niedostatecznie rozwinięty należy ocenić system opieki geriatrycznej (liczba szpitali, ośrodków opieki, liczba lekarzy), zwłaszcza w związku z rosnącymi potrzebami wynikającymi z przemian demograficznych.

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Analysis care services offered in polish social welfare system

The article is an attempt to present and analyze the services offered in the Polish social welfare system. The State offers the public welfare in the institutional social policy. The main target of social policy is to support people and families in difficult situations, which despite the use of its resources and capabilities in order to alleviate still constitute a barrier to the further normal functioning. This is of particular importance to the lengthening of the human life, less and less multi–generational families there is a problem in the care of elderly and dependent. Social welfare services and institutions providing services were successively discussed, as well as attempt to evaluate these services and solutions in this area. The entire article is summarized by postulates referred to creators and implementers of social policy.

Keywords: *social assistance, nursing homes, nursing services, social support centers.*

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Аналіз опікунських послуг, пропонованих польською системою соціальної допомоги

Зроблено спробу аналізу сфери опікунських послуг, пропонованих польською системою соціальної допомоги. Держава у рамках інституційної соціальної політики пропонує суспільству допомогу. Головною метою допомоги є підтримка осіб або сімей в скрутних життєвих обставинах, які, незважаючи на використання власних ресурсів і можливостей з метою пом'якшення цих обставин, й надаліне можуть нормально існувати. У зв'язку зі збільшенням тривалості людського життя, зменшується кількість багатопоколінних сімей і з'являється проблема догляду над старшими і неповносправними особами. У статті були проаналізовані послуги соціальної допомоги та соціальні установи, що надають ці послуги. Автори спробували оцінити якість цих послуг та підвести підсумки. Стаття підсумовується постулатами на адресу творців і виконавців соціальної політики у сфері опікунських послуг.

Ключові слова: *соціальна допомога, будинки соціальної допомоги, опікунські послуги, центри соціальної підтримки.*

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Анализ опекунских услуг, предлагаемых польской системой социальной помощи

Сделана попытка анализа сферы опекунских услуг, предлагаемых польской системой социальной помощи. Государство в рамках институциональной социальной политики предлагает обществу помощь. Главной целью помощи является поддержка лиц или семей в сложных жизненных обстоятельствах, которые, несмотря на использование собственных ресурсов и возможностей с целью смягчения этих обстоятельств, и в дальнейшем не могут нормально существовать. В связи с увеличением продолжительности человеческой жизни, уменьшается количество многопоколенных семей и появляется проблема ухода за пожилыми и неполноисправнымилицами. В статье были проанализированы услуги социальной помощи и социальные учреждения, предоставляющие эти услуги. Авторы попытались оценить качество этих услуг и подвести итоги. Статья суммируется постулатами в адрес создателей и исполнителей социальной политики в сфере опекунских услуг.

Ключевые слова: *социальная помощь, дома социальной помощи, опекунские услуги, центры социальной поддержки.*

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THE HISTORY OF LONG–TERM CARE IN POLAND AND IN THE COUNTRIES OF THE EUROPEAN UNION

The following article presents the history of the origin, as well as the determinants of development of long–term care both in Poland and the European Union. For the purposes of Polish health care system, the long–term care has been defined as long–lasting, continuous, professional care and rehabilitation, as well as continuation of either pharmacological or dietary treatment, realized institutionally (stationary or domestic), in order to maintain the health and safety of patients with significant deficits in self–care. In the first part, I present demographic situation, which is the main factor contributing to the emergence and development of long–term care in Poland and in the world. In the second part, I present the general principles for the implementation of health services provided to chronically ill people within the contracting of the National Health Fund. To sum up, the article is concluded by the summary.

Keywords*:long–term care, health care services, chronically ill patient.*

(стаття друкується мовою оригіналу)

The aim of the article is to present thefactorsthat influenced theemergence and development oflong–term carein Poland, as well asin selected European Union Member States.

