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Realizing the Right to Special Geriatric Care

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Abstract

The demographic trend of an aging population places increasing demands on healthcare systems worldwide, which necessitates adapting public health services to the needs of older adults. In Poland, current regulations lack provisions specifically tailored to the elderly. Recent legal reforms by public authorities represent an attempt to address this gap by establishing a network of entities providing special geriatric care. This article analyzes these regulatory frameworks and assesses the feasibility of their implementation.

Keywords: geriatric care, healthcare system, local government responsibilities

1. Introduction

The global trend of population aging is reshaping the landscape of healthcare. According to the World Health Organization, the number of individuals over 60 is projected to reach approximately 2.2 billion (World Health Organization, n.d.). As demographics shift, public administration, especially within healthcare, must adapt to these changing demands (Gorbatov, 2023). In Poland, the Constitution enshrines the right to healthcare for all citizens, as specified in Article 68, irrespective of their financial status (Konstytucja Rzeczpospolitej Polskiej z dnia 2 kwietnia 1997 r. [Constitution of the Republic of Poland, April 2, 1997], art. 68). This provision includes a particular commitment to elderly citizens, who, alongside children, pregnant women, and disabled individuals, are identified as priority groups. Poland's universal healthcare system, managed through the National Health Fund (NFZ), implements this constitutional guarantee.

The recently introduced Act on Special Geriatric Care (Ustawa o szczególnej opiece geriatrycznej z dnia 17 sierpnia 2023 [Act on Special Geriatric Care, August 17, 2023])

(hereafter referred to as "the Act"), which is central to this analysis, represents the first national legislation to mandate county-level governments to deliver a specific healthcare service. This legislative step is noteworthy, as it marks an unprecedented delegation of responsibility to local governments in the field of healthcare, alongside detailed specifications of these duties. The Act targets geriatric care for individuals over 75, a demographic with complex and often costly healthcare needs that also involve social, economic, and psychological considerations (Szwałkiewicz & Kaussen, 2006).

Additionally, the Act represents the first comprehensive attempt to define the government's role in addressing the needs of an aging population. By comparison, previous legislation, such as the Seniors Act, merely requires periodic monitoring and reporting on the status of older adults, but falls short of a comprehensive strategy (Ustawa z dnia 11 września 2014 r. o osobach starszych [Act on Older Persons, September 11, 2014]).

To better understand the significance of the Act, it is helpful to examine an excerpt from its justification: "The primary objective of this legislative initiative by the President of the Republic of Poland is to ensure special geriatric care for individuals over the age of 75, thereby promoting healthy aging. The proposed measures also lay the groundwork for transforming geriatric care toward a community-based model, in which medical services are accessible near the senior's place of residence" (Uzasadnienie do ustawy o szczególnej opiece geriatrycznej [Justification for the Act on Special Geriatric Care], June 13, 2023).

As indicated, the Act is widely viewed as a starting point and in its current form, it will most likely not reach full implementation. This cautious outlook is shared by public officials commenting on the bill draft.[1]

2. Normative Scope of the Act on Special Geriatric Care

The Act in question is a regulatory measure that defines the responsibilities of public authorities and healthcare providers in administering "special geriatric care." While the Act does not provide a direct definition of this term, its scope and the entitlements associated with it are thoroughly detailed in Polish law. The right to special geriatric care is part of the public health protection rights guaranteed by the Polish Constitution, which positions elderly individuals as a distinct and privileged group, meaning this right should be implemented with particular focus and priority. Comparable in significance is the right to long-term care, which holds distinct importance for senior citizens (Berezowski & Guzak, 2013). In line with the regulation, special geriatric care is

1 Deputy Minister of Health Wojciech Konieczny criticized the act as "ill-conceived and unrealistic," citing its disconnection from the actual conditions for implementation, such as the severe shortage of medical staff, which cannot be addressed in a short time. The minister also opposed dividing eligibility for statutory benefits into groups of those below and above 75 years of age. He noted numerous errors in the act, suggesting it requires radical changes, which may prove difficult due to the political power dynamics (Pietrzak, 2024).

to be provided through geriatric hospital wards, 75+ Centers (hereinafter referred to as Centers), and primary healthcare facilities. Particular attention is given to establishing geriatric wards at the appropriate tier of medical care, as well as to the planned number of beds and wards required to meet regional needs across all voivodeships, as outlined in Article 10. The timeframe for this task, along with establishing the Centers, is set at five years from the Act's enactment, per Article 55. The Act meticulously regulates the duties of the Centers, including the organizational structure of such units. It also assigns new mandatory responsibilities to county governments and, indirectly, to other local government bodies operating hospitals at the required level of medical service provision, to establish, expand, or adjust geriatric wards in line with these regulations.

