Aging society: organization of long-term care for the elderly in Poland

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Abstract

Background: Aging society is one of the main challenges of the organization and provision of health care in XXI century. In 2030 more than one third of Polish population will be older than 65 years old and every tenth person will be more than 80 years old. Ageing of the population and dependency trends fuel the demand for long-term care. This raising demand is challenging for both finance and organization of health and social care. Despite of existing reports and publication on long term care or elderly care in Poland, there is a lack of publications that include all forms of available support that are scattered in various provisions systems. A robust overview is needed for accurate planning of required changes to prepare the system for future demographic challenges.

Goal: description of organization of formal and informal long-term care for the elderly in Poland considering various financial systems.

Methods: Review of available reports, publications and legal bills related to long term and/or elderly care in Poland. A non-systematic literature review in English and Polish sources has been conducted in March 2018.

Results: Long term care of elderly patients in Poland is scattered through various financial and provisions systems. Population aging and growing dependency ratio requires to prepare the system for growing demand for long term care.

Introduction

Aging society is a challenging demographic trend in the whole Europe and Poland is no exception.[1] Demographic estimations show that until 2050 we will observe a continuous growth of elderly population with a decreasing number of total population.[2] Together with extended life expectancy and growing share of the elderly group in the population, Poland will face challenges related to long-term care provision that will be able to address demographic trends. Long-term care is based on services that are delivered through health care system, social care system and private sector. Private sector includes also informal care that mainly is being delivered by family members. Currently informal care is the main form of delivering support for elderly patients in Poland.[3]

Goal of this article is a description of organization of formal and informal long-term care for the elderly in Poland considering various financial systems. To gather information a non-systematic literature review in English and Polish sources has been conducted in March 2018. The review is based not only on peer-reviewed publications, but also on available reports and legal bills related to long term and/or elderly care Poland.

Demographic situation assessment

Current demographic trends in Europe and in Poland are mainly defined by post war baby boom, that happened depending from region between 1940-1960. First generation from this peak have already entered retirement age. In the same time, we can observe increased life expectation and lowered fertility rates. It's being estimated that until 2050 Polish population will decrease by 11%, from reported 38,5M in 2013 to 33.9 M in 2050. In the same time, median age will increase from 38,6 in 2013 to 54,3 in 2050. Until 2050 we will observe 1.9 fold increase of the elderly population (defined as 65+) that will reach 11 M.[2] Even more rapid increase will be observed in a population of 80+ citizens, with a 2.33 fold growth between 2013 and 2050 reaching 3.5 M in 2050 (Figure 1). This rapid growth of elderly population and decrease of working age population leads to an increase in a dependency ratio of elderly population that is measured as a ratio of number of people age 65+ to working age population. It's being estimated that the dependency ratio will reach 59% in 2050, and will increase 2.5 times from 2015. This is a good measurement to picture the rapid changes in the Polish demography and challenges that both health and social care will have to face to cater for needs of growing elderly population. These challenges should be addressed now, as already in 2025 dependency ratio will get to the level of 34% (Figure 2).

Long-term care

OECD defines long-term care as an organization and provision of a wide range of services and assistance to people who have limited ability to function independently on a daily basis for a long time due to physical and/or mental disability.[4] The Act on Vocational and Social Rehabilitation and Employment of People with Disabilities defines disability as "inability to fulfill social roles due to permanent or long-term impairment of wellbeing, in particular resulting in inability to work", it may be permanent or periodic.[5] The demand for long-term care depends directly from individual disability not from age itself, however there is a strong correlation between age and disability level. It's necessary to assess correctly disability levels to assist with targeting individualized support needs or to plan for required support on a population level. The tools that are being widely used for determining the level of disability are Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The first scale (ADLs) includes basic activities such as eating, bathing, dressing, getting out of bed, using toilets, activities related to household management such as preparing meals, shopping, housekeeping, are covered by the IADLs scale.[4] On IADL scale, an assessed patient can score from 8 to 24 points. Independent functioning is attributed to people reaching the value of 24 points, people with partially impaired functioning achieve results 23-19 points, and people with severely impaired functioning 18-8 points. In the group of people aged 65+, 52.1% require some form of help in daily functioning. This group is not homogeneous, with a highest level of impaired daily functioning in 90+ age groups reaching more than 90%.[6] Assuming an unchanging level of impairment in individual age groups overtime, we can estimate that in 2050 5.8 million people will require help in everyday functioning.