One of the most important causes of the need to develop long–term care is the populaton ageing due to, among

others, lengthening the average duration of human life and lower birth rates. Along with increasing age, there are growing problems of performing daily activities – such person may become dependent on the others.In manycases, it isthe consequenceof previousnegligences, as well as delayedresponseto emergingneeds andthe lack of comprehensivepatient care.What is more, dependence onthe help of the othersmeansin turnincrease ofthe demand forvariousforms of health care, the provision of care and permanent careof other personsin the ordinary everyday activities, which becomes a challengeforsocial and health policy [11; 22]. Demographic projections ofCentral Statistical Office (GUS)show thatby 2035,subpopulationof people65 years old ormoreinPoland will growby 62% compared to 2010, while the subpopulationof people80 years oldor morewill risein the same periodby as much as96%. In turn, the increase in the number of the oldest people has a significant impact on even greater demand for the provision of care [2; 11].

Population ageing hasa long–term nature, and its consequenceswill be feltin the future.In the social sphere, this process affects the structureof the family,housing demand, migration trendsand the demand forhealth services.The scale of the problem is further emphasized by high rate of change of the demographic structure in Poland, in comparison to the average changes of European Union Member States.Longerlife expectancy, lowerbirth rates, changing model of the family–all thesefactors makethe role offormallong–term carewill increase.While assessing the impactof demographicindicationsof the scale ofthe demand forcare services, itshould be emphasizedthat the mainfactor generatingthis demandisageing,although we cannot forget about theincreasing numberof both young and middle–aged people, who in turn of disease, accident or trauma become dependent on the others.Moreover,the ratio ofelderly peoplecovered bylong–termcaretopeople usingitinother age groupsis80:20 in most countries [3].

The development of long–term care in PolandHalf of the90sof the twentiethcentury in Polandhas broughtrapid developmentof various forms oflong–term care. The 1999–2001periodwas the breakthrough, whenreformof the healthcare systemhas madelots of changesin this area [18].The development oflong–term caresector was started in Poland as a part of therestructuring of thehealth care. Moreover, at that time, healthcare facilities appeared on the Polish market of medical services, which are providing health services to chronically ill and disabled people.The need forthe creation oflong–term carefacilitiesresulted from theincreasing demand forthis typeof health services, which was directly related to lengthening of thehumanlife, as well the increasing number ofboth elderlyanddisabled people,changingmodel of the familyand increased professional female activation. On the other hand, the economization ofthe health care systemforcedshortening ofthe period of stayofpatientsin hospitalsto the minimum – to performspecialized procedures. This is why the establishment of the new facilities became necessary. Such facilities were founded to continue thelong–termtreatment and rehabilitation, as well as the care of people, when familiescannot providesuch care.Due to the growingdemand forhealth servicesin the field ofcare for the disabledandchronically ill people, we can observerapid developmentof various forms oflong–term care [9].Prior to 1990, it wasimplemented mainlyin the form ofservices such as medical social workers and nursing homes, as well as daily nursing homes. A commonphenomenonwas also theextension ofhospitalization of theelderly, who were occupying beds intended for treatment of acute conditions [12].The breakthroughin the development oflong–term care has become a reform of health care system in Poland,in whichthe following changes have been made:

– creation ofmany publiclong–term carefacilities as a part of restructuringof health care institutions;

– elaborationand implementation of newrules for financinglong–termcare servicesinthe health insurance system;

– creationof privatelong–term carefacilitiesby non–governmental organizations, church andindividuals;

– extension ofthe catalog of servicesoflong–term care,addressed tovarious groups of recipients;

– development ofthe standards forpatients regarding qualifications systemand the requirementsfor the specific services in each categoryof long–termcare facilities.

