Przegląd Prawa Konstytucyjnego
-----ISSN 2082-1212-----
DOI 10.15804/ppk.2020.05.12
-----No. 5 (57)/2020-----

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The Right to Health Protection and the Actual Access of Elderly People to Medical Services in Poland

Keywords: the right to health care, equal access to healthcare system, old age
Słowa kluczowe: prawo do ochrony zdrowia, równy dostęp, starość

Abstract

The paper considers issues regarding the right to health protection on the basis of the Constitution of the Republic of Poland of 1997 and the actual performance of the health protection system for the elderly. Particular attention is devoted to the constitutional guarantee of equal access to medical services. The purpose of this study is to check to what extent public guarantees of access to medical services are in conflict with the reality of the health protection system for the elderly.

Streszczenie

Prawo do ochrony zdrowia a rzeczywisty dostęp osób w wieku podeszłym do świadczeń medycznych w Polsce

Artykuł obejmuje rozważania dotyczące problematyki związanej z prawem do ochrony zdrowia na gruncie Konstytucji Rzeczypospolitej Polskiej z 1997 roku oraz rzeczywistego funkcjonowania systemu ochrony zdrowia wobec osób w wieku podeszłym. Szczególną uwagę poświęcono konstytucyjnej gwarancji równego dostępu do świadczeń medycznych. Celem niniejszego opracowania jest próba ukazania, w jakim stopniu publiczne

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gwarancje dostępu do świadczeń medycznych stoją w rozbieżności z realiami systemu ochrony zdrowia osób w wieku podeszłym.

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I. The Right to Health Protection in the Constitution of the Republic of Poland

The right to health protection safeguards one of the basic assets of every individual – health. For this reason, the issue of broadly understood health is characterized by, on the one hand, a subjective interpretation of the state of the organism defined as 'health,' and, on the other hand, by objective guarantees to ensure the protection of that health. However, expectations expressed toward this system often are in conflict with the real conditions provided by the healthcare system.

The practical operation of the World Health Organization (WHO) is an important foundation on which are based activities aiming to ensure high health capital of society, including its individual groups, e.g. the elderly. Particular attention should be drawn to the Constitution of the World Health Organization containing a definition of health understood as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (disability)"[2]. The subjective sense of health together with medical premises have become equivalent (and in many cases, subjective reasons dominant) concepts used to determine the state of health, which is a social value[3].

The Polish legal system places a very strong emphasis on the solutions for the right to health protection – the Art. 68 of the Constitution of the Republic of Poland is of fundamental importance for further considerations regarding the right to health protection[4].

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[2] The Constitution of the World Health Organization, Agreement concluded by the Governments represented at the International Health Conference and Protocol on the International Office of Public Hygiene, signed in New York on 22 July 1946 (Dz.U. 1948, No. 61, item 477).

[3] K. Zamorska, *Prawa społeczne jako program przebudowy polityki społecznej*, Wrocław 2010, p. 188.

[4] The Constitution of the Republic of Poland of 2 April 1997 (Dz.U. No. 78, item 483, as amended).

Matter governed by the Art. 68, para. 1 of the Constitution states that "everyone has the right to health protection". The next paragraphs, by contrast, introduce obligations in relation to public authorities, the implementation of which would make the right to health protection to be carried out in practice. The state's obligations thus comprise the following:

- providing citizens with equal access to healthcare services financed from public funds, regardless of their financial situation (Art. 68 (2));
- providing special health care for children, pregnant women, people with disabilities and the elderly (Art. 68 (3));
- combating epidemic diseases and preventing adverse health effects of environmental degradation (Art. 68 (4));
- promoting the development of physical activity, especially among children and adolescents (Art. 68 (5)).

The norms contained in para. from 2 to 3 of Art. 68 of the Constitution create a guarantee system that an individual obtains benefits in the form of: medical services, care for the disabled, children, pregnant women, and the elderly. At the same time, the developed legal system of health protection guarantees reflects a determination to ensure the best possible state of health of individuals, but also the realization of the idea of a welfare state.

