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Problems with the organization of medical long-term care for elderly in Poland

Tomasz Sroka[*]

Poland has approximately 38.5 million inhabitants, of which 15% are over 60 years old. For many years a trend of increasing numbers of elderly is apparent – it is forecasted that in 2035, the number of people aged 65 and over in Poland will constitute a quarter of all residents[1]. This means that already a significant number of Polish residents are people who, because of their age, require increased care adapted for this group of patients, including medical care. The increase in the number of older people poses the need to increase the availability, effectiveness and quality of health care for this group, that is to be answered by the state authorities. Action must be taken both in terms of hospital and specialist treatment, as well as long-term care provided in a variety of institutions. Long-term care includes all activities for people with chronic diseases that result in advancing disability in terms of medical care, nutrition, movement, nursing, etc., provided by a variety of caregivers, care facilities or in terms of palliative care that is provided to patients with incurable , progressive disease in the final period of their lives.

Aging of the population also increases health care costs, also due to the constant progress in medicine. The continuous increase in the number of patients in old age and progress in medicine, which also involves the continuous increase in the cost of medical care for the elderly, creates a need to shape medical care for this group of patients in a very functional manner. Activities in the field of functional approach to medical care for the elderly should also be undertaken when it comes to long-term care. In my opinion such actions must be undertaken in other countries as well. Therefore a few remarks should be devoted to problems encountered by long-term care in my country.

In March 2015 Supreme Chamber of Control published a report on medical care for the elderly in Poland[2]. The report shows that in Poland there is no functional system of medical care for the elderly. The availability of such care is inadequate, there are no universal, comprehensive and standardized procedures in medical care for the elderly. The

[*] Jagiellonian University, the Department of Bioethics and Medical Law

[1] The information about age of population in Europe – see R. Hrevtsova, *Access of Elderly People to Affordable Helathcare: Problems and Solutions (A View from a Newly Independent State)*, European Journal of Health Law 19 (2012) p. 157-158.

[2] https://www.nik.gov.pl/plik/id,8319,vp,10379.pdf

regulations of the Long-term Senior Policy are not realized. The preparation of the physicians to care for the elderly is insufficient – there's a lack of geriatricians. The current system of settling the bills for medical services financed from public funds is an important barrier, because it is not adapted to multidiseasness that is seen in the elderly. In addition, the availability of medical care for the elderly in recent years has deteriorated, as the number of geriatric clinics and wards to which patients are admitted without having to wait has been reduced. Despite the increase in funding for health care services for the elderly, the number of patients waiting has increased as well as the actual waiting time for granting medical services.

In the face of such bad results of the report of the Supreme Chamber of Control, the Polish government faced the necessity to implement rapid changes that are aimed at improving the health care system for the elderly. The plans disclosed by the government disclosed show that in 2016 the funding of palliative care and hospice care are to increase (from 384 to 414 billion)[3]. In turn, the 2018 is be the year of concern for seniors - among others, a package of regular checkups for older people " Senior's Balance " and strengthening and integrating of the long-term care are planned. Data from the Ministry of Health of 2015 show that in Poland there are only 332 physicians holding the title of specialist in geriatrics, and in the course of specialization there is only 169 to follow. To improve access to medical specialists for the elderly, the Ministry of Health is planning a special training course for doctors under the so-called. fast track. However, this year only 22 places for specialization in geriatrics were established in the country. Action is also planned in the field of social care for the elderly. Polish government adopted a "Senior - Vigor" Programme in 2015, envisaging the establishment of nursing homes for the elderly, where there will be the ability to obtain current medical care or spend their free time. However, it will be a primarily social not medical care[4].

Analysis of the Polish government's plans for medical care for the elderly leads to conclusions that there are no organized activities planned in the field of reorganization, or at least improvement of long-term care provided primarily in care and treatment facilities. Meanwhile, in this field substantial problems in organization, financing and pertaining to the quality of medical care appear and they also require a quick solution.