The initialdynamism ofthe development oflong–term careis currently slowing down. This is analarming phenomenondue to thefact that the demand for both nursing and care services is rapidly growing up.The increase inthe number oflong–term care facilities andbedsis slowerthan the process ofageing of the population and risingnumber ofchronically ill anddisabled people.The causes ofthisphenomenoncan beseen in,among others,the followingfactors:

– division of tasksin the field oflong–term carebetweentwo independentsectors, ie. health sectorandsocial assistancesector, resulting in a lackof coordinationof healthcare services;

– lack ofnursing staff;

– lackof qualifiedcare personnelin the number coveringdemand(education in the profession of medical caretaker has started in 2013 on a large scale);

– too low levelof financing oflong–term care(understatement of the provisionamounts to40–60%);

– lack of properdefinition anddifferentiation oflong–term careservicesranges;

– lack of standards ofequipment as well as functioningof long–termcare facilities, whiletaking into accountthe specificitiesof health services;

– lack of appropriatecriteria forenrollment of patients inlong–term carefacilities(according tothe National Health Fund, the same kind of patients is taken to all types of facilities);

– lack of“clear”system of data collectionin order toassess the realsocial need forthe provisionoflong–term care;

– negativeimage oflong–term carefacilitiesin the society;

– inconsistencies inregulations [1; 11].

The organization of long–term care system in Poland.Both benefits and servicesavailable within thelong–term careare spreadbetweendifferent parts of thesocial security system,more specificallybetween: health care system, social insurance systemandsocial welfare system.Long–term careis designed for bedriddenandchronically ill patients who are not requiring hospitalization, who have significantdeficitsin self–care, and who require permanent, professional, intensive care and nursing, as well as the continuation of treatment [21]. The

continuation of treatmentmeansfurther medical procedure corresponding to the healthof the patient, including administering medicines anddiagnostic testsnecessary forchronic diseases. Long–term care does not include candidates qualifying for nursing homes or those requiring care due to either difficult social conditions or advanced cancer [6].

Long–term carein the stationary form isconducted by care, nursing and healing facilities (ZOL and ZPO), providing permanent both nursing and rehabilitation services as well as continuation of treatment to patients who are not eligible for treatment in hospital, who havea referral from a health insurance and have received 40 or fewer points in Barthel scale [17; 22], what have been definedin the Health Care Actof 30August 1991. The purpose ofthe long–term care facilities is permanentcare and treatmentof peoplewho have completedthe process ofdiagnosis andsurgical treatment,andno longer requirehospitalization. An application to thelong–term carefacility isissued either bythe family doctorora doctor who was assigned to the treatment of the patient in the specific hospital. The similarityof ZOL and ZPO definition prevents propercategorizationforeachof group of patients, while the Barthel scaledrastically reduces theavailability oflong–term careservices.

Within the stationary long–term care in Poland, there also operate health care centers for mechanically ventilated patients, in which the provider ordered an additional requirement to provide permanent, either mechanical or pressure ventilatory support to patients with circulatory insufficiency, who require continuous therapy using respirator, but do not require hospitalization in Intensive Care Units (ICU). The National Health Fundfinances health services in care facilities, while the patient bears thecost of both foodand accommodation. What is more, monthly charge is calculated in the amount equivalent to 250% of the lowest pension, but that the fee cannot be higher than the amount equivalent to 70% of the monthly income of the beneficiary within the meaning of the regulations on social assistance. The feeis usuallymuch lower than theactual costs of stay, thus facilities are forcedto look for significant savings [11; 17; 22].The services providedat homeare carried out bylong–term carenursing provided by medical social worker, as well as long–term care facilities for adults, children and adolescents, who are mechanically ventilated [5]. The following care can coverpatients who acquiredfrom0to40 pointsinBarthel scale, who do not qualify forstationary treatmentbutrequire regular and intensivenursing care.The services realized bylong–term care nursinginclude, among others,care, rehabilitation and assistance in solvingthe biological, psychological and social problems [3].

In the case ofthe mentally ill persons, who arein the acutephase of the disease, the services are secured in accordance with thedecree of the Presidentof the Fundon determining theconditions for the execution of contracts concerningpsychiatric care and treatment ofaddictions, as well as the Regulationof the Ministerof Health of 30August 2009onguaranteed servicesin the field of both mental healthandaddiction treatment(Dz. U. [Journal of Laws] from 2009, No. 140, item 1146).