The right to health protection, and especially its social aspect expressed in the right to health services financed from public funds, is also confirmed by the position of the Constitutional Tribunal, which in justification to one of its judgments stated that the subject of the right to health protection "is not (…) an abstractly defined (…) state of "health" of the individuals, but the possibility of using a healthcare system, functionally targeted at combating and preventing diseases, injuries and disabilities"[5]. Therefore, the right to health protection requires state authorities to take specific actions directed at the sphere of broadly defined health.

Although the analysis of the constitutional right to health protection allows to draw the conclusion that it is a programme norm that binds the addressees, in this case public authorities, indicating the desired goals, which is the protection of each individual's health, but does not define specific tools

[5] Judgment of the Constitutional Tribunal of 7 January 2004, reference number K 14/03 (OTK ZU 2004, series A, No. 1, item 1).

for achieving these goals. Furthermore, the goals indicated in the programme norm are of a lasting nature and they cannot be achieved, thus removing from public authorities the obligation to act in this area[6].

The right to health protection expressed in terms of the programme norm defines the purpose of the state's health policy, which is to ensure health security by creating such a health protection system that provides citizens with equal access to healthcare services. The problem arising from the indicated norm is the practical dimension of its implementation, i.e. guaranteeing every individual the right to health protection.

II. (In)equality in Terms of Access to Medical Services for the Elderly

The concept of equal access to the healthcare system and, consequently, to medical services is associated with the axiology of social law, which also affects the implementation of the state's health policy itself. The main practical dilemma is to create conditions enabling the implementation of the right to health protection – ensuring the availability of medical services. Such availability, however, depends on several factors.

Equal access to medical services is a fundamental right. The Art. 68, par. 2 of the Constitution imposes an obligation on public authorities to create a healthcare system that, taking into account actual social inequalities, will minimise negative health risks, while providing access opportunities for every citizen, regardless of their financial situation, because: "The principles of using healthcare services … are (…) independent of the scope of participation of individual members of the civil community in creating the resource of public funds constituting the source of their funding. Therefore, like access to benefits, it must be actual equality, not just in formal terms"[7].

However, the practice indicates that the Polish healthcare system is characterized by the growing phenomenon of unequal and age-dependent access to medical services, especially among the elderly.

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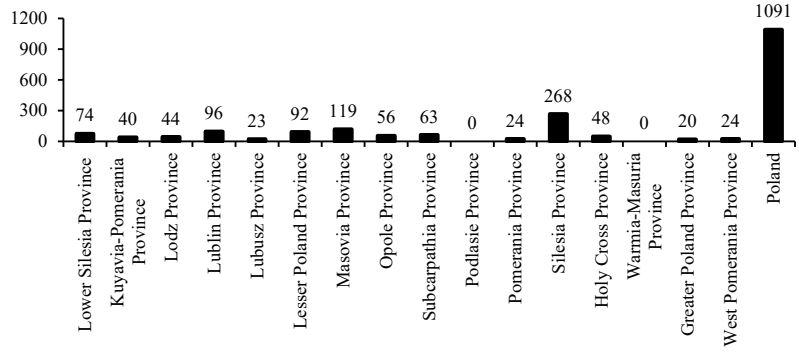
[6] P. Sarnecki, *Normy programowe w Konstytucji i odpowiadające im wolności obywatelskie*, [in:] *Sześć lat Konstytucji Rzeczypospolitej Polskiej. Doświadczenia i inspiracje*, eds. L. Garlicki, A. Szmyt, Warsaw 2003, p. 252.

[7] Judgment of the Constitutional Tribunal of 7 January 2004, reference number K 14/03 (OTK ZU 2004, series A, No. 1, item 1).

Health safety of the elderly is based mainly on geriatric care provided by geriatric physicians, whereas, in practice, specialist care of this type is a missing component of the healthcare system for the elderly in Poland because the high demand for health and care services cannot be met due to the causes of deficit in terms of facilities as well as geriatric staff. The presented phenomenon of specific 'geriatrization of health care' covers the relation of the disproportionately high percentage of elder people who are patients of healthcare facilities to their share in the entire population. It should also be emphasized that the term 'geriatrization' itself does not mean specialist care of geriatric physicians, but only highlights the health need of the type indicated.