3. Demographic and Legal Context for Implementing Special Geriatric Care

As highlighted in the legislative justification, individuals over 75 currently comprise more than 7% of the population in Poland (based on 2021 data) and are projected to make up approximately 11% within the next five years. This age bracket, often referred to as "advanced age," had previously not been recognized as a distinct demographic in healthcare legislation. Presently, the only entitlement specific to this age group is a care supplement paid out by ZUS (the Polish Social Insurance Institution) to those over 75, as part of their pension benefits. Eligibility for this supplement, as stipulated in Article 75, Section 1 of the Act on Pensions and Annuities from the Social Insurance Fund, is contingent upon reaching a certain age or having a certified disability status (Ustawa z dnia 17 grudnia 1998 r. o emeryturach i rentach z Funduszu Ubezpieczeń Społecznych [Act on Pensions and Annuities from the Social Insurance Fund, December 17, 1998]). The legislature has set 75 as the statistical threshold for "advanced age," while the WHO describes this period as "late old age."

While some may argue this threshold is arbitrary, as it excludes those who may need these services before reaching 75, the age criterion is consistent with widely recognized categorizations and is thus not uniquely subject to criticism. According to the WHO, the span from 75 to 90 years is considered to represent advanced age. This period of life poses heightened demands on special healthcare and support services. For example, outpatient consultations for individuals over 65 accounted for a full third of all consultations provided through Specialist Outpatient Care (AOS) in 2022, according to GUS data (Główny Urząd Statystyczny [Statistics Poland], 2022, p. 43). Similarly, over a third of consultations in Primary Healthcare (POZ) were also for this age group, which indicates that the demand for both specialist and basic medical services for people over 65 outpaces that of other population groups. Such findings make a strong case for age-based entitlements to healthcare services. However, it may be worth considering

the potential benefits of granting access to special geriatric care before the age of 75, depending on health status or specific care needs, especially as current legislation defines older adults as individuals aged 60 and over.

Unfortunately, efforts to ensure equal access to guaranteed healthcare services encounter numerous implementation hurdles due to limited availability of such services. These limitations arise not only from a low number of providers and limited funding in the National Health Fund (NFZ) budget but also from a critical shortage of medical staff. Additionally, the geographic concentration of healthcare facilities is uneven, which further complicates accessibility. The rising demand for healthcare services is spurred by a combination of greater health needs and advances in medical technology. According to a report from the Watch Health Care Foundation, the average waiting time for services reached 3.5 months in 2023—an alarmingly long delay given the often fragile health of older adults, who generally have limited ability to seek private, full-fee healthcare options. Waiting periods for specific services, such as physical therapy (average of 7 months) or orthopedics and musculoskeletal trauma care (8.3 months), are particularly troubling considering the acute needs of older adults in these fields (Jackowska, 2023). Expanding the range of available healthcare services is essential to accommodate the changing demographic structure and evolving public health needs. The urgency of this issue was brought to light during the COVID-19 pandemic, which exposed grave weaknesses in the preparedness of virtually all healthcare systems to handle similar crises that will almost certainly arise in the future (Bazyar, 2021).

4. Right to Special Geriatric Care

The right to special geriatric care grants access to publicly funded healthcare services as stipulated in Article 2 of the Act on Publicly Funded Healthcare Services (Ustawa z dnia 27 sierpnia 2004 r. o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych [Act on Publicly Funded Healthcare Services, August 27, 2004]) (hereafter, the Public Healthcare Services Act). Under this legislation, these services are available primarily to individuals covered by universal, mandatory, or voluntary health insurance. Additionally, under Article 5, point 36 of the Public Healthcare Services Act, special healthcare services are classified as special care.

Eligibility for special geriatric care is granted through a referral, as outlined in Article 36 of the Act. This referral must be issued by a licensed physician with authority under the health insurance scheme. Such providers include:

- primary care physicians,
- physicians offering specialist outpatient care in geriatrics, and
- physicians working in a geriatric ward or, in the absence of such a ward, another hospital unit.