Long–term care facilitiesformechanically ventilated patients includecare ofpatients who do notrequire hospitalizationinICU–sor stayinfull–time care institutions, however,who require constantmedical supervisionof the specialist, as well asprofessional nursing and rehabilitation. Home care formechanically ventilated patients can be provided to personswhohave suitable conditionsat their homes, educated family (or caregivers) inthe use of medical apparatus, as well as first aidina way that ensurespatient safetyduring the treatment [1; 6; 11; 20; 22].

Long–term care on example of other countries, trends in the development of the long–term care.Due to population ageing, European countrieshaverecognized theneed to providecarefor the elderly, chronicallyill and disabled people long time ago, and thusthe need to developlong–term care. All European Union Member States are required to provide their citizens with universal access to long–term care, which is characterized by high quality and reasonable prices.Since the population is ageing, it is more and more difficult tomeet thefinancialandlogisticalchallengesduring the implementationof thecommitments tothe elderly. The term of long–termcare has setthreecomplementary objectivesin terms ofprovided services: universal accessibility, high quality and long–term effectivness.Moreover, there is a generalconsensus asto the fact thataccessto health carecannot berestrictedby ability to pay feesordependent ontheirbothincome ormaterial status.The needfor careshould not be acause of povertyorfinancialdependency. However, theuniversal rightsensureuniversal access,and both inequalitiesand obstaclescontinue toexist.The problemsstart withthe lackof funds forinsuranceand certaintypes of care, and end withlongperiods ofwaiting, disinformtion and complicated administrative procedures. The degree ofoccurrence of theseeventsmay varyin different regions ofthe same country, not necessarily in the individualEU Member States. It may be difficult to provide patients with the equivalent care.Effortsinsome EU Member Stateswith the aim ofproviding the patient with assistancein the investigationtofull working order,eg.throughrehabilitation,canbeineffectivewhether thesocial systems of health insurance do not provide the possibility of refinancing long–term care services. The policy of the European Unionis aimed atthe development of localnetworksof both support andassistance inthe place of residenceof an elderly person.What distinguishesPoland from otherWestern European countriesin terms offorms of careservicesfor the elderly is theirdiversity [10].

German health systemis rated asone of the bestin Europe.On the other hand, the cost of treatment and care services for seniors and the chronically ill persons is very high.The health system forthe elderlyaimed at supportingin organizingtheir livesand fulfillingtheir needstakes into accountseveral forms oflong–term care. One of such forms arenursing homes,where themonthly costmayevenreach 3400€. The alternative isnursingservice(Pflegedienst), which reacheseventhe farthest corners ofGermany.The cost of Pflegedienst daily services canamount toan averageeven 3,200€ a month. When the patient needs 24–hour care – in case of Pflegedienst, the cost could be twice as high [16].Anotheravailable form ofcare forGerman seniorsis calledBetreutesWohnen. The minimum cost of 2500€ contains a flat with so–called caregiving offer (basic servies + additional services).Some Germanseniorschoose Senioren–WG2. In this case, the monthly cost starts from

1400€ and includes room, food provision as well as care [11].The most attractive alternative for the elderly is 24–hour care in the patient's home. Along with employment of caregiver from Eastern Europe, German customer must reckon with costs from 1300€ to 2000€, depending on the level of knowledge of German language and experience in caregiving.Responsibilities of such caregivermay includehouse keeping, daily hygiene of the patient, preparing meals and all otherforms of both supportand companionship, eg. duringwalksorvisits to the doctorwithout interfering with thepatient's body. Generally, caregiverssecondedby their employersto work in Germanycome for1–3months andlive inthe home of theirpatients,so they couldprovide24–hour care. What is more, the employment of German caregiver is associated with a montly expense from 2700€ to 5000€ [14].