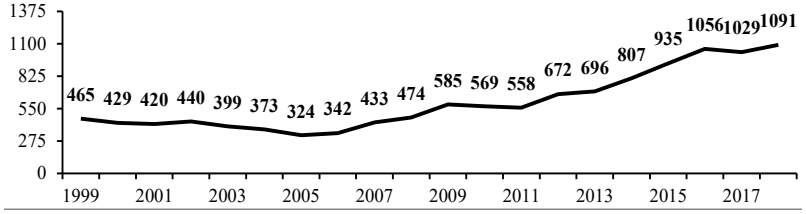
The geriatric care system in Poland has (as of 31.12.2018) 1 091 geriatric beds, which are mainly available in the Silesia Province – 368 beds. There are no beds of this type at all in many provinces, e.g. in the Podlasie or Warmian-Masurian provinces (Figure 1). However, it should be added that in 1999–2014 the number of these beds more than doubled (Figure 2), whereby the index of geriatric beds per 10,000 of total population did not exceed 0.2 (Figure 3), and their occupancy in days amounted to over 234 days (64.4%), which in the case of in-patient treatment translated into 8.4 days of stay (Table 1).

Figure 1. Beds in geriatric wards by provinces in absolute numbers (as of 31.12.2018)



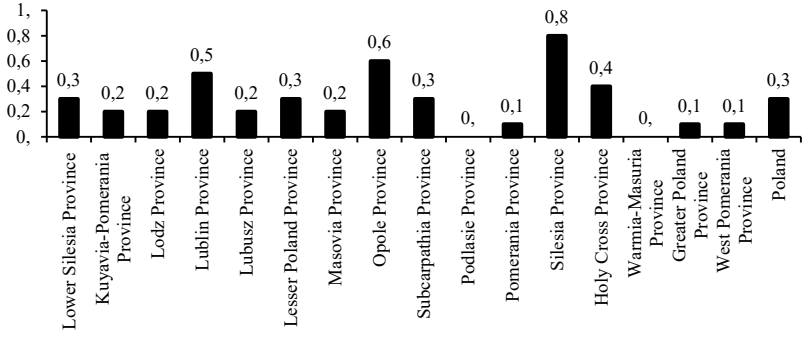
Source: *Biuletyn Statystyczny Ministerstwa Zdrowia 2019 r.*, Warsaw 2019, p. 83, https://www.csioz.gov.pl/projekty/statystyka/biuletyn-statystyczny (30.03.2020).

Figure 2. Beds in geriatric wards by provinces in absolute numbers in 1999–2018



Source: *Biuletyn Statystyczny Ministerstwa Zdrowia z okresu 2000–2019*, https://www.csioz.gov.pl/projekty/statystyka/biuletyn-statystyczny (30.03.2020).

Figure 3. Beds in geriatric wards by provinces per 10,000 population (as of 31 December 2018)



Source: *Biuletyn Statystyczny Ministerstwa Zdrowia 2019 r.*, Warsaw 2019, p. 81, https://www.csioz.gov.pl/projekty/statystyka/biuletyn-statystyczny (30.03.2020).

Table 1. Selected indicators of geriatric ward activities in Poland in 2018

Annual in-patient treatment				Day time treatment in in-patient wards, absolute number	Bed occupancy	
absolute number	per one bed	person-days of treatment in thous.	average patient stay in days		days	%
30 070	27.8	253.6	8.4	951	234.4	64.4

Source: *Biuletyn Statystyczny Ministerstwa Zdrowia 2019 r.*, Warsaw 2019, p. 79, https://www.csioz.gov.pl/projekty/statystyka/biuletyn-statystyczny (30.03.2020).

