OEWGA9: Input of Poland to the analytical documents

I/ *Equality and nondiscrimination*

1. Forms of discrimination against older persons

Does your country produce information about discrimination against older persons in the following or other areas (employment, access to goods and services, social protection, health care, social care, justice, inheritance, decision-making and autonomy, living environment and others)? If so, what are the main findings?

Within the healthcare system in Poland the main role in monitoring any form of patient's discrimination in access to health services is delegated to Commissioner for Patient's Rights established on the basis of the Act of 6th November 2008 on Patient's Rights and the Commissioner for Patient's Rights.

2. Access to services

Is there information available about inequality of opportunities or outcomes experienced by older persons in the following areas: (a) availability of, access to and quality of health care services; and (b) financial services?

In most cases older people living in Poland have been obligatorily insured (in the universal health insurance system) and therefore they get access to all health care services as other insured people. The basket of health benefits has been defined by Ministry of Health and is mainly financed by National Health Fund. The guaranteed services address the needs of all groups of people, including older citizens. Uninsured older people could be voluntarily insured in the universal health insurance system. There is also a special administrative procedure for uninsured people with a very low economic status, which could be applied to offer these people temporary access to all healthcare services, financed by a public payer.

Regarding the availability of, access to and quality of healthcare services for the elderly, there are no specific preferences for senior citizens, as it is mainly the seriousness of healthcare problem and severity or acuity of health condition that is a major factor determining the access to healthcare services.

There are also no specific preferences nor schemes regarding the different quality of health services for the elderly.

3. Special measures and differential treatment

Are there any areas where differential treatment based on old age is explicitly justified (for example: access to goods; mandatory age of retirement; age limits in financial services and products; and age-based benefits)?

Differential treatment based on old age is sometimes very justified in medicine. Therefore whole field of geriatric health services have been created. In Poland with ageing society the whole healthcare system must be reactive to demographical changes. This means that not only healthcare services but also healthcare education must include more services dedicated

to older people or some existing services must be adjusted to the specificity of the elderly. Promotion of health and preventive care of older people are carried out on the basis of Public Health Act and regulation of the Council of Ministers regarding the National Health Program for 2016-2020 (hereinafter referred to as the NHP). In the NHP the Operational Objective number 5 “Promotion of healthy and active aging” has been included. It is dedicated directly to the needs of people aged over 60. Among the activities carried out within the framework of the NHP there are:

- implementation of tasks to improve compliance with therapeutic recommendations,
- training courses in reading food product labels,
- training courses for dieticians in the field of knowledge about specific needs and dietary conditions of seniors (including prevention of weight loss and metabolic diseases),
- conducting geriatric care training for the group of physiotherapists,
- proposing a patient assessment scheme for patients aged 60 and more in hospital wards and on that basis carrying out a training course for medical staff,
- health education in the prevention of injuries and in the promotion of safety,
- education of employers in the field of creating and implementing health management programmes for aging employees within the workplace,
- analysis of adequacy and effectiveness of healthcare services provided in relation to the identified health needs of older people
- extensive research into individual areas of the health condition of older people, including the quality of life related to health.

II/ *Guiding questions for the focus area of the IX session of the Open-ended Working Group on Ageing – Long Term Care and palliative care.*

1. In your country/region, how is long-term care for older persons defined and provided for in legal and policy frameworks? What types of support and services are covered?

The provision of Long Term Care (LTC) does not depend on the age of the patients itself, but on need of the assistance from others due to the problems with their daily life activities.

LTC is provided in two types of services:

1) Home care services:

a) Home-based nursing services. Entitlement to services is based on the assessment of health needs;

b) Home based services for mechanically ventilated patients.

2) Residential services

a) care and treatment facilities,

b) nursing and care facilities.

2. What are the specific challenges faced by older persons in accessing long-term care?

No challenges are faced by older persons in accessing and receiving long-term care and palliative care. In healthcare system access to long-term care and palliative care is solely based on medical recommendations. In-depth information on the issue of accessibility is included in point 3 below.

3. What measures have been taken/are necessary to ensure high-quality and sustainable long-term care systems for older persons. Including for example:

• *Sufficient availability, accessibility and affordability of services on a non-discriminatory basis?*

Data concerning waiting time for inpatient long term care services so far are not recorded by the Polish health care system, with an exception of a long term care for psychiatric patients (see the table below).