The institutional help in Francecan be divided intotwo types ofcenters: long–term carecenteraimed at peoplerequiring24–hour careandnursinghomes forthe elderlydesigned forseniorsthat do not requireassistancein performing basicactivities.Due to theincrease in the numberof people aged85 and more, the demand for placesis growingin institutionsof the first type.However, due tolower costs, the main aim is toprovide carein the currentplace of residenceof the senior.Moreover, the support given to the caregivers is worth emphasizing – among others, the provision of accommodation in temporary homes for the elderly [2]. Facilities of the first typeare caring forpeople in need ofconstantmedical supervision, who are unableto live independently. Most of patientsof these facilities are more than75 years old – the homes for the elderly are not able to provide them adequate care. In 1996, long–term carefacility disposed approx.80thousandbedsacross the country.One part of thecosts oflong–term careis coveredby the health insurance. Patients pay the other part – the amount is individually determined for each facility by the General Council of the department placed in specific region. Long–term home care for the elderly is provided by the municipality.The costs of the care are covered bysocial insurance, in addition to the costs ofphysiotherapy, medication and doctors' fees, which arepaid by the patient,and thenreimbursedon general principles [18].

In the United Kingdom, the responsibility forlong–term careisheld by thesocial welfare departmentsof local authoritiesand the NationalHealth Service (NHS).Local authoritiesarerequired to developlocalchartersin the field oflong–term care. It contains informationconcerning the competences ofcitizens to their entitled rights to health services, social care and health insurance in case if they need help. Departments ofSocial Welfareareresponsible for identifyingneeds forlong–term carewithin their jurisdictions, as well as setting both priorities andplans. Social workersassessthe needs of specificpeople, while choosing the appropriate care. The assessment should also contain the amount of both income and assets of specific person, which gives an indication to what extent the patient will have to co–finance the long–term care.Medical care providedby the NHSis usuallyfree, except fordental treatment and medication (exceptfor people over60 years old). On the other hand, the fee for the stay in facilities such like nursing homes isdepending onassets of the patient.A person who hasassetsof more than16.000£covers all the costs ofresidential care, while the owner of 10.000£ to 16.000£undertakestobear just a part ofthese costs. These principlesarousemanyprotests, since many olderpeople have beenforced to selltheir homesin order topay forcare costs. The rulesof payment forhome care are established bylocal authorities, taking into account the possibilities ofthe patient.As in manyother countries,the United Kingdommoves away frominstitutional care tothecareinthe recipient's own environment.In the United Kingdom, there is5.7millionworkingcaregivers, while the state politics prefers development of the privatesectorin the area oflong–term care [16; 18].

In Belgium, there are hospitalsspecializingin both palliative careandtreatment of chronic diseases. Peoplewith chronic illnessesmay also benefit from24–hour facilities, as well as both day and home care.For peoplerequiringconstant care who are over 60 years old, there are residential and care homes. There is no state system of home care, thus it is performed by public and private providers. Long–term care is financed by the health insurance with the co–financing of recipients. Insurance companies devote daily fee for stay per one patient, depending on the degree of his independence. Expenditure in excess of this rate is covered by the patient. Nursing home services are also partially paid by the health insurance system. For the chronically ill people, incurringmedical expensesexceeding a certainlimit(in Belgium exists the principleof co–paymentforhealth services), there are providedhealth insurancesubsidies [11; 16; 18].

In Sweden, the responsibility for long–term care of the patient take over the local authorities from the time of his discharge from the hospital.Long–term care is fundedby local taxes, state grants as well as subsidies of the patients.Municipalitiesruncarefacilitiesandhomes for theelderly and disabled people. Half of themtook over the organization ofnursing home care fromthe counties.Municipalities maydecideto entrust theconduct oflong–term care to privateproviders.Currently, only7 percent of the services in this areatook overthe private sector(mostly nursing home care).The basic principleincaring for the elderlyis to allow them tostay at home whowish to do sodespiteillnessand limiteddependency. Home carefor the elderlyis provided with 24–hour access. Among peopleaged 65 and over, only8–9percent use this form ofcare, and a similar percentagestays innursingfacilitiesor athomesfor the elderly. The specific care facility does not employ a doctor in full–time dimension, although the nurse or physiotherapists could contact him if necessary. The services provided by the doctor ought to be paid by the patient, the amount of such service depends on the income of the recipient.The standard of long–term carein Swedenis high,eg. incarefacilities, patients generally havetheir ownroom [16].