The proper operation of the geriatric care system requires an appropriate number of geriatricians in relation to the needs and structure of the population, while in any of the fields of medicine in Poland there can be no relevant indicators that would include the number of professionally active medical specialists in relation to the specified categories. The number of specialists in the field of geriatrics practicing the profession in 2014 was 321 people, and during the course of their education there were only 119 physicians[8], and currently their number is 500, with 489 practicing this profession[9]. The reasons for this situation should invariably be seen, *inter alia*, in the absence of systemic solutions to improve the conditions of training medical staff in the field of geriatrics, the small number of hospital geriatric beds which negatively conditions educational opportunities. Furthermore, the inadequate valuation of geriatric procedures effectively prevents the expansion of the pool of geriatric beds available. Currently, 47 bodies with 283 training places have the right to conduct specialised training in geriatrics. It should also be emphasized that despite the fact that geriatrics has become a priority field of medicine[10], this has not changed the structure of medical specialists, i.e. we still observe a significant deficit of geriatricians. Indicators covering the number of geriatricians per 10,000 inhabitants in Poland (0.16) differ significantly from comparable indicators in the Member States of the European Union, both in so-called the 'old Union,' as in, for example, the Czech Republic or Slovakia (Figure 4).

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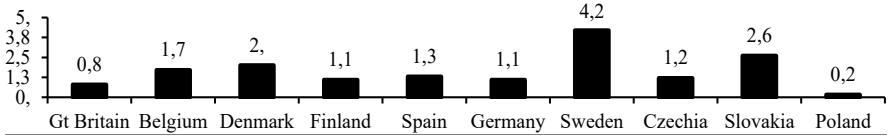
[8] Najwyższa Izba Kontroli, Departament Zdrowia, *Opieka medyczna nad osobami w wieku podeszłym, Informacja o wynikach kontroli*, KZD–4101–003/2014, No. 2/2015/P/14/062/KZD, Warsaw 2015, p. 8.

[9] Naczelna Izba Lekarska w Warszawie, *Zestawienie liczbowe lekarzy i lekarzy dentystów wg dziedziny i stopnia specjalizacji z uwzględnieniem podziału na lekarzy wykonujących i nie wykonujących zawodu*, https://nil.org.pl/rejestry/centralny-rejestr-lekarzy/informacje-statystyczne (30.03.2020).

[10] Currently, it is based on the Regulation of the Minister of Health of 6 September 2018 on determining priority areas of medicine (Dz.U. item 1738), previously based on the Regulation of the Minister of Health of 20 December 2012 on determining priority areas medicine (Dz.U. item 1489); Regulation of the Minister of Health of May 21, 2009 regarding priority areas of medicine (Dz.U. No. 84, item 709); and Regulation of the Minister of Health of December 22, 2003 regarding priority areas of medicine (Dz.U. 2004, No. 1, item 7).

Figure 4. Number of medical specialists in the field of geriatrics per 10,000 inhabitants aged 65 and more in selected European countries

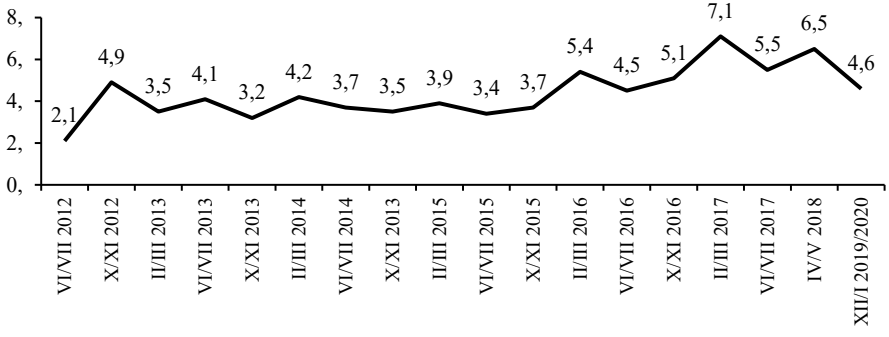


Source: M. Majewska, M. Michna, M. Ostojska, A. Ostojska-Inglot, A. Żygas, J. Gogała, M. Jesionowski, P. Więch, *Polityka senioralna w Polsce w kontekście zmian demograficznych. Analiza problemu*, [in:] *Ocena jakości usług publicznych*, ed. A. Jaroń, Warsaw 2015, p. 106.

An important element indicating the difficulties in ensuring the availability of geriatric services is the average waiting time for guaranteed geriatric health services, which at the turn of 2019 and 2020 amounted to almost 5 months (Figure 5). The elderly waited the longest for a stay in a care and treatment institution (almost a year), an implantation of deep brain stimulation (9.3 months) and a stay in a nursing and care center (8.8 months). A visit to a geriatrician was preceded by an almost two-week wait (Figure 6).