The group of people requiring most intensive assistance are the disabled patients, whose ADL value ranges from 0-2. Patients with this score are unable to wash themselves, dress themselves, use the toilet. Similar to daily functioning assessment this group isn't homogenous. In the 65-69 age group, only 0.1% of the population is disabled and required high level of support, whereas in the 90+ group this share reaches 12%.[6] We can estimate that in 2050, over 440,000 people aged 65+ will depend completely from support caregivers in their daily activities. This means that for every 1,000 people aged 15-64, there will be 24 disabled older people, who due to health condition are unable to manage basic daily activities as washing or dressing themselves or use a toilet. This impose a need to provide an appropriate assistance tailored to the state of disability and the individual needs of elderly people considering demographic changes in Poland.

Long-term care system in Poland

There is no distinct and uniform long-term care system, and available benefits and services are distributed among various sectors of the broad social security system (Figure 3). There is also no long-term care system targeted directly at elderly population, however there are specific services focusing on this group.

Health care services

Long-term care provided in scope of health care services is intended for severely impaired and chronically ill patients who do not require hospitalization, and due to significant deficits in self-care abilities require, professional health care support and treatment continuation. Long-term care cannot be provided to persons qualifying for social assistance homes or for whom the support is needed due to a difficult social situation or advanced cancer[7] Long term health care services are not intended for elderly patients only, however patient 65+ are main beneficiary of these services (Figure 4).

Long-term care can be provided in inpatient setting in following services:

- Nursing and treatment institutions (zakłady opiekuńczo-lecznicze - ZOL);
- Nursing and care institutions (zakłady pielęgnacyjno opiekuńcze - ZPO);
- Palliative care homes (domy opieki paliatywnej - DOP);
- Hospital (department for the chronically ill patients).

Care services can be provided in outpatient and home setting as well i.e. nurse support at home; hospice care at home; visits in the hospice care clinic.[8]

Patients requiring support from ZOL or ZPO institutions receive an application issued by a family doctor or from a hospital after a treatment in a hospital setting. Requirement for the institution care is being assessed using Modified Barthel Index.[9] Health care services provided in the facilities are financed from the National Health Services(NHS) budget, while the costs of meals and accommodation are covered by patients. The monthly out of pocket cost is fixed at the level of 250% of the lowest pension with a ceiling rule, that the amount paid cannot exceed 70% of patient's monthly income. If patient requires enteral or parenteral nutrition, NHS reimburse this expenditure.

DOP are intended primarily for patients in a difficult health condition in the end of life stage of disease. The hospice care is aimed at improving the quality of life, aims to prevent pain and other somatic symptoms and to relieve them and to alleviate mental suffering. This care also includes support for the patient's family.[10]

In 2016, there were 554 ZOL and ZPO institutions and 155 hospice facilities. Long-term care and hospice and palliative care facilities had a total of 34.9 thousand beds, 1.6% more than in the previous year. The facilities provided care in stationary setting for 98.5 thousand people.[11]

In addition, health care for the elderly patients is dispersed among the standard benefits under health care insurance, such as: primary care; outpatient specialist care (including geriatric wards); hospital treatment; rehabilitation therapy. Some of these services are organized and have financial incentives to ensure the quality of care for the elderly. For example, NHS has established higher capitalization rates for primary care for patient's elderly patients amounting 2,1 and 2,5 for 65+ and 75+ patients respectively.[12] It should be stressed that these benefits do not qualify as long-term care for the elderly, however are important aspects of health care provisions.

Social welfare system

In the social welfare system, benefits can be divided into cash benefits and service benefits, the latter being the subject of this analysis. As in the case of healthcare system, services provided to elderly people are scattered through various forms of available benefits and are not intended for elderly patients only and can be provided in an inpatient and outpatient setting or at patient's home. There are three main types of services available: Social welfare homes (domy pomocy społecznej - DPS); Day care social welfare homes; Home care services.