The designated physicians, after conducting a preliminary geriatric assessment, refer eligible individuals to the appropriate local center based on their place of residence. The Act differentiates between two types of assessments in this context: preliminary and comprehensive. Primary care physicians are responsible for conducting the preliminary assessment, after which the patient is assigned to a suitable category on the VES-13[2] scale and referred to the center with this score. Other authorized physicians perform a comprehensive geriatric assessment before issuing a referral. Under Article 1, the Act grants individuals aged 75 and older distinct rights to special geriatric care. According to Article 3, this care includes:

- Preserving maximum functional capacity and independence,
- Providing healthcare services as defined in the Act,
- Conducting a full geriatric evaluation,
- Developing and implementing a personalized therapeutic plan,
- Offering medication reconciliation,
- Implementing preventive health measures and health promotion activities to reduce disability and dependence risks,
- Providing health education to patients and their caregivers, and
- Offering psychological support.

This statutory list is exhaustive, meaning it clearly defines the entitlements for seniors aged 75 and over, along with the corresponding obligations for healthcare providers delivering special geriatric care.

One notable provision is the right to a comprehensive geriatric assessment. The Act defines this assessment as a multidimensional and interdisciplinary diagnostic approach designed to identify health and caregiving issues, optimize treatment, facilitate healthcare planning, and improve both functional abilities and quality of life. This thorough definition underscores a progressive approach in establishing patient rights, as it guides patients and healthcare providers alike and prioritizes accurate and holistic diagnosis prior to initiating medical interventions.

The list outlined in Article 20, Section 2 of the Act specifies the services included within healthcare provisions, which encompass:

- Geriatric services provided by physicians and nurses,
- Physical therapy services provided by physiotherapists,
- Psychiatric support from psychologists,
- Nutritional counseling,

2 According to the dictionary of the Act, the VES-13 scale (*Vulnerable Elders Survey 13*) is a questionnaire-based assessment that includes self-evaluation of health status and daily activities, helping identify individuals at increased risk of significant deterioration in health and functional fitness.

- Occupational therapy, and
- Health education.

The comprehensive geriatric assessment forms the cornerstone for developing an individualized therapeutic plan, as mandated by Article 38 of the Act. This plan includes:

- Documentation of the patient's primary health and social issues,
- A clear outline of therapeutic goals,
- Specification of therapeutic methods,
- Identifying appropriate healthcare services,
- Determination of the patient's caregiving and support needs, and
- A timeline and schedule for implementing the personalized care plan.

The services guaranteed by the Act to eligible individuals go beyond the standard obligations of the healthcare system. Within the framework of the individualized care plan, which guides both therapeutic and support interventions, the assessment of care and support needs includes an evaluation by the relevant social welfare or social service center to ascertain eligibility for social assistance benefits or services. Furthermore, as stipulated in Article 40 of the Act, if the evaluation of health and living conditions reveals that a patient may require social services—such as general or special caregiving, or even placement in a residential care facility—the provider of geriatric care services is obligated to notify the relevant social welfare center or social service center of the need to evaluate these requirements.

Beyond coordinated healthcare services, patients in need of special geriatric care benefit from health education and psychological support at the Center. Health education, delivered by a health educator in a range of formats, is also available to caregivers of geriatric patients. Under Article 29 of the Act, the goal of health education is to raise awareness among patients and their caregivers concerning social and environmental factors that influence health. The program also includes evaluating the patient's capability to independently manage their health, monitor disease progression, mitigate its effects, develop coping strategies, increase physical activity, and encourage engagement in social life. Since outpatient geriatric care services are provided at the Center, transportation is necessary for patients to access these services. The provisions entitle them to daily transportation to and from the day-care facility. However, as per Article 24, Section 2 of the Act, this right to transportation is restricted to individuals attending the geriatric day-care center.

The right to access the day-care center is time-limited, as stipulated in Article 24, Section 4 of the Act, and allows for a maximum of 12 weeks within a 12-month period from the start date of geriatric day-care services. Individuals who cannot be transported to the day-care center due to their health conditions may receive services at home under Article 25. These home-based services are provided by a geriatric home care team. Although

the specifics of these home services are not explicitly defined, it is generally understood that they should mirror the offerings available at the geriatric day-care center. Naturally, due to the logistical challenges of delivering care at home and the need for medical staff to travel, the scope and intensity of these services may be significantly reduced.