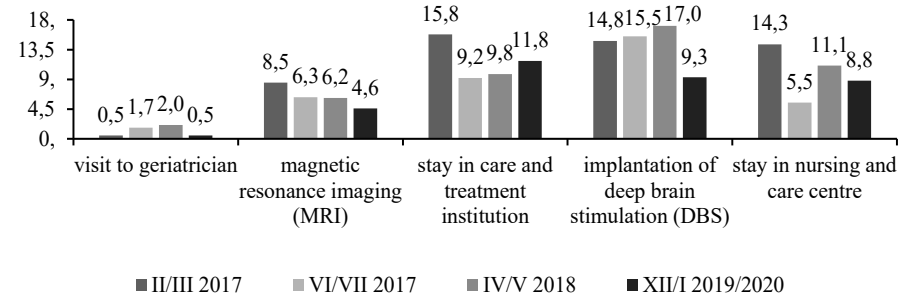
Another problem worth addressing in terms of access to the healthcare system of the elderly is the provision of care services in the place of resi-

Figure 5. Average waiting time for guaranteed geriatric health services in Poland in 2012–2020 (in months)



Source: Barometr WHC, *Raport na temat zmian w dostępności do gwarantowanych świadczeń zdrowotnych w Polsce nr 19/15/02/2019. Stan na grudzień/styczeń 2019/2020 r.*, http://www.korektorzdrowia.pl/barometr/geriatria (30.03.2020).

Figure 6. Average waiting time for selected guaranteed health services in geriatrics in Poland (in months)



Source: Barometr WHC, *Raport na temat zmian w dostępności do gwarantowanych świadczeń zdrowotnych w Polsce nr 19/15/02/2019. Stan na grudzień/styczeń 2019/2020 r.,* http://www.korektorzdrowia.pl/barometr/geriatria (30.03.2020).

dence. Although these services are the element of support for the elderly, by helping to meet daily life needs or providing contact with the environment, they also include hygienic care and care recommended by a physician. Therefore, home care services are a more favorable than staying in 24-hour nursing homes.

The provision of care services at the place of residence is one of the municipalities' own tasks that are compulsory, whereas 19.1% of municipalities in Poland do not provide this type of services[11]. The problem of the lack of access to care services is a derivative of the lack of diagnosis regarding the situation and needs of elder people in municipalities. Most social welfare centers do not have the knowledge of current and future need for care services. Failure to act to gain broader knowledge about the elderly in this area may result in municipalities not being prepared for an increase in demand for care services. This is particularly irresponsible in a situation of dynamic demographic change. In 2016, the percentage of the elderly covered by care services in the country amounted to slightly over 1% of the population over 60 years of age and increased slightly each year, from 0.99% in 2014 to 1.04% in 2016. In the

[11] Najwyższa Izba Kontroli, Departament Pracy, Spraw Społecznych i Rodziny, *Usługi opiekuńcze świadczone osobom starszym w miejscu zamieszkania*, KPS.430.006.2017, No. 31/2018/P/17/043/KPS, Warsaw 2018, p. 10.

analyzed period, the number of elderly people in the country increased by almost 6%, from 8.5 million in 2014 to almost 9.1 million in 2016[12].

The situation of elderly people in the field of care services was evenly offset by the introduction of the '75+ Care' programme by the Ministry of Family of Labor and Social Policy in 2018, enabling financial support for municipalities in providing care services for the elderly in the place of residence. Smaller municipalities up to 20,000 residents, and currently up to 60,000 residents, could originally use 50% of co-financing from the state budget for the provision of care services and specialist care services, if a given municipality carries out the provision itself[13].

As a result of the implementation of the '75+ Care' programme, the number of municipalities providing care services increased by 3% (from 2,083 municipalities in 2017 to 2,142 municipalities in 2018). In 2018, a total of 394 municipalities participated in the '75+ Care' programme, of which 18 municipalities had not previously provided care services (approx. 5%)[14].