[3] Projekt planu finansowego NFZ na 2016 rok

[4] https://www.mpips.gov.pl/aktualnosci-wszystkie/seniorzy/art,7245,senior-wigor-opieka-wiedza-aktywnosc.html

The basic organizational problem is the insufficient number of facilities providing comprehensive medical care for the elderly. These institutions are called care and treatment facilities or nursing and caring facilities. It is estimated that the entire country has only about 500 such centers, and – for example – in Krakow there are only seven. Nonetheless, it must be borne in mind that six of them are institutions of general profile, while only one is a facility of psychiatric profile. The sharp rise in the number of people requiring long-term medical services coincides with an unchanged number of care and treatment facilities, because these days are no new centers of this type created. This increases the waiting period for a place in the facility, in particular in those establishments financed from public funds. The length of the waiting period is also dependent on the type of long-term care facility. In a psychiatric profile facility the waiting period is on average about a year and in the general profile facility – the average is from 3 to 6 months.

It follows that there is a fundamental difficulty in the real and actual access to medical service when it comes to long-term care for the elderly. Moreover, the long waiting period (six months or even a year) can lead to a situation where an older person, has several co-existing diseases and requiring constant specialist treatment, and above all immediate, may not live to see a vacant place in an appropriate facility.

It seems that the Polish government should take action to support individuals, companies or institutions that would create new facilities providing long-term medical assistance, for example in the form of co-financing the expenditures for construction of such facilities. Without building new facilities, ensuring effective access to such services for the elderly will not be possible even if financial expenses on long-term care increase.

The second organizational problem is the insufficient number of personnel in care and treatment facilities. Ensuring adequate supervision and medical assistance to people who need constant help even with most basic everyday activities (hygiene, nutrition) must involve the hiring an adequate number of people, mostly nurses.

The Jagiellonian University runs a legal clinic in which law students, under the supervision of academic staff, provide free legal advice to people who cannot financially afford professional help. Legal advice provided includes the field of medical law. In recent years, one of the clients was a woman whose mother went to one of the care and treatment facilities. The client drew attention to the shortage of medical staff in relation to the number of patients in long-term care facilities, where she stayed by her mother. The result was frequent dereliction of patients, primarily in the field of personal hygiene and proper nutrition. The client pointed out that for her mother to be provided with adequate conditions

of hygiene, at least at the basic level, and to be adequately fed, she had to spend several hours a day in a care and treatment facility – to care for her mother personally. At that time, she executed operations that belonged to the tasks of nurses, but due to the number of patients the nurses were not able to perform those tasks to the extent appropriate for each patient.

Therefore, steps should be taken towards increasing the employment of qualified staff in long-term care facilities. It seems that it will not be possible without an increase in pay of nurses to work in such institutions for such work to became more attractive also from an economic point of view.

The analyzed issues is linked to the realization of patient's right to personal contact with others, especially family members, and the right to additional nursing care, exercised most frequently also by family members[5]. People visiting patients often notice an inadequate level of hygiene or an inadequate quality of nutrition. The consequence is to take legitimate legal action against medical personnel. Family members often call for appropriate medical care and nursing for their loved ones, so that such people are often negatively perceived by medical personnel[6]. There are cases in which the director of the facility takes steps to limit access of family members to the patient, in order to eliminate the problem of a demanding family members. One may observe an abuse by managers of long-term care facilities of the authority to limit the use of the patients' rights to communicate with others and the right to additional nursing care by minimizing the patients' contact with the family[7]. The rationale for such actions is the lack of appropriate organizational capabilities as well as the health safety of patients - often family members who insist on proper care for the elderly and at the same time try to ensure better hygiene and nutrition - are accused of acting to the detriment of the patient. This reduces the contact of the elderly located in the facility with their families to minimum and allows to eliminate the problem of demanding family members. However, these people often file justified demands against medical staff.

Therefore, the authorities protecting the rights of patients, in particular patient rights ombudsman, should pay special attention to situations in which the managers of medical facilities, primarily those of care and treatment facilities, restrict access of the patient's family members. Such instances may be a result of the abuse of powers of the managers and suggest

[5] See art. 31 and 34 of the Act of 6 November 2008 of the patient's rights and the Patient's Rights Ombudsman (Dz. U. 2016 position 186).

[6] In literature the statement is made that close relatives of elderly shall enjoy a priority right to become guardians of such patients – see A.N. Pishchita, *Elderly Patients as a Vulnerable Category of the Population Requiring Special Legal Protection With Respect to the Provision of Medical Care*, European Journal of Helath Law 14 (2007) p. 354.