An individualized care plan should account for the differences between day-care and home-based geriatric services. It is worth noting that the right to special geriatric care, whether provided at day-care centers or through home-based services, is consistent with the recommendations of the Polsenior 2 project. This project emphasizes the need to "expand the network of day-care facilities and ensure access (in terms of affordability and transportation) for older adults" as well as to "identify and swiftly reach individuals requiring support through improved coordination and information flow among social and healthcare services, in conjunction with local government entities" (Błędowski et al., 2022, p. 48).

In addition to receiving care at the Center, the right to special geriatric care may also be realized in a geriatric hospital unit. From the date of the Act's implementation, hospital-based geriatric services should concentrate on meeting the objectives specified in Article 3, Section 2 of the Act, particularly those addressing the right to special geriatric care. Given the phased process of establishing the network of Centers, implementing this component of the Act should be given priority. This strategy allows patients in geriatric hospital units to exercise their right to special geriatric care in a hospital setting. The establishment and operation of these Centers appear to be a well-conceived solution, akin to models adopted in other countries. For instance, in the United States, studies have demonstrated that community-based home care is not only more effective but also more cost-efficient than long-term institutional care, which remains one of the most common forms of support for older adults (Agency for Healthcare Research and Quality, 2012).

5. Entities Providing Geriatric Care Services

The Act in question not only introduced new entitlements within the public healthcare system but also established a new type of service provider: the Center. Under Article 17 of the Act, this entity can be a healthcare facility set up in accordance with the Healthcare Activity Act. Notably, the Act does not impose any specific organizational structure for the Center, which means that, in line with Article 4, Section 1 of the Healthcare Activity Act, the Center can be operated by an entrepreneur as defined by the Act on Freedom of Business Activity (Ustawa z dnia 2 lipca 2004 r. o swobodzie działalności gospodarczej [Act on Freedom of Business Activity, July 2, 2004) or by an independent public healthcare facility. Additionally, a district may choose to establish the Center within an existing healthcare entity.

The Act also permits districts to enter into agreements with neighboring districts, which would allow them to carry out special geriatric care tasks through an entity created or separated by the neighboring district. The Act does not prohibit the establishment of the Center within completely independent entities, such as regional hospitals or private healthcare providers offering paid services outside of the public health insurance system. However, the privatization of services has not been envisaged in the provisions of the Act.

The Center's area of operation is initially the district that established or separated it. This area can be expanded to include any district that has signed an agreement to transfer the statutory tasks. Given the scope of these responsibilities and the underestimated costs presented in the justification for the Act, it is anticipated that more districts will be willing to sign agreements to delegate tasks rather than directly assume them. Patient transport constitutes a significant cost, albeit one that is difficult to accurately estimate. As noted earlier, the services provided by the Center are ambulatory, which means that patients will require daily transportation to and from their homes. In larger districts, transportation costs could become particularly burdensome, especially since patients may live in various parts of the district. If tasks are transferred to a neighboring district, this cost could be further amplified by the need for transport across an even broader area.

The structure and organization of the Center are thoroughly outlined in Article 22 of the Act, which stipulates that the Center will consist of:

- A consultation clinic – providing specialist consultations and nursing services,
- A geriatric day care center – offering temporary, daytime care,
- A home geriatric care team – delivering healthcare services to patients who cannot receive them in an ambulatory setting due to their health condition,
- A team of geriatric care coordinators,
- A team of health educators, and
- An information and reception desk – offering information on the scope and rules of the services offered by the Center.

The Center, in its provision of healthcare services, is authorized to obtain health information about patients from other medical institutions as well as from social assistance organizations. The goal of this practice is to ensure comprehensive care for patients whose health is influenced by a range of factors, including their living conditions. Moreover, these individuals often require services from multiple healthcare facilities due to their complex health needs. However, these services are frequently provided independently of one another, without a holistic view of the elderly patient's overall health, and tend to focus solely on specific medical issues. In practice, the most demanding aspect of the Center's operations is likely to be managing the daily care facility. Coordinating individualized therapeutic plans for patients residing in different locations will be demanding. Additionally, the logistics of transporting eligible individuals from various parts of the district to the facility, and back, will be both complex and costly.

