

Long-term home care in Poland – framework, problems, prospects

Opieka długoterminowa domowa w Polsce – ramy, problemy, perspektywy

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Liczba osób starszych, przewlekle chorych i niepełnosprawnych we współczesnych społeczeństwach staje się obecnie ekonomicznym i organizacyjnym wyzwaniem dla polityki zdrowotnej i socjalnej państw. Wymaga ono stworzenia stabilnie finansowanego modelu opieki długoterminowej, będącego w stanie spełnić rosnące potrzeby obywateli i zagwarantować wysoką jakość usług. Współczesne zmiany demograficzne, epidemiologiczne, społeczne i kulturowe stopniowo zmieniają tradycyjne modele opieki, prowadząc do zwiększonego zapotrzebowania na opiekę domową. Mimo to, niektóre kraje, w tym Polska, nie wdrożyły dotąd programów narodowych w zakresie opieki długoterminowej, bazując na opiekunach nieformalnych w połączeniu z fragmentarycznymi usługami formalnymi różniącymi się pod względem jakości i miejsca. Z perspektywy zdrowia publicznego, rozwój opieki długoterminowej jest obecnie jednym z największych problemów do rozwiązania.

Słowa kluczowe: opieka długoterminowa domowa, starzenie się, niepełnosprawność

The number of the elderly, the chronically ill and the disabled in modern communities is currently becoming an economic and organizational challenge for the state social policy. It requires creating an optional long-term care model to fulfill the needs of citizens and guarantee high quality services with a large, steadily increasing financing. Modern demographic, epidemiological, social, and cultural trends have been gradually changing the traditional patterns of care, leading to the need and demand for home care. In spite of that notion, some countries – including Poland – have not yet established comprehensive national long-term care programs, relying on informal caregivers combined with a fragmented mix of formal services that varies in quality and by location. From the public health perspective, the development of long-term care is currently one of the main problems to be solved.

Key words: long-term home care, ageing, disability

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Wykaz skrótów

LTC – Long-term care

GP – General Practitioner

Background

Life expectancy in modern Europe has been gradually increasing, reflecting the decrease in mortality rates at all ages, which means that more and more people live longer and enter an age when they may need care. Average life expectancy at birth for 2008-2010 across the 27 member states of the European Union reached 75.3 years for men and 81.7 years for women, a rise of 2.7 and 2.3 years respectively over the decade from 1998-2010. In more than two-thirds of EU member states, life expectancy exceeded 80 years for women and 75 years for men [1]. The future will

therefore bring increasing rates of care-dependent elders. Moreover, recent demographic, epidemiological, social, and cultural trends have been gradually changing the traditional patterns of care, which will soon lead to gaps in the care of elderly or disabled family members. Falling birth rates, the break-up of the traditional large family groups, increased female professional employment and changes in residential habits often contribute to an increased need for paid care. Consequently, countries urgently need to find innovative and sustainable ways to cope with these challenges. As reported by John Beard, director of the World Health Organization's Department of Ageing and Life Course: "With the rapid ageing of populations, finding the right model for long-term care becomes more and more urgent" [2]. In Poland, about 13.5% of the population (OECD average 15%) is over

the age of 65, while 3.2% of the population (OECD average 4%) is over the age of 80 [3]. Poland, however, has not yet established a comprehensive national program of long-term care, relying on informal caregivers combined with a fragmented mix of formal services that varies in quality and by location [4].

Home care, being a sustainable approach to prevent the need for unnecessary institutionalization and maintain individuals in their home and community as long as possible, could become an answer to these issues [5]. Polish home care is located at the intersection between the health care (financed from national health insurance instituted in 1999 as a program of healthcare reform) and the social system. The right to receive care is expressed in The Act on Social Care: “People living alone, who because of age, sickness or other reasons require the help of others, and do not receive it, have the right to help in the form of care services. (...) Care services can be also received by people who need assistance, which the family is unable to provide.” The Act provides welfare to individuals in particular situations e.g. in case of advanced age, disability or chronic illness [6].