DPS is an institution providing support services 24 hours a day in an inpatient setting, the standard of care is regulated by the Minister of Labor and Social Policy.[13] Care for the elderly in DPS is considered the last resort of support, used when other assistance options have been exhausted. Admission to DPS institution is preceded by an assessment of patient's health state and a verification if help cannot be provided in the home care system. In the case of DPS, unlike in healthcare system, there is a distinction for the elderly care. In the same time, elderly care is not limited to these centers only. Patients are obliged to cover cost of stay in the DPS, similar to ZOL and ZPO fee, it cannot exceed 70% of income. If patient or family is not able to cover the fee, the costs are covered by the municipality budget.

Support services provided at home, apart from care for patient suffering from mental illness, belong to the local community's tasks and budget. These services are delivered for impaired patients, where families are not able to deliver required assistance. The care provided includes both support in meeting everyday life needs, hygiene, an assistance related to functioning in society and support in medical treatment tailored to individual needs.[14]

Private Care

Private care includes care provided by private vendors and paid out of pocket by patient or family members. In the Mazowieckie Voivodeship there are 102 private nursing homes registered and 108 DPS.[15] This form of care is partly regulated by local authorities. Private care is fully paid from patients and / or families funds, which is a barrier to access to this type of care. Private care, as in the case of health and social care, can be provided in an inpatient or outpatient setting or delivered at home. It's difficult to assess how many elderly people are using private care in Poland, an analysis from Szczecin conducted in 2011 shows that out of over 2,000 patients using long term care system including both health and social care, only 5% were covered by private care.[16] This analysis focus on institutionalized care and doesn't include private, professional caregivers providing support at home.

The most common form of providing long term care for elderly patients in Poland is the informal care.[3] Informal long term care is based on support provided free of charge by the family members or friends. This form of care in the case of a low level of disability of an elderly person is the most cost-effective form of care. In this cases support focuses on household tasks and basic medical support i.e. monitoring medication. In case of patients with higher levels of dependence the burden of caregivers becomes too large and replacement or supplementation with formal or institutionalized care is necessary. Currently, such supplementation is possible within the framework of health and social care services, but the coordination of these services is very limited. Even though this form of care is the basic form of elderly care in Poland, there is little information and regulation on the support of caregivers with additional services, such as daily stays for the elderly, trainings, and temporary long-term inpatient stays. Informal caregivers of elderly patients receive also limited financial benefits, they are not entitled for care allowance applying for caregivers of disabled child. State covers caregivers' pension contributions under the condition of resignation of employment because of the need to provide long-term care for seriously ill family member.[17] It's important to consider informal care in accurate planning of required changes in the long term care for elderly, although seemingly free of charge informal care is asso-

ciated with indirect costs, which are often overlooked in the assessment of care systems for elderly.[18]

Discussion

Long-term care for elderly patients in Poland is a hybrid system based on services provided within healthcare and social care systems and private care delivered mainly through informal caregivers. Although in theory a broad scope of services tailored to different levels of disabilities are available, the systems and services offered seems to be disconnected. There is also a lack of clear coordination between different systems and services that have a potential to complement each other i.e. daytime support and informal care at home.

To provide optimal care for elderly patients, individual needs related to disability level should be considered. Providing care in hospitals or nursing institutions to patients with only minor disability is not a cost-effective resource allocation, as health care sector generates relatively high costs, regardless of patients' degree of dependence.[19] Economic analyses suggest that in case of low degree of dependence home based services are sufficient and provide optimal care. In the same time providing care at home in case of severely disabled patients can generate higher cost than in a hospital setting. Cost of home care based on support of informal caregivers are frequently underestimated, as cost of informal caregivers that include indirect costs are usually not takes into consideration in cost estimations. To sustain quality of home based care on a cost-effective level when patients' dependency ratio increases, informal caregivers should be supported with additional home based services. Social welfare system should provide this support, however currently available solutions are not sufficient and not well connected. Every summer there are recurring press articles how elderly disabled patients are being abandoned in hospitals, even though patients' condition doesn't require hospitalization. It's a clear example of resource allocation that it's not tailored to specific patients' needs, that causes unnecessary health care expenditures. This problem could be solved by better coordination of services and proper inclusion and recognition of informal caregivers.