Article 24, Section 4 of the Act empowers the Minister of Health to establish regulations that define the operational framework and minimum scope of services provided by the geriatric day care center. These regulations are intended to guarantee proper support for patients and fulfil the objectives of special geriatric care. However, the decree has yet to be issued, and it is uncertain whether it will be, particularly in light of proposed amendments to the bill. According to the justification provided for the Act, the anticipated decree would specify a minimum set of services to be delivered by the center. These include daily care for patients, support and guidance for caregivers regarding the organization of care and treatment, meals on the days care services are provided, transportation of patients to and from the day care center, assistance from a geriatric care coordinator, and educational support from a health educator tailored to the needs of both the patients and their caregivers.

It is worth noting that, under to Article 51, Section 4 of the Social Assistance Act (Ustawa z dnia 12 marca 2014 r. o pomocy społecznej [Social Assistance Act, March 12, 2014]), it is currently possible to operate social assistance facilities for day care. These facilities can provide both general and specialist care services to individuals who, due to age, illness, or disability, require partial assistance to meet their essential daily needs. However, the scope of services provided by day care centers predominantly revolves around caregiving and catering to basic living needs.

In contrast, as specified in the discussed legislation, the activities of the Center are distinctly geared toward health protection. Given that the Center functions as a medical entity, it must adhere to the stipulations outlined in the Medical Activity Act. This entails obligations such as mandatory liability and medical event insurance (as detailed in Article 25 of the Medical Activity Act), compliance with general spatial, sanitary, and installation standards (as stated in Article 22 of the Medical Activity Act), and the requirement that health services be delivered solely by certified medical professionals who meet the qualifications set out in separate regulations (Article 17, Point 3 of the Medical Activity Act).

6. Center Personnel

The core team within the medical facility will consist of healthcare professionals, including doctors, nurses, physiotherapists, pharmacists, and dietitians. Health educators, whose qualifications are specifically defined by law, will also comprise medical staff. One of the most pressing staffing challenges will be recruiting geriatricians, whose expertise is indispensable to the Center's work. The legislative justification notes that the current number of practicing geriatricians in Poland is alarmingly low at only 562 (Uzasadnienie do ustawy o szczególnej opiece geriatrycznej [Justification for the Act on Special Geriatric Care], 2023). To meet healthcare system demands, the PolSenior 2 project recommends

that Poland should have 3,000 practicing geriatricians, with a projected need of approximately 4,500 in the near future (Błędowski et al., 2022).

It is worth noting that the Act establishes a new medical profession, namely that of a medical educator. According to Article 29 of the Act, the responsibilities of a medical educator include:

- Identifying educational needs,
- Planning the patient's health education,
- Raising patient awareness of social and environmental factors affecting health,
- Enhancing knowledge and skills related to navigating the healthcare system and understanding its functioning, and
- Evaluating the patient's independence in health monitoring and self-assessment, as well as their autonomy and engagement in physical and social activities.

Under Article 28 of the Act, a health educator must fulfill two main requirements: holding a higher education degree in medical or health sciences and completing training in health promotion and health education. The Act also stipulates that this training should expand and update professional knowledge and competencies in health promotion and health education, specifically tailored to the needs of geriatric patients. The curriculum for this mandatory training will be developed by the Medical Center for Postgraduate Education, in collaboration with experts who have substantial professional and academic experience in geriatrics. The final training program must receive approval from the Minister of Health.

Another position within the Center is that of the geriatric care coordinator. The educational requirements for this role are specified in Article 26 of the Act. The formal qualification includes holding a higher education degree in medical sciences or health sciences or completing postgraduate studies in fields such as gerontology, geriatrics, elder care, or geriatric care. According to Article 27 of the Act, the exclusive responsibilities of the coordinator include:

- Providing patients of the center and their caregivers with information on the organization of therapeutic procedures,
- Participating in the development of individualized care plans,
- Overseeing the implementation of these plans,
- Ensuring collaboration among entities and individuals involved in therapeutic procedures,
- Supporting center patients at all stages of therapeutic procedures, and
- Collaborating with entities providing medical services, social welfare units, and social service centers in matters related to the center's patients.

The clearly defined duties of the coordinator and the rigorous qualifications required for the role accentuate the importance of coordination in delivering special geriatric care.