Conclusion.Long–term care services have a broad potential which is still evolving, as a result of ongoing changes in the structure of the society. Demographic changes, as well as upcoming problems along with ensuring adequate care of the older part of the society are and will bea challenge for the younger generation, but also for the health care system and social assistance. There is aneed to ensureappropriateservicesover a longer period of timeforthis group of people. In addition todemographicreasons,there areaspectsof social lifestimulatingan increasedneed forcare services. The authoritiesof individual countries are

attempting to try different methods ofhow to dealwith theexpected increase indemand for servicesin the field oflong–term care. This phenomenon will occur only when alongwith the increase inthe number ofolder people whorequire care, we will notice a decrease in the number of peoplein working age. What is more,the phenomenon ofthe decreasing numberof family memberswhile increasingthe number ofsingle–parent familiescausesa decrease inthe number of peopleable toprovideinformalcare.There isa generalagreement on thefact thatpeopledependent onlong–term careprefer it to be provided in either family or nursing home, rather than in institutional form. Tomeet the growing demand, European Union Member States will have towork outthe connection methodof financinghealth carefrom publicand private sources,to ensureeffective coordinationwithin variouslong–term caresystems, as well as to implement the principle ofuniversal access tolong–term care [8].

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Історія довгострокового догляду в Польщі та в країнах Європейського Союзу

Прослідковуєтьсяісторія походження, а також фактори розвитку довгострокового догляду в Польщі та в Європейському Союзі. У польській системі охорони здоров'я довгостроковий догляд визначено як тривалий, безперервний професійний догляд та реабілітація, а також необхідне фармакологічне чи дієтичне лікування, яке здійснюється інституційно (стаціонарно чи вдома) для підтримки здоров'я та безпеки пацієнтів, яким важко самим доглядати за собою. У першій частині представлено демографічну ситуацію, яка є основним чинником, що сприяє виникненню і розвитку довгострокового догляду в Польщі та в світі. У другій частині розглянуто загальні принципи здійснення медичних послуг, що надаються хронічно хворим людям згідно укладених контрактів з Національним фондом охорони здоров'я. Підсумовуючи, стаття завершується резюме.

Ключові слова: *довгостроковий догляд, послуги охорони здоров'я, хронічно хворий пацієнт.*

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История долгосрочного ухода в Польше и в странах Европейского Союза

Прослеживается история происхождения, а также факторы развития долгосрочного ухода в Польше и в Европейском Союзе. В польской системе здравоохранения долгосрочный уход определяется как длительный, непрерывный профессиональный уход и реабилитация, а также необходимое фармакологическое или диетическое лечение, которое осуществляется институционально (стационарно или дома) для поддержания здоровья и безопасности пациентов, которым трудно самим ухаживать за собой. В первой части представлено демографическую ситуацию, которая является основным фактором, способствующим возникновению и развитию долгосрочного ухода в Польше и в мире. Во второй части рассмотрены общие принципы осуществления медицинских услуг хронически больным людям согласно заключенных контрактов с Национальным фондом здравоохранения. Подытоживая, статья завершается резюме.

Ключевые слова: *долгосрочный уход, услуги здравоохранения, хронически больной пациент.*

* * *

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ЕТИЗАЦІЯ ПОЛІТИКИ ЯК ЗАСІБ ВИРІШЕННЯ ПРОТИРІЧ МІЖ ПОЛІТИКОЮ І МОРАЛЛЮ В КОНЦЕПЦІЇ ІСАЇЇ БЕРЛІНА

Проаналізовано сутність етизації політики на прикладі концепції плюралізму цінностей Ісаії Берліна. Розглянуто можливості вирішення протиріч між політикою і мораллю через усвідомлення необхідності робити раціональний вибір між цінностями. Ґрунтуючись на поглядах І.Берліна, робиться висновок про очевидність взаємозалежності політики й моралі, яку необхідно осмислювати для запобігання можливих протиріч. Мислителем