Long-term care framework

Long-term care (LTC) is a variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time. In Poland, LTC is divided between:

- health care system,
- social assistance system,
- informal care,
- non-governmental organizations,
- private sector.

LTC can be provided as institutional, semi-institutional, outpatient and home care. In 2008, only 0.9% of the Polish population over the age of 65 received long-term care in an institutional setting, well below the OECD average of 4.2%. The number of long-term care beds in institutional settings (17.2 per 1000

population over the age of 65) also falls below the OECD average (44.5 per 1000 population) [3]. The vast majority of the elderly with limitations in the activities of daily living benefits from informal home care provided by the family. In fact, more than 80% of LTC is provided within the family, a phenomenon due to the culturally strong family ties. The significance of the role that families play in the Polish care system is best described by 2 indicators: the “co-residence index” (number of elderly parents living with their children), and the “non-working women aged 55-64” index. The levels of both situate Poland in the extremely high position in terms of family commitment [7]. The main caregivers are women, particularly daughters or daughters-in-law. As previously mentioned, care services may only be granted in the cases where there is no family or if the family is unable to provide such help. Legally, children are obliged to provide for their elderly or disabled parents and this can be enforced in court if necessary [8]. According to the Civil Code, it is also legally possible to make an agreement with someone to exchange the ownership of property for help and nursing in case of sickness [9].

The table I presents Polish long-term care framework.

As shown in the table I, formal home care is located at the intersection between the health care system and the social system and has its own peculiarities within each. Traditionally, the separation between health care and social systems relies on the nature of the service provided. Home care typically includes chore and housecleaning services, and home health care usually involves helping seniors recover from an illness or injury, home health care may include some home care services and vice-versa.

The social assistance system offers assistance for home health care through home care services, specialized care services and nursing care allowances. Home care services include assistance in everyday activities, hygiene care, nursing care recommended by a physician and providing social contacts. Specialized services

Table I. Polish long-term care framework

Type/Provider	Social assistance system	Health care system	Informal care/Private sector
Home/outpatient care	Care services Specialized care services Nursing care allowances	Environmental nurse/GP health services	Family, informal care Paid private care Paid services through social welfare Exchanging ownership of property for help and nursing
Environmental/semi-institutional care	Daycare homes of social assistance (DDPS) Assistance centers	Care and treatment facilities (ZOL) Nursing and care facilities (ZPO) Hospital departments for LTC, palliative facilities, hospices	Private LCT homes

Source: Błędowski P, Finansowanie opieki długoterminowej w Polsce. [w:] Augustyn M (red). Opieka długoterminowa w Polsce – opis, diagnoza, rekomendacje. Warszawa 2010, p.139, translated and modified

focus on particular areas of care, and being adjusted to the needs resulting from the type of illness/disability, can include physical rehabilitation, help in managing finances, fixing meals, handling official matters etc. They are realized by qualified personnel. Nursing care allowances, with a monthly payment of PLN 153 (EUR 38) are granted by the state budget upon the Act on Family, Nursing and Parental Benefits [10]. They are essentially income-support measures with fixed amount not related to the beneficiary's income level. They are allotted automatically for people over the age of 75 regardless of their state of health unless they live in institutions [8]. Nursing care allowances are also granted to younger people on the basis of their disability level.

Health sector units provide home based nursing and care assistance offered by an environmental nurse or General Practitioner (specialist doctor upon referral only). Environmental nurse institution developed as a result of the Polish health care reform (1999). Environmental nurses arrange for their contracts with the National Health Fund (NFZ) for care in the patient's home [11]. In spite of apparent variety of services, the vast number of people receive inadequate assistance or do not receive assistance at all. Moreover, partly due to the organizational framework, home care field is particularly exposed to various problems.

