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Caring for the Health of Seniors as an Element of Health Policy in an Ageing Society

Demographic ageing is becoming a challenge in many areas of life, including public health policy. The increase in life expectancy leads to an increase in the number of diseases of old age, a decrease in the quality of life of older adults and difficulties in providing adequate care. Comorbidity, lack of proper knowledge, limited access to health promotion and prevention programmes are among the factors that lead to older adults not adopting health-promoting behaviours, which in turn leads to further deterioration of their condition. Social and health policies should equally provide complex care for seniors who experience deterioration of their condition, as well as activities to delay ageing and alleviate its consequences, which in return would enable them to live independently. Prevention and health promotion appear to be crucial elements of the aforementioned public policy.

The aim of the article is to present the objectives of health policy in relation to prevention and health promotion among older adults and to verify whether the health programmes implemented take seniors into account as their addressees. The article therefore presents the demographic situation in Poland and its consequences for the health care system, the ageing process in the context of health status, and the tasks and goals of health promotion and health prevention in the light of demographic development – the overview takes into account the scientific and factual situation in this area. The last part presents the results of an empirical analysis of national health policy programmes with regard to the criterion of age.

Keywords: demography, older adults, health policy programs, prevention, health promotion

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Introduction – the demographic situation in Poland

According to the Central Statistical Office data from the National Population and Housing Census 2021, the population of Poland on 31 March 2021 was 38.1798 million. Compared to the 2011 Census, the structure of the population by economic age group has changed significantly – both the percentage of the population in the pre-working age group (0–17 years) has decreased – from 18.7% in 2011 to 18.2% in 2021, as well as in the productive age group (18–59/64 years) – from 64.4% to 60%, while the proportion of people in the post-productive age group (60/65 years and over) increased significantly – from 16.9% to 21.8% (CSO 2022).

The demographic forecast for Poland indicates that its population will continuously grow older, with a simultaneous depopulation of the country – it is estimated that Poland's population will reach 34 million in 2050. In 2030, Poland's population aged 60+ will increase by almost 11% compared to 2021, reaching 10.8 million, and in 2050 will increase by almost 41% compared to 2021, reaching 13.7 million in this age group. This means that in 2050, people aged 60 and over will comprise 40.4% of the total population (Kamińska-Gawryluk 2022). According to the above-mentioned forecast, the structure within the elderly group will also change in 2050, as there will be a decrease in the number of people aged 60–64 (from 26.3% in 2021 to 19% in 2050), 65–69 (from 25.6% to 21%) and 70–74 (from 20.4% to 19%). In contrast, older groups of seniors will see a rise in numbers – in the 75–79 age group (from 11% in 2021 to 15.2% in 2050), in the 80–84 age group (from 8.5% to 10.7%) and in the 85+ age group, where the largest increase is projected (from 8.2% to 15.1%) (Kamińska-Gawryluk 2022).

In contrast, the 2014 forecast illustrates the following trends among the two younger groups: 0–14 and 15–64 age groups (Szałtys 2014)[2]. It estimates that the population of 0–14 year-olds will decrease by 1.65 million by 2050 to reach 4.1 million in 2050, while the 15–64 age group will decrease by 8.3 million, from 26.8 million to 18.5 million.

One indicator is also worth mentioning in this brief analysis – the old-age dependency ratio. It represents the number of people aged 65+ per 100 people aged 15–64. A dynamic increase in this indicator has been noticeable since 2011 (from 19.4 in 2011 to 28.9 in 2021). Previously, it was at a relatively stable level (18.9–19) (Kamińska-Gawryluk 2022).

The final two measures to which reference is warranted include life expectancy and health expectancy (or healthy life years – HLY). The former measure is one of the most popular simple synthetic measures used to assess the overall health of

[2] This forecast by the Central Statistical Office was based on biological, not economic, age groups, hence the differences in age ranges compared to the 2021 forecast.

a population, while the latter is a composite measure. In order to calculate it, the entire lifespan is divided into years lived in good health and those lived in ill health. Therefore, what is the average life expectancy? According to the *PolSenior 2* research report, in 2018, women aged 60+ in Poland had an average of 24.2 years of life ahead of them, whereas men could expect to enjoy a further 19.1 years (Wojtyniak 2021; Kamińska-Gawryluk 2022), i.e., 1.6 and 2.9 years fewer, respectively, than their peers in the European Union (Wojtyniak 2021). Analysis of the most recent data shows that, from 2019 onwards, the average life expectancy in Poland has started to decrease – in 2021 it was 22.4 years for women (24.2 in 2019) and 17.3 years for men (19.3 in 2019) (Kamińska-Gawryluk 2022). Regarding HLY among people aged 65 and more, it was 8.2 years for men and 8.8 years for women in 2018 (Wojtyniak 2021).

