the new practice model in the provision of the basic services. **The family doctor was to ensure long-term health care and give an opportunity for the longest, as possible, life at a good health condition to the elderly people.** In 1994, the project of an act dealing with the services guaranteed by the state was proposed. The basic premises during the work on the act project were:

- the current financial means of the state,
- maintenance of the common access to the health services on the basis of equality of every citizen's right.
- the principle of access to emergency medical help in case of a direct life threat,
- increase of the citizen's responsibility for the condition of his own health,
- the rule of fees and surcharges for some of the services [7].

In 1994, an evolutionary transformation of the model of health care financing was proposed. The basic financial source for the services should be the National

Insurance Fund, which would function on the basis of autonomy and self-governance.

The authors of the majority of the projects that were proposed in the discussed period, agreed that the insured person should only have the right to the basic health service, and the non-standard services should be paid by the interested party. There was to be a possibility of an additional insurance that would exceed the guaranteed range. What is more, one had in mind the introduction of a partial charge for some of the services of the emergency ambulances and hospitals. Those charges should be set on a level that does not hinder any access to the health service, but only stimulate the national use of the health service. Reimbursement of the costs for those who needed the help of 90% the real medical service cost was assumed, and the 10% should be paid by the patient. Exclusion of some of the professional groups from the mandatory part in the health insurance was also planned. The employees could establish for themselves alternative insurances of a range and quality not lower than the common insurance [7].

In 1996, the change of the act on the health care institutions was approved; the first registration of an independent unit acting on the basis of the Polish commercial law rules that authorizes the private operators to sign contracts with the government. There was also the National Health Program, approved by the Parliament, which set the aims of the health prevention and promotion to 2005. In 1997, the act on the common mandatory health insurance that included the new mechanism of resources generation, their redistribution by and accordingly to the regional insurance offices, but also the new system of payment for the treatment, was approved.

The act approved in 1997 has never come into life, and in 1998 the first amendments to the Act on the Common Mandatory Health Insurance were made. The introductory actions aimed at creation of a new system of information about the patients and the new simplified system of cost calculation for the hospitals and clinics. After introduction of a few amendments on the 1st of January 1999, the government led by Jerzy Buzek introduced in Poland the common, mandatory insurance.

3. The health care system in Poland after 1999

The aim of the 1999 reform in Poland was the introduction of elements of the market mechanism to the health care system, as well as hindering the rising debts among the service providers, implementation of the medical staff payment rise, increase of the financial funds for the health care (see: [4], [7]). There were also the new organisations established, i.e. the Health Insurance Control Office and the National Association of the Insurance Offices. According to the Act, the task of the Health Insurance Control Office was protection of the insured issues,

that in reality was simply a kind of formal control executed over the activity of the insurance offices. Whereas the National Association of the Insurance Offices was to represent the joint aims of the Offices. As a result of the reform there were 16 Regional Offices established and 1 Industry Insurance Offices. The insurance Offices were established in accordance with the new division of Poland into voivodeships. The branches of the Insurance Offices had their seats at the capital cities of the voivodeships. The Regional insurance Office was the basic organisational unit, obliged to include into its members every person who underwent the mandatory health insurance within the range of its district.

In Poland, in the discussed period, the percentage of the rate was equal for every insured person. The rate, i.e. the income tax, was established at 7,5% (1999–2000), and then in 2001 to 7,75% of the rate base. For the rate base one assumed the rate base of the social insurance rate. For the people who did not pay the social insurance rate, one estimated the income of the insured (e.g. the pension height). The Insurance Office was obliged to include a person with a declared income, regardless of the age or whether someone was ill or healthy. The insurance offices had some financial problems that forced them to take actions aimed at reduction of the expenses.

The introduction of changes and the project of reform of the health care financing system was considered. The aim of establishing of the National Health Fund was elimination of all the pathological situations within the health care system. Mariusz Łapiński, the author of this concept and the first Minister of Health in the government established after the parliamentary elections in 2001, presaged a sudden and immediate improvement of the health care state. The Act of the 23rd of August 2003 appointed the National Health Fund, that superseded the insurance offices. This act radically changed the philosophy of acting set in the previous act on the health insurances, eliminating the principle of the competitiveness among the regional insurance offices and introducing one operator that financed the public and non-public medical service providers.

The rate for the health care in 2004 was of 8,25%, and since 2007 it is 9%. The control over the activity of the Fund was ascribed to the Minister of Health, and one of the additional instruments of control over the Fund is the Fund's Board.

The role, ranges of the organisations, financial management of the health care system is often described in the literature. Nonetheless, there is no information or a monitoring system of the phenomena taking place in the health care. It applies not only to the information of the health condition e.g. of the elderly, their health needs, but also the data serving for establishment of the system solutions that will allow to take care over the elderly and disabled person in his or her residential environment with the respect of the rights and assuring the highest of all possible levels of quality of care and treatment. The issue of the society aging was raised in the National Health Program for the period of 2007–2015.

The operational aim described in part III was creating conditions for healthy and active life. The program of promotion of active aging till 2015 should have very important results, e.g. provide the elderly the sense of living a fully-healthy life, security and active participation in the economic, cultural, social and political life.