Table 1. Real waiting time to psychiatric long term services care (the 3rd quarter of 2017)

No.	Health care unit		Number of people who got access to HC long term care psychiatric services in the 3rd quarter of 2017							
			Total	Real waiting time (in months)						
	Code	Name		Less than 1 month	from 1 to 2	from 2 to 3	from 3 to 6	from 6 to 12	from 12 to 24	More than 24 months
1	2	3	4	5	6	7	8	9	10	11
1	5162	Inpatient psychiatric nursery long term care unit (for adults)	22	14	1	2	3	2	0	0
3.	5172	Inpatient psychiatric long term care unit (for adults)	124	41	8	12	16	24	17	6

Source: Quarterly reports of National Health Fund to Ministry of Health, III quarter 2017.

The access to psychiatric long term care, according to data presented above, has not been restricted in the case of psychiatric inpatient long term nursing care for adults and in the case of children. However, about 50% of adult patients had to wait more than 3 months (sometimes much longer) for services of inpatient psychiatric long term care units.

Patients of inpatient long term care partly cover hotel cost (food and accommodation) during their stay in inpatient long term care units. Despite of it, services of inpatient long term care have been affordable for them because – in line with article 18 of the act on health care services funded from public financial resources – the patient has been granted with the right to pay no more than 70% of his/her monthly revenue.

• *High quality of services provided?*

Regarding the measures taken to ensure high quality and sustainable long-term care systems for older persons, including the high quality of services provided, apart from the defined set of medicines free of charge for the elderly aged 75 or more, the quality health services are aimed at the entire patient population and there are no age specific measures.

• *Autonomy and free, prior and informed consent of older persons in relation to their long-term care and support?*

The right to free and informed consent of patients is a general law to all citizens which include older citizens and is regulated in the act on Patient's Rights and the Commissioner for Patient's Rights.

• *Progressive elimination of all restrictive practices (such as detention, seclusion, chemical and physical restraint) in long-term care?*

Restrictive practices such as detention, seclusion, chemical and physical restraint are regulated by the act on mental health protection. It should be underlined that all restrictive practices described as different forms of direct coercion are used only when necessary. Enumerative list of situations when direct coercion can be used is included in above-mentioned act. The act also regulates who orders the direct coercion (in most cases it can only be administered by a certified physician) and what are the mechanisms of its obligatory supervision. Obligatory supervision of the use of the direct coercion measure determines if it was justified.

• *Sustainable financing of long-term care and support services?*

Long-term care is financed from public and private resources. Care provided by private units and informal care remains fully paid by users and their families. The main sources of public LTC funding are health insurance, general budget, self-governments' budgets and social security funds. Home nursing and residential nursing care provided within the health sector are financed mainly from the social health insurance. In the case of residential care in nursing facilities in the public health sector, only the costs of accommodation and catering are covered through co-payment.

In years 2013 and 2015 annual increase of financial resources, for services of long term care, was equal to about 5.6 and 7.4 percent respectively, however in years 2014 and 2016 the increase was much more moderate – about 1,7 and 0,9% (see table below).

Table 2. Total cost of long term care and nursery services

Years	Total cost (000 of PLN)	Increase (nominal value) (year to year)
1	**2**	**3 (%)**
2013	1 074 939	105.59
2014	1 099 058	101.74

2015	1 183133	107.41
2016	1 295 979	100.9

Source: Annual Reports of National Health Fund presented to the Polish Parliament

In this context it has to be mentioned that in the period of 2013-2016 the inflation rate in Poland was very low (sometimes below zero) – see the table below.

Table 3. Level of inflation in Poland

Year	Annual inflation
2013	100,9
2014	100,0
2015	99,1
2016	99,4
2017	102,0

Source: Central Statistical Office http://stat.gov.pl/obszary-teiTiatyczne/ceny-handel/wskazniki-cen/wskazniki-cen-towarow-i-usluq-konsuiTipcyjnych-pot-inflacja-/roczne-wskazniki-cen-towarow-i-usluq-konsumpcyjnych-w-latach-1950-2014/

Therefore it could be concluded that in this case the financing of long term care was sustainable in Poland.

• *Redress and remedy in case of abuse and violations?*

One of the main mechanisms in dealing with any sort of violations and abuse in terms of patients' rights is initiating the procedure before Commissioner for Patient's Rights.

4. What other rights are essential for the enjoyment of the right to long-term care by older persons, or affected by the non-enjoyment of this right?

The two main areas of the enjoyment of the right to long-term care by older persons are accessibility and social education. In the case of the latter the key element is extending the awareness that all patients (long-term care and palliative) regardless of where the services are provided (stationary or home care) should be approached in a way that guarantees them dignity. Moreover social education may raise the awareness and understanding of experiences and difficulties faced by LTC patients. Furthermore, it should be mentioned that the right to intimacy and dignity is one of the rights regulated in the act on Patient's Rights and the Commissioner for Patient's Rights.