It is reasonable to agree with the legislature's view that effective geriatric services must be planned and coordinated. Only through such a structured approach can the implementation of new service provisions achieve the desired outcomes. Elderly individuals often encounter barriers when trying to navigate and fully benefit from the public health system independently, which draws attention to the importance of the active role of the coordinator as mandated by the Act.

- After completing an individual plan, the coordinator should conduct a summary conversation to review its implementation.
- If a patient's needs that could be met by social welfare services are identified, the coordinator must, with the patient's consent, inform the Social Services Center about the necessity of assessing those needs.
- The coordinator should ensure that the patient receives an information card containing recommendations for post-therapy procedures upon the conclusion of the therapeutic plan.

Finally, it is important to discuss the qualifications and scope of competencies for the Center's Director—or, more accurately, the absence of specific regulations. The Act mentions the Director of the Center only briefly in Article 31, which sets forth their duty to provide information. This implies that the regulations from the Act on Medical Activity (Ustawa z dnia 15 kwietnia 2011 r. o działalności leczniczej [Act on Medical Activity, April 15, 2011] apply in this context. Article 46 of the Act specifies the requirements for the director of a medical entity that is not a business enterprise, which include:

- A higher education degree,
- Knowledge and experience that guarantee the proper execution of the director's duties,
- A minimum of five years of experience in a managerial position, or completion of postgraduate studies in management and at least three years of work experience, and
- No final conviction for an intentional criminal offense.

These requirements can be considered the minimum standard. The employing entity may establish additional criteria, such as familiarity with the field of geriatrics. Beyond the medical staff, the Center should also employ an occupational therapist and a psychologist. The Act does not regulate the competencies for these professions. However, Article 20 of the Act lists the range of health services provided by the Center, which includes psychiatric care services performed by psychologists and occupational therapy.

7. Competencies of Public Administration Authorities in Implementing Special Geriatric Care

Under Article 5 of the discussed Act, the responsibilities for implementing special geriatric care are directly assigned to the Minister of Health, the voivode, and the county government. The chief and most significant task of the voivode involves drafting the regional plan that governs the operation of special geriatric care facilities. As stipulated in Article 9 of the Act, the regional plan must include:

- The placement of hospital geriatric wards within the voivodeship and the determination of the minimum number of beds in these wards,
- The location and service areas of individual centers, and
- The collaboration between each hospital geriatric ward and no more than three centers within the voivodeship.

The goal of the regional plan is to strategically position geriatric wards to ensure adequate access to geriatric care for all eligible residents within the voivodeship. Hospital geriatric wards may be established in national-level hospitals or those classified as level II or III referral centers. In exceptional situations, wards can also be located in level I referral hospitals or other medical facilities that have contracts with the National Health Fund (NFZ). The mandated minimum for hospital geriatric wards is 50 beds per 100,000 residents aged 60 and older, as of December 31 of the preceding year.

It is noteworthy that, when determining the number of beds, the focus is on individuals aged 60 and above, as opposed to the age of 75 and older considered for Centers. For Centers, the population range used to establish their service area is between 6,000 and 12,000 county residents aged 75 and above. This implies that, under the provisions of the Act, counties with larger numbers of eligible residents should have more than one Center. If the population of eligible residents in a county falls below the minimum threshold of 6,000, Article 19 advises that the county should pursue an agreement with a neighboring county within the same voivodeship to transfer the responsibility for establishing a Center.

Nonetheless, it is difficult to unequivocally state that, in cases where the number of eligible individuals is insufficient, the obligation to create a Center becomes mandatory.

The procedure for developing a regional plan is meticulously outlined. According to Article 13 of the Act, once the voivode announces the commencement of work on the plan, counties have 60 days to submit their proposals for the organization of the Center. Should a county fail to present its proposal or fail to submit the required declaration from an operational healthcare entity confirming the establishment of the Center, the voivode, pursuant to Article 11, section 3, will designate its location within an existing healthcare facility in the county, provided the legal criteria for creating a Center are met. However, the Act does not specify what actions should be taken if no healthcare facility exists in the county or if such a facility is privately operated.

The voivode publishes the draft regional plan available in the Public Information Bulletin to solicit feedback from stakeholders, who are given 30 days to submit their opinions. Following the review of these opinions, the voivode finalizes the plan in collaboration with the National Health Fund, though the Act does not stipulate a specific timeframe for this stage. Ultimately, the approval of the regional plan is within the jurisdiction of the Minister of Health.