Problems and prospects

Integration and coordination

According to Golinowska: "The integration of home care services faces two types of problems: (I) problems with the integration of institutions that operate on the margins of the health care system with institutions that operate within the social assistance scheme, and (II) problems with the integration of residential care and home care. (...) According to the creators and legislators of the social and health policy systems established after 1990, local governments coordinate the two systems for their clients. However, such coordination is not always efficient. The main reasons for these inefficiencies are limited financial resources and managerial constraints. Restrictions in the availability of nursing personnel in both the social assistance and health care sectors also pose a significant constraint to the integration. These internal barriers (...) additionally hamper the availability of LTC services" [11]. In order to fulfill the actual needs of citizens, an establishment of an extra body dedicated to the integration at the local self-governmental level seems necessary.

For the medical and social spheres of LTC in Poland function separately, few financing sources exist. The lack of coordination in this field seems to

be the main problem of LTC in Poland, as it effects in unreasonable financing, mainly within environmental and home care area. While institutional care funding is usually restricted, beneficiaries of home care can simultaneously take advantage of environmental nursing, care services, nursing care allowances, private care services, and others [12]. On the other hand, the state policy concerning assistance to the elderly focuses on financial aid to the socially and economically weakest citizens, which means that needs of people on low incomes are often unmet [8].

Admittedly, Polish seniors receive an extra cash allowance – a nursing care allowance of PLN 153 (EUR 38) a month or an additional payment to the old-age pension and disability pension of a value of PLN 173,1 (EUR 42) a month. Both are automatically and permanently granted for people over the age of 75 years, regardless of their degree of dependency unless they are institutionalized. However, both are obviously extremely low and do not cover even the basic needs of nursing care. At the same time, those expenditures seem unjustified and unreasonably assigned in the case of independent seniors and due to the repartition manner comprise a significant position in the state budget. In order to narrow the circle of beneficiaries and increase the actual financial aid, more precisely designated care benefits should be introduced.

Socioeconomic determinants and eligibility

Although it is generally assumed that home care is cheaper than institutional care, the analysis of cumulative home care costs often questions this assumption. The expenditure calculations should therefore include all home care components that guarantee adequate quality of services [13]. As previously mentioned, the vast majority of people unable to exist independently in Poland receive care from family and relatives. In fact, as many as 75% of informal caregivers feel they are obliged to take care of their relative [14]. Significant public pressure on providing care to the elderly by children as a moral obligation contributes to this phenomenon. In the Eurobarometer questionnaire of 2007, almost 60% of the Polish respondents, in contrast to 4% of the Dutch, expressed such expectation. Obviously, providing care affects many aspects of the caregiver's life, often altering their financial, professional, social and health situation. In Poland, the needs of informal care providers are usually ignored and support is very limited. In the recent report, only 18% of the respondents indicated knowledge of caregiver support services in their residential area, while almost 65% expressed the necessity of such assistance" [15]. Lack of support may result in inability to provide care or even necessity to benefit from public aid by the caregiver. Consequently, the final costs are

likely to considerably exceed the initial expenditures. The respite care development could help relieve the caregiver's burden and avoid negative consequences of excessive work load, improving both the caregiver's and patient's quality of life. Economic value of informal care in view of possible financial loss should be noticed and appreciated by the social assistance units [16].