[7] See art. 5 of the Act of 6 November 2008 of the patient's rights and the Patient's Rights Ombudsman.

incorrectness of care for the elderly, to which family members respond. It appears that control carried out by the ombudsman of patients' rights in Poland in this area is insufficient.

Organizational problems are connected with problems with the quality of medical care that is provided to the elderly in long-term care facilities.

There appear some indications of improper medical care for the elderly in care and treatment facilities, especially when it comes to legitimacy of the use of certain drugs, etc. According to information obtained from the National Health Fund, the entity concerned with the organization and financing of health care services from public funds, there are major difficulties in checking the correctness of medical procedure with respect of the elderly in long-term care. All consultants in various fields of medicine, including national consultant in the field of geriatrics and palliative medicine, refused to help in this regard by explaining that long-term care does not fall within the scope of their duties and responsibilities. This leads to a situation in which the medical services provided in care and treatment facilities are in "the gray zone" and regularity of their use is not subject to any substantive control.

It seems that action should be taken towards either the appointment of a consultant responsible for judging the adequacy of services provided in long-term care facilities, or imposing an obligation in this respect on one of the existing consultants, for example in the field of palliative medicine or geriatrics. The Ministry of Health should have control tools, allowing verification of whether the patient is ensured a sufficient level of safety during treatment and twenty-four hour stay in healthcare units. It seems that such controls should exist in every country.

In the context of appropriate quality of medical care in a care and treatment facilities and its compliance with current medical knowledge there are indications from family members about the possible abuse of sedatives on the elderly. In particular, the drug called Haloperidol, a potent medicine used in psychiatry, but also of sedative effect.

From the relations of the aforementioned woman who was a client of the university legal clinic, she observed changes in her mother's behavior while in the care and treatment facility and after leaving the plant. At the time of admission to the facility the client's mother was an energetic person, easy to make verbal contact with, "full of life". Next few days ensued a clear change in her behavior – she became very sluggish, lethargic, spent most of her time in bed, contact with her was much more difficult. In case of health state deterioration the mother was transported from the facility to the hospital, where after a few-days stay she returned to her original condition – she was energetic, easy to establish contact with. After returning from the hospital the woman's behavior changed to worse. It should be added that

similar descriptions of patient's behavior change while in care and treatment facility are indicated in the relations of others.

The above-described sudden changes in the behavior of patient may indicate that while in the care and treatment facility, the medical staff could abuse sedatives against her, in particular the aforesaid Haloperidol. This allows the elimination of problems associated with care for the elderly in long-term nursing - patients are partially intoxicated with psychiatric drugs, and therefore less disruptive for medical staff and require less attention. If such situations occur, it must be recognized that they violate the dignity of the elderly as patients and require a strong response from the state.

It is necessary for the state to make systematic, unannounced inspections of long-term care facilities, in order to verify that the patients are provided with proper security levels, and whether medications are appropriate in accordance with the medical indications. It seems that sole analysis of medical records is insufficient in this respect, because unjustifiably used drugs will not be reflected in the patient's medical history. Thus control should include not only medical records. The analysis encompass the entire process of buying and then using drugs in the treatment of patients.

Special attention should be drawn to the question of proper financing of those medical services and supplementary services, as accommodation and boarding of the patients.

According to Polish law, the beneficiaries have the right to, inter alia, guaranteed medical services of nursing and caretaking within the scope of long term healthcare[8]. It should be brought to mind that in Poland medical services provided in caretaking and medical treatment facilities and caretaking and nursing facilities are financed within long term caretaking, and not within palliative or hospice care[9]. From the perspective of the caretaking and medical treatment facilities and caretaking and nursing facilities' functioning, the range of guaranteed services provided in stationary conditions is important, and those comprise of: medical services provided by physicians and nurses, general rehabilitation, psychological services, occupational therapy, pharmacological and dietetic treatment, medical products supply and health education consisting in preparing the beneficiary and his family or carers to self-caring and self-nursing in in-house conditions. These services are guaranteed to the patients who gained not more than 40 points in the process of evaluating according to the

[8] See art. 15 section 2 of the Act of 27 August 2004 of health services financed from public funds (Dz. U. 2015 position 581 with further amendments).
[9] See executive regulation of the Minister of Health of 22 November 2013 concerning the guaranteed services of nursing and caretaking within long term caretaking (Dz. U. 2015 position 1658).

scale of the level of demand for care. The proper way of settling is a payment for a person-day unit[10].