The voivode is also responsible for overseeing the Center's operations with regard to the organization and accessibility of healthcare services. This oversight is conducted in accordance with the regulations set forth in the Act on Medical Activities. Under Article 118, the voivode is granted the authority to:

- Inspect the Center's facilities,
- Observe procedures related to the provision of healthcare services,
- Review medical documentation,
- Evaluate compliance with the Center's organizational guidelines, and
- Evaluate the management of assets and public funds.

During inspections, authorized individuals, as specified in Article 122, section 2 of the Act on Medical Activity, have the right to enter the premises of healthcare facilities, review documentation, and request explanations from employees. Based on monitoring data, the voivode compiles an annual report detailing the organization and accessibility of services provided by regional centers, which is subsequently submitted to the National Health Council. This monitoring data and subsequent report can be used by the voivode to revise the regional plan, in compliance with Article 16 of the Act, to ensure the availability of special geriatric care services. If any deficiencies are identified, particularly in terms of gaps in access to geriatric care, the voivode is expected to take further corrective action to address and improve the situation. It is important to bear in mind that the voivode also exercises oversight over county governments. Article 77a of the County Government Act (Ustawa z dnia 5 czerwca 1998 r. o samorządzie powiatowym [Act on County Government, June 5, 1998]) empowers the voivode to request information and data related to the organization and functioning of the county, which is necessary for exercising their supervisory duties. This provision provides a sufficient legal basis for obtaining the required information from county authorities in connection with the implementation of tasks defined in the Act.

The county government, as a public administrative body, holds the primary duty of organizing access to special geriatric care services. The general legal framework for this is provided by Article 4, Section 1, point 2 of the County Government Act, which enumerates health promotion and protection among the county's obligations. This list also includes point 5a, which pertains to the county's role in senior policy, though Article 3f of the Act indicates that this typically involves the formation of senior councils. Furthermore, some competencies are regulated by the Act on Healthcare Services, but

these pertain to the county's obligation to facilitate equitable access to healthcare. As per Article 8 of the County Government Act, these tasks include implementing health prevention programs and other activities aimed at promoting, organizing, and initiating services in health promotion and health education.

As previously mentioned, the Act establishes mandatory duties related to the organization of healthcare entities tasked with providing special medical services. These newly imposed obligations place county governments in a unique position within the public administration structure for healthcare protection. Currently, Poland has 313 county hospitals, operating in nearly every county. Regrettably, reports from the Supreme Audit Office indicate that most of these hospitals are in debt (Najwyższa Izba Kontroli [Supreme Audit Office], (2023), a condition that has persisted since their transfer to county management on January 1, 1999, largely due to a lack of inadequate restructuring and the excessive number of facilities. These additional responsibilities could exacerbate financial difficulties, as insufficient funding for services or infrastructure may lead to further fiscal strain on the counties or the hospitals themselves if they are required to incorporate special geriatric care centers within their existing structures.

The key advisory body to the Minister of Health, established by the Act, is the National Council. The National Council's responsibilities include advising on geriatric care, proposing changes to geriatric care practices, reviewing regional plans, and evaluating the financing of geriatric services. The Council consists of 19 members appointed by the Minister of Health, chosen from public officials, patient advocacy groups, and national consultants. The Minister also appoints the chairperson of the Council. Although the Council's tasks are broadly defined, its influence on geriatric care could prove substantial. It seems prudent for the Council to begin recommending amendments to the Act to ensure effective implementation. Securing adequate funding for special geriatric services through the National Health Fund (NFZ) will also be a pivotal element of the Act's success. In this regard, the National Council should advocate for the most favorable valuation of services. Article 31a of the Act on Health Care Services grants the Minister of Health significant powers over rate setting, including the ability to approve and modify pricing rates. The role of the National Council in this process could be vital, as it can submit objections to the valuation of special geriatric care services and can influence the Minister, who holds the final approval. The first members of the National Council were officially appointed by the Minister of Health on March 1, 2024, under Article 51 of the Act.