III. Conclusions

The right to health protection is one of the most important rights in the group of economic, social and cultural rights. Its constitutional guarantee contributes to the realization of both the private and public good, and the public authorities themselves are obliged to ensure universal and equal access to the healthcare system. Meanwhile, social reality indicates that in the field of health protection for the elderly in Poland, this system does not operate properly. The availability of geriatric care benefits and services is inadequate, and procedures for dealing with the elderly which would be universal, comprehensive and unified do not exist. The Gerontology Team established by the Min-

[12] Ibidem, p. 37.

[13] Ministerstwo Rodziny Pracy i Polityki Społecznej, *Program „Opieka 75+" na 2019 rok*, Warsaw 2019, https://www.gov.pl/web/rodzina/program-opieka-75 (30.03.2020).

[14] Ministerstwo Rodziny Pracy i Polityki Społecznej, *Informacja o sytuacji osób starszych w Polsce w 2018 roku*, Warsaw 2019, p. 84, https://webcache.googleusercontent.com/search?q=cache:RjTizlIpWjIJ:https://www.gov.pl/web/rodzina/informacja-o-sytuacji-osob-starszych-w-polsce-za-rok-2018+&cd=1&hl=pl&ct=clnk&gl=pl (30.03.2020).

ister of Health prepared '*Standards of conduct in geriatric care*'[15] which have not been implemented in the form of a regulation, and their impact on the geriatric care system is limited.

The number of geriatricians and geriatric wards prepared to care for the elderly is also insufficient. This condition is determined by, *inter alia*, a system of accounting for medical services by the National Health Fund in the form of Homogeneous Patient Groups (similar to the Diagnostic Related Groups system), which makes it impossible to settle the cost of treating a patient with multiple diseases. Therefore, there is a contradiction between the standards of medical procedure and economic efficiency because the provision of medical procedures according with the indicated standards leads to financial losses.

A necessary requirement is the development of an integrated system of activities that will harmonize the objectives in the sphere of organization of the healthcare system of elderly people (including standardization of care, quality assessment, development of financing procedures in the field of prevention of aging, rehabilitation, geriatric and long-term care).

The acceleration of the demographic aging process in Poland requires the implementation of adaptation measures, especially in the sphere of the healthcare system, as securing the growing health needs of the elderly will require both a larger number of geriatricians and specialists in geriatric services.

Literature

Bień B., Błędowski P., Broczek K., Derejczyk J., Grodzicki T., Kędziora-Kornatowska K., Kokoszka-Paszkot J., Przygucka-Gawlik M., Klich-Rączka A., Kostka T., Machaj Z., Szczerbińska K., Wieczorowska-Tobis K., Żak M., *Standardy postępowania w opiece geriatrycznej. Stanowisko Polskiego Towarzystwa Gerontologicznego opracowane przez ekspertów Zespołu ds. Gerontologii przy Ministrze Zdrowia*, "Gerontologia Polska" 2013, vol. 21, No. 2.

[15] B. Bień, P. Błędowski, K. Broczek, J. Derejczyk, T. Grodzicki, K. Kędziora-Kornatowska, J. Kokoszka-Paszkot, M. Przygucka-Gawlik, A. Klich-Rączka, T. Kostka, Z. Machaj, K. Szczerbińska, K. Wieczorowska-Tobis, M. Żak, *Standardy postępowania w opiece geriatrycznej. Stanowisko Polskiego Towarzystwa Gerontologicznego opracowane przez ekspertów Zespołu ds. Gerontologii przy Ministrze Zdrowia*, "Gerontologia Polska" 2013, vol. 21, No. 2, pp. 33–47.

Majewska M., Michna M., Ostojska M., Ostojska-Inglot A., Żygas A., Gogała J., Jesionowski M., Więch P., *Polityka senioralna w Polsce w kontekście zmian demograficznych. Analiza problemu*, [in:] *Ocena jakości usług publicznych*, ed. A. Jaroń, Warsaw 2015.

Sarnecki P., *Normy programowe w Konstytucji i odpowiadające im wolności obywatelskie*, [in:] *Sześć lat Konstytucji Rzeczypospolitej Polskiej. Doświadczenia i inspiracje*, eds. L. Garlicki, A. Szmyt, Warsaw 2003.

Zamorska K., *Prawa społeczne jako program przebudowy polityki społecznej*, Wrocław 2010.