When it comes to accessibility one of the most important initiative in recent years is increasing expenditure on healthcare which is to take place on the basis of the act of 24th November 2017 amending the Act on healthcare services financed from public funds – signed by the President of the Republic of Poland on 19th December 2017, with effective date from 1 January 2018. The newly adopted law provides that funds from the state budget dedicated to healthcare system cannot be lower than 6% of gross domestic product with reservation that the amount of funds intended for financing healthcare system in 2018- 2024 cannot be lower than:

- 4.67% of gross domestic product in 2018;

- 4.86% of gross domestic product in 2019;
- 5.03% of gross domestic product in 2020;
- 5.22% of gross domestic product in 2021;
- 5.41% of gross domestic product in 2022;
- 5.60% of gross domestic product in 2023;
- 5.80% of gross domestic product in 2024.

5. In your country/region, how is palliative care defined in legal and policy frameworks?

The services guaranteed under palliative and hospice care constitute a comprehensive and complete care of the patients with terminal diseases and their symptomatic treatment. This type of care is focused on the improvement of the quality of life by preventing and alleviating pain and other somatic symptoms as well as mitigating mental, spiritual and social suffering.

Palliative and hospice care is regulated by regulation of the Minister of Health on guaranteed services in the field of palliative and hospice care.

The following kinds of palliative care[1] are provided by the health care system:

- home palliative care,
- residential services (two types of residential palliative care: stationary hospice and department of palliative medicine), which provide medical treatment and nursing,
- outpatient palliative care.

6. What are the specific needs and challenges facing older persons regarding end-of-life care? Are there studies, data and evidence available?

No challenges are faced by older persons in accessing and receiving long-term care and palliative care. In healthcare system access to long-term care and palliative care is solely based on medical recommendations. Detailed information on the issue of accessibility is included in point 3 above.

7. To what extent is palliative care available to all older persons on a non-discriminatory basis?

To avoid any type of discrimination regarding access to palliative care, it is based solely on medical recommendations.

The palliative care has been available to all older persons on a non-discriminatory basis in the case of all insured people. Uninsured older people could be voluntarily insured in the universal health insurance system. There also is a special administrative procedure, for

[1] Jednym z rodzajów opieki paliatywnej w Polsce jest również perinatalna opieka paliatywna (szczegółowe informacja dalej) – z uwagi na zakres podmiotowy kwestionariusza nie została ona uwzględniona w tekście powyżej. Perinatal palliative care – this is a fairly new field of children's palliative care. In Poland, pregnant women who have been diagnosed with fetal anomalies have the choice to continue the pregnancy and give birth or alternatively terminate the pregnancy. The period after diagnosis can be very difficult for these women who often feel deprived of motherhood. In response, Ministry of Health started a perinatal palliative care project dedicated for these women and their families

uninsured people with a very low economic status, which could apply for temporary access to all healthcare services financed by a public payer.

The waiting time to units taking care of palliative patients was presented in the table below (in the case of hospitals only*).

Table 4. Real waiting time to palliative hospital services offered by hospitals (the 3rd quarter of 2017)

HC unit		Number of people who got access to palliative inpatient care							
			Real waiting time (in months)						
Code of a unit	Name	Total	Less than 1 month	From 1 to 2 months	from 2 to 3 months	from 3 to 6 months	from 6 to 12 months	from 12 to 24 months	More than 24 months
1	2	3	4	5	6	7	8	9	10
4180	Hospital ward of palliative care	57	56	1	0	0	0	0	0

*no data is available on waiting times to palliative inpatient care offered out of hospitals

Source: Quarterly reports of National Health Fund to Ministry of Health, III quarter 2017

According to the information presented above, there are no problems with access to inpatient palliative services. However, in this case, data is limited only to inpatient palliative care offered by hospitals. There is no reliable information concerning access to inpatient palliative care units which operate out of hospital sector.

8. How is palliative care provided. In relation to long-term care as described above and other support services for older persons?

Please see the answer in point 5 above.

9. Are there good practices available in terms of long-term care and palliative care? What are lessons learned from human rights perspectives?

Regulations on long-term care and palliative care provide citizens with equal right to health services adequate to their needs and are based on values such as living with dignity no matter what circumstances citizens are facing. In the case of patients in palliative care the services provided are aimed at ensuring that the remaining part of patient's life is not deprived of dignity and that relief from symptoms, pain, physical and mental stress of a terminal diagnosis is ensured. The aim is to improve quality of life for both patients and their families.