Home care eligibility is based on the modified Barthel scale assessment together with determination of the patient's special needs, for example an intravenous drip infusion, catheterization, tube-feeding [17]. Barthel index examines an individual's level of independence in basic everyday life activities, such as grooming, toilet use, feeding, transfers (e.g. from chair to bed), walking, dressing, climbing stairs, bathing, and presence or absence of fecal and urinary incontinence. For each activity, a maximum of 10 points is granted if it can be done independently and 0 if it cannot be done at all, which in practice is a relatively high level of dependence. Since 2008 to qualify for LTC services within the health sector, scoring below 40 points in the Barthel index is required [11]. The scale, being the only long-term care eligibility criterion, significantly restricts access to LTC financed from the National Health Insurance, not securing actual needs. It pretermits mentally ill individuals, who may be able to perform activities of daily living, although their mental state does not allow them to stay at home unassisted. Obviously the person's living conditions (such as degree of poverty) or caregivers' health situation, which might effect in inability to cope with providing, or even assisting at providing care are not taken into account either. In such cases the families, particularly those on low incomes, may not be able to ensure adequate care or continuation of treatment and rehabilitation [13]. Unfortunately, in practice the scale of care benefits seems to reflect the provider potential, not the actual needs. Without proper re-definition of LTC access in the near future, the estimation of the adequate level of needs for nursing and care will be difficult.

Range and quality of nursing services

According to current legal regulations, nursing services are to be provided Monday through Friday – or on Sundays, Saturdays and holidays in medically justified cases – from 8.00 am to 8.00 pm, at least four times a week for a single beneficiary [17]. The district nurse's daily working time is 7 hours 35 minutes. However, it does not involve the time needed to reach the patient's home and transfer between patients, which on the average takes about 2 hours, or even more for 30% of the nurses. Actual work time can be therefore elongated to about 10 hours a day or

more in rural/mountain areas. Another issue is the nurse-patient contact time, restricted by the type of the service contract. The time that nurse can dedicate to one patient is 1-1.5 hour a day, which, due to frequent communication problems or slow work pace that obviously has to be adjusted to the patient, usually is insufficient [18].

Formal division between care and nursing seems to be confusing in both theory and practice. For the essence of nursing is care, thought, assistance and support, nursing benefits cannot function without these components. As previously mentioned, social care services theoretically concern assistance to medical treatment, but (in justified cases) they might as well involve nursing activities. On the other hand, the district nurse's role is not limited to the treatment process itself. Educating patients and their families or preparing them for independent existence are equally important [19]. Consequently, situations of doubling medical and care and support services are not rare. Compiling cooperation rules in order to avoid them, which would require a complex redefinition of nursing and social care benefits, is inevitable [13].

Nursing services realization manner directly depends on the beneficiary's living conditions as they influence work quality, performance and safety. Home environment can constrict and hamper performing LTC services, in particular when it comes to activities requiring holding, lifting or moving the patient. These are often performed in a restricted, non-ergonomic space, without other people's support and assistive devices. Consequently, the safe techniques of holding and transferring patients might not be applicable. It results in physically overloading nurses and entailing patients' safety and comfort [18]. Environmental hygienic and sanitary conditions are equally important. They are often unidentified in terms of occurrence of contagious diseases such as tuberculosis, hepatitis, or HIV. Unavoidable contact with contagious material during hygienic activities exposes both nurses and patients to various health hazards. In poor sanitary conditions, providing safe nursing conditions is seriously hindered [13].

Conclusions

Home care in Poland shares current issues with both the health care system and the social assistance system. Bureaucracy, insufficient funding, lack of qualified personnel all hugely restrict access to LTC services. It results in rapid development of the private sector, which is inaccessible for the major part of the society. The Polish tendency to provide care within the family, which currently fills this gap, is unlikely to continue in the future. Amongst other reasons, the sharp decrease of the indicator of nursing potential

(the share of women aged 45-65 years with reference to the population aged over 75 years), which will soon be halved, is the most spectacular. People requiring care will simply outnumber the potential number of women able to provide assistance [20]. In order to fulfill the increasing needs of citizens and guarantee high quality services, creating an optional long-term care model with a large, steadily increasing financing seems unavoidable. Inspired by solutions already

introduced in other European countries, proposals to implement additional LTC financing in form of the long-term social care insurance have also been considered in Poland. However, public debate on these issues is barely conducted. It has to be realized though that further postponement of addressing the problem will undoubtedly have serious negative consequences [21].

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