4. The tasks and organisation of the health care of the elderly in Poland

Aging of societies and the growth of the health care needs of the elderly caused a rapid development of various forms of the stationary, long-term care. Within the health care system and according to the Act on the common health insurance the General Practitioner takes care of an elderly patient in the same way as he would in case of any other adult patient. The long-term care is designed for the people who suffer from chronic diseases, mostly the elderly who do not require hospitalization, but need a 24-hour, intensive care and prolongation of treatment (see [2]). In Poland, the long-term care is implemented within the health care system, just like within the social assistance. The health care system provides the patients in Poland with the long-term care implemented by:

- general nurses who work under the supervision of the general practitioner,
- personal nurses (employed on the basis of a contract for the long-term health care nurse),
- multidisciplinary long-term health care teams.

The finance the benefits within the long-term health care benefits are financed by the National Health Fund. In case of the guaranteed benefits from the care provisions, the regulation of the Health Ministry from 30th of August 2009 came into life (see [2]). The conditions of signing and implementation of contracts for the long-term health care in the form of care provisions since 2010 are clarified in the Regulation no. 84/2009/D50Z of the National Health Fund President. The institutional care is realized within the health care system by:

- care and treatment institutions, the task of the institution is to provide a 24-hour-care and prolongation of treatment of the chronically sick patients, and for patients who require a constant respiratory therapy,
- nursing institution their task is to constantly provide a 24-hour-care of the patients who suffer from chronic diseases,
- wards for the chronically sick patients,
- hospices.

The features characterising the number of institutions of the long-term care in Polish voivodeships underwent the horizontal analysis.

Table presents the number of care and treatment institutions, nursing institutions and hospices.

Table. The number of care institutions, nursing homes and hospices

Voivodeship	Care and treatment institutions		Nursing institutions		Hospices	
	2012	2010=100	2012	2010=100	2012	2010=100
Łódź	7	87,50	23	115,00	1	100,00
Masovian	26	130,00	46	112,20	13	118,18
Lesser Poland	2	100,00	34	109,68	8	200,00
Silesian	25	96,15	40	117,65	6	120,00
Lublin	7	140,00	16	133,33	5	100,00
Subcarpathian	17	121,43	22	110,00	6	200,00
Podlaskie	9	90,00	13	118,18	4	100,00
Świętokrzyskie	2	100,00	13	100,00	3	300,00
Lublin	2	100,00	13	100,00	3	100,00
Greater Poland	9	150,00	16	94,12	5	166,67
West Pomeranian	10	111,11	4	57,14	2	100,00
Lower Silesian	22	122,22	39	95,12	7	87,50
Opole			20	100,00	5	125,00
Kuyavian-Pomeranian	11	137,50	20	95,24	3	100,00
Pomeranian	2	200,00	28	155,56	9	112,50
Warmian-Masurian	5	83,33	13	118,18	3	150,00

Source: own calculations [11]

The presented data show that the number of the care and treatment institutions, nursing institutions and hospices is rising. The highest rise of the number of the care and treatment institutions can be noticed between 2010 and 2012. It was over 100% in Pomeranian Voivodeship and 50% in Greater Poland Voivodeship. The number of the care and treatment institutions rose in every voivodeship except for the Kuyavian-Pomeranian, Lower Silesian and West Pomeranian voivodeships. While the number of hospices rose greatly, e.g. 200% in Świętokrzyskie voivodeship. Whereas, there is also a possibility of a half-stationary care that is implemented within the health care system at a daily ward for the mentally ill. What is more, within the range of the social assistance the domestic care of an elderly can be realized through:

- domestic care (economic care services and a basic care),
- a nurse or some other therapist (social care services),
- a social worker.

The institutional care within the social assistance in Poland can be provided for the elderly at the social assistance institutional houses, and the half-stationary day-time welfare assistance institutional houses.

Conclusion

The health care system in Poland that is faced with new challenges related to the aging population is presented in the article. The theoretical discussion conducted in the following article presented the changes that took place in the health care system and its organization for the elderly in Poland. The evaluation of change of the long-term health care turned out to be an important issue, however, due to lack of available data, it was conducted only partially. The data presented in the article shows that the number of the care and treatment institutions, nursing institutions and hospices is rising. One should also mention that the form of the stationary long-term health care units for the elderly is often related to the culture and tradition of a given country. In the North European countries one can observe the tendency to institutionalize the elderly. Holland, for example, notices most of its seniors spending their time at a various nursing institutions of this type. Whereas, in the South European countries (e.g. Spain, Italy) the elderly mostly stay at their family's environment. The cultural and economical factors influenced the rise of various forms of the stationary long-term care. Apart from the institutions taking patients straight from hospitals to a constant help, one can name institutions that provide care and treatment of the patients who suffer from chronic diseases but do not require any specialized treatment, institutions for the biologically handicapped who are in a difficult family and financial situation and require help due to some social reasons.

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Demograficznie starzejące się społeczeństwo w systemie ochrony zdrowia w Polsce

Synopsis: Pojęcie „długoterminowa opieka zdrowotna” według OECD jest złożoną kwestią polityczną, która obejmuje cały zakres usług dla osób niesamodzielnych, potrzebujących pomocy w podstawowych codziennych czynnościach przez dłuższy czas. Taki rodzaj opieki zdrowotnej jest najczęściej potrzebny osobom z najstarszej grupy wiekowej, które są najbardziej narażone na długo utrzymujące się przewlekłe schorzenia powodujące niepełnosprawność fizyczną lub psychiczną.

Celem niniejszego artykułu jest przedstawienie zmian w sferze organizacji systemu opieki zdrowotnej nad osobami starszymi w Polsce. W pracy dokonano opisu opieki realizowanej nad osobami starszymi przez zapewnianie obywatelom świadczenia usług długoterminowej opieki zdrowotnej.

Słowa kluczowe: zdrowie, system opieki zdrowotnej, długoterminowa opieka zdrowotna.