The problem arises when the agreed person-day unit payment is not sufficient to cover the costs of providing all necessary services to the patient on proper level and in necessary scope. Additionally, it has to be brought to mind that the National Health Fund applies different payment rates for different parts of the country. From this arises the threat that the service providers will cut down on the amount of services provided or on the scope of services provided to the patients, due to the lack of cost coverage by the National Health Fund.

The service providers try to gain additional funds to cover the costs of provided medical services, however, those are not always legal. In practice, one can encounter the cases of dividing the medical services into the standard ones, which must be provided to the beneficiary due to his needs and state of health, and the extra-standard ones, which are not in the scope of obligatory services, and as such are not refunded. This differentiation gives the service providers the possibility to acquire additional payments from the patients for extra-standard services. It should be remarked that Polish law requires every patient to be provided with medical services appropriate for his state of health and needs. When it comes to the patients of the caretaking and medical treatment facilities or caretaking and nursing facilities no provisions regulate the question of the standard of services provided, especially those provisions do not divide those services into standard and extra-standard ones – they only state that the services are to be adequate to the state of health and needs. From this a conclusion arises that the minimal and obligatory range of medical services is determined by the health state and needs of the particular patient. The worse the state and greater the needs, the greater the number of services deemed to be appropriate.

It is worth noticing, that the patients of the facilities are usually elderly people, seriously ill, who have problems with exercising even the basic every day activity. In this context, the appropriate range of services, which should be guaranteed to the patients of the caretaking and medical treatment facilities or caretaking and nursing facilities, is very broad nd only in extraordinary cases particular services may be determined as extra-standard ones. What is more, an abstract determination of such services is impossible, only determination according to a particular patient is possible. The determination of the exact health state and needs of a particular patient might allow to state, that some services are extra-standard, but

[10] See T. Filarski, T. Sroka, *Zrozumieć prawa pacjenta (To understand patients' rights)*, Warsaw 2014, p. 91.

solely when pertaining to a particular person. Therefore, creating a catalogue of extra-standard services by the service providers is inadmissible.

According to Polish law, the beneficiary, who stays at the caretaking and medical treatment facility or caretaking and nursing facility that provides services 24 hours a day, has to bear the costs of board and accommodation by himself. Nonetheless, Polish law establishes the maximum costs of board and accommodation collected from the patients which cannot exceed 70 % of the beneficiary's income according to the Social Security Act[11].

In practice on may encounter cases, where the caretaking and medical treatment facility or caretaking and nursing facility breaks the aforesaid provisions. Within that phenomena two situations can be pointed out. The first, where the rate established for a particular patient for board and accommodation exceeds the stated 70 % of the beneficiary's income. There is no doubt that this is a breach of the patient's right to acquire the services for proper payment. Such activity of the service providers is illegal.

The second situation is when the caretaking and medical treatment facility or caretaking and nursing facility determines the payment for board and accommodation by percent, in compliance with Polish law (70 % of the beneficiary's income according to the Social Security Act). Nonetheless the service provider also determines a minimum amount of money, that is the minimum payment for board and accommodation. In this manner the service providers try to ensure themselves with an amount of money that will be sufficient to cover the basic costs connected with the patient's stay at the cility. If the aforesaid amount of money stays within the 70 % of the beneficiary's income, there is no problem. When this is exceeded, the situation is different. Such activity of the facility should be considered illegal.

The financing of board and accommodation is connected with the problem of providing proper meals at the caretaking and medical treatment facilities and caretaking and nursing facilities. Despite the fact, that the beneficiaries bear the costs of the board, very often the meals are not adequate to their age, physiological conditions and state of health. While it should be pointed out that proper board has massive meaning for effective medical procedures application, in fact being an element of applying them properly. What is more, improper food may cause additional illnesses for the patient, e.g. food poisoning, which should be especially avoided by the entities providing medical services. It is deemed proper for the caretaking and medical treatment facilities and caretaking and nursing facilities to

[11] See art. 18 of the Act of 27 August 2004 of health services financed from public funds.

employ nutritionists who would establish individually the kinds of meals for every patient, according to his age and state of health.