8. Legal Framework for Financing Geriatric Care

The funding of special geriatric care services, as stipulated in Article 45 of the Act, follows the principles set out in the Act on Health Care Services. Unlike other healthcare providers, however, the NFZ enters into contracts for services with the Center based on its inclusion in the regional plan. Although the explanatory memorandum of the Act offers various financial details regarding infrastructure funding for the Centers, these are not legally binding. Nevertheless, they are vital for both recipients of care and entities responsible for organizing and delivering special geriatric services, as they help anticipate infrastructure funding needs.

Article 49 of the Act on the Medical Fund introduces amendments that expand the catalogue of fund allocations. Specifically, point 9 has been added, which provides for financing tasks such as the construction, modernization, reconstruction, or equipping of Centers. It is important to note that investment financing through the Medical Fund is awarded on a competitive basis. Consequently, counties must prepare and submit applications for funding once the Medical Fund announces a call for proposals. The minister for health is responsible for managing the application and evaluation process.

The general financial implications of the Act for the financing of geriatric services, as outlined in its explanatory memorandum, are estimated at approximately 2.1 billion PLN, assuming that around 300 Centers will eventually be operational in Poland. This financing will be based on contracts with the National Health Fund (NFZ), as mentioned previously. This sum is identified in the memorandum as a target figure, and actual expenditures from the NFZ will depend on how many Centers are eventually established. Given the obligation stipulated in Article 55 to establish these Centers within five years of the Act's enactment, it is expected that most costs will arise towards the end of this period—provided there are no legislative changes delaying implementation.

The estimated costs outlined in the explanatory memorandum are largely attributed to staffing expenses. Monthly salary costs are projected at 172,000 PLN, which covers roughly 20 full-time positions. These figures, based on 2023 data, are preliminary and will likely be markedly outdated by the time the Centers become operational. Moreover, salary costs are anticipated to vary depending on the specific county hosting the Center. Regarding infrastructure, the estimated funding for the creation of approximately 300 Centers ranges from 735 million to 870 million PLN. These estimates are based on calculations of the resources needed to set up a Center. According to the memorandum, adapting an existing facility would cost around 500,000 PLN, reconstruction would require approximately 2 million PLN, and constructing a new facility from scratch is projected to cost 5 million PLN.

However, it appears, without going into detailed analysis, that these amounts may no longer be accurate. This conclusion can be drawn by comparing the estimates to current

market prices for commercial properties. The authors of the memorandum acknowledge that these figures are merely indicative and were derived from interviews with directors of institutions engaged in activities similar to those envisioned for the Centers.

Conclusions

The WHO has observed that the historic demographic transformation, which will see older adults become a substantial portion of the population, necessitates profound adjustments to social structures across virtually all areas of state governance. Foremost among these is healthcare, which significantly influences the well-being of older adults. Policymakers, when designing public policies for improving the situation of this demographic, must take into account its inherent diversity in terms of health conditions and socioeconomic statuses (Nieszporska, 2021). The growing demand for healthcare services calls for a comprehensive overhaul of the current healthcare system to ensure accessibility and equity.

The proposed Act represents a step in resolving these challenges. However, it must either be implemented as planned or revised and adapted before integration into Poland's healthcare system. Further actions are necessary, particularly the reorganization of long-term care services, which in their present state are ill-suited to the realities of this demographic change. The proposed creation of a network of county-level Centers is a promising solution, but its practical implementation may face obstacles, such as a shortage of qualified personnel and underestimated investment costs. Nevertheless, the idea is worth pursuing, albeit with refinements, as it responds to the pressing social and health needs of Poland's elderly population.

In the author's view, the success of the planned solutions hinges on constructive dialogue and effective collaboration with county governments, which will shoulder the responsibility of the Centers' organization. The costs associated with operating the new units must not be underestimated. Currently, hospital debt—especially at the county level—remains alarmingly high, exceeding 22 billion PLN (Fandrejewska, 2024). Without a realistic accounting of all anticipated expenses, the initiative risks becoming another failed attempt at reforming Poland's healthcare system.

Finally, it is essential to highlight the fragmented nature of the legal framework governing the healthcare rights of older individuals. This lack of cohesion undermines the ability to provide comprehensive healthcare security for an aging society. Moreover, the responsibilities of public authorities in this domain are poorly coordinated. As Maj points out, despite an extensive body of national, international, and EU regulations concerning older adults, the protection afforded to this group is inadequate. A cohesive reform effort is urgently required to establish clear and robust healthcare and welfare rights for older individuals.

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