Considering growing size of elderly population and dependency ratio in Poland, decision makers should better integrate currently available support services including informal caregivers, to tailor care to individual patient needs. Tailored care would not only provide optimal care for patients but will allow most cost-effective resource allocation. Informal home based care, that is currently most common form of providing care in Poland might not be sufficient anymore to provide optimal support for elderly. There is a need to find a right balance between home-based care and in-patient care, using better integration of available services and strengthening support for informal caregivers. To plan for these systemic changes in Poland, it is necessary to conduct a comprehensive cost assessment of different forms of care that will include also cost of informal care.

Conclusions

The organization of long-term care will have to face future demographic challenges and a growing dependency ratio. It is important to adapt the long-term care system to the specific patients' needs considering their level of disability. Proper integration of various forms of care including informal care and different financial systems is necessary to make optimal use of available, limited resources.

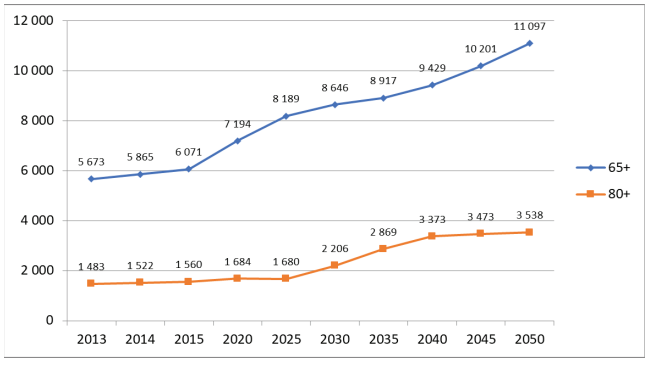

Figure 1. Estimated Polish population 65+ and 80+

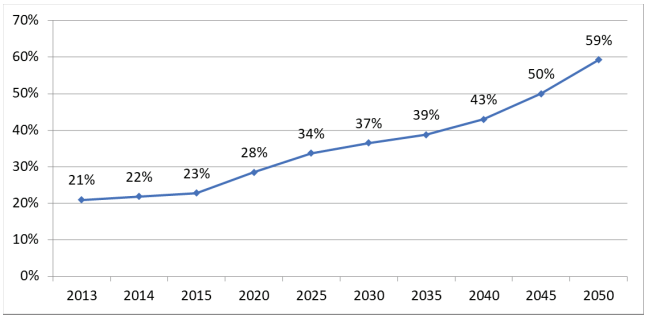

Figure 2. Dependency ratio of elderly population by year

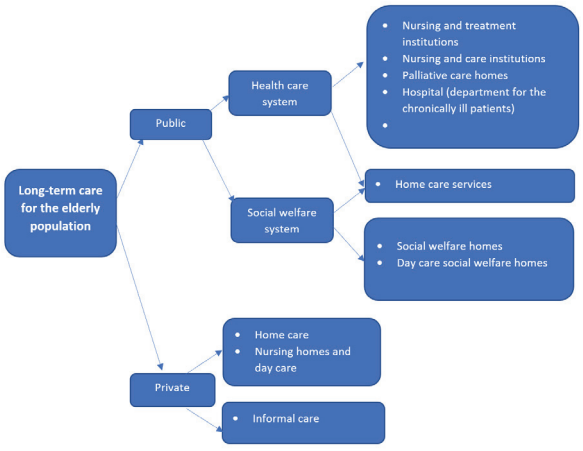

Figure 3. Organization of long-term care for the elderly population in Poland

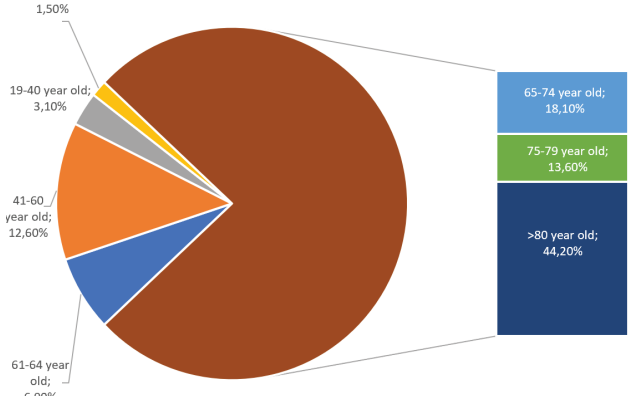

Figure 4. Patient's age structure in in-patient long-term care facilities [11]

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