As demographic analyses show, the growing interest in the issues of old age, ageing and older people is well founded. Ageing is a subject of research and a driving force for the development of many scientific disciplines, but also an area of planning for all state policies – economic, social and health-related. As written by Stanisława Golinowska:

> In economic policy, efforts are made to seek ways of boosting economic dynamism despite the impact of demographic factors that weaken overall labour productivity. In social policy, considerations revolve around methods of ensuring financial security for the elderly population, which allow for the preservation of intergenerational financial equilibrium within redistribution systems. In healthcare policy, the analysis focuses on the possibilities of providing healthcare to the elderly population whose health condition naturally deteriorates, as well as mitigating the ageing process to enable older individuals to maintain their functionality and independence for as long as possible (Golinowska 2016).

Older people are living longer, but their quality of life is significantly reduced in their declining years. In addition, the old-age dependency ratio is increasing, which, coupled with their growing frailty and dependence, leads to a range of negative psychosocial and economic consequences. Therefore, issues related to actions that enhance health resources of older age should become a significant area of the country's healthcare policy. The responsibility of the state should not only involve providing medical care in times of illness but also the undertaking of actions aimed at delaying the ageing process and mitigating its consequences to enable older individuals to maintain their independence for as long as possible.

The concern for the health of the elderly within the framework of state health policy addressed in the article is justified in the light of the data presented on the demographic situation in Poland and its consequences for the health of the elderly. The article has two objectives. First, to illustrate the tasks of health policy in the area of prevention and health promotion with regard to older people. This analysis

will be presented from a scientific perspective, taking into account the concepts of ageing processes, and in the light of documents defining the strategic and operational goals of health programmes as well as the entities and units responsible for their creation and implementation. Secondly, the aim of the article is to examine what the implementation of health programmes looks like in practice in the light of the tasks and objectives assumed in the health policy of an ageing society, based on an analysis of nationwide health programmes. The analysis of the types of health problems addressed by the programmes and the number of programmes targeting the elderly made it possible to verify the main hypothesis of the article, to wit, that nationwide health programmes do not address seniors sufficiently.

Ageing processes and health

Ageing is a process of regressive changes characterised by individual course (Ogińska-Bulik, Zadworna-Cieślak and Rogala 2015) and old age is defined as the declining phase of the life cycle, leading to death (Kijak and Szarota 2013). The individual course of the ageing process is a combination of genetics, living environment, personality factors and life experiences. **In the physical dimension**, ageing is characterised by changes such as: weakening of physical and mental fitness, decreased physical capacity and strength, balance disorders, motor coordination, falls, more frequent fatigue, heaviness and aversion to active physical efforts, loss of muscle mass (sarcopenia) and loss of bone mass (Kostka and Koziarska-Rościszewska 2009; Kubińska and Pańczuk 2019). In addition, insomnia, headaches, joint pain, back pain, illness, disability, i.e., loss of health and fitness, may occur (Kubinska and Panczuk 2019). **In the psychosocial dimension**, ageing processes are associated with the transformation of social roles (exclusion from professional, social, societal, and family life), loss of loved ones, deterioration of financial situation, loss of independence and sense of self-worth (Kijak and Szarota 2013; Kubińska and Pańczuk 2019). Both of these dimensions are interdependent, which is clearly illustrated by the three types of ageing (Renn-Zurek 2021). **Successful ageing** is a process in which external factors play a positive role. It is associated with a high degree of physical and mental fitness, a low risk of developing chronic disorders and, consequently, an active life. Socio-economic factors such as higher education, having a partner, a better financial situation, a proper lifestyle and having support are conducive to successful ageing. Positive attitudes to life (satisfaction with life, control over life, low health care demands, positive self-assessment of health status) play an important role. The last group consists of physical conditions – absence of chronic diseases, high initial physical fitness and normal body weight. **Normal ageing** is an ageing process in which some deficits

are perceived, but no clear pathology is present. External factors can exacerbate the negative consequences associated with this type of ageing. Such factors include: loss of control over one's life, reduction in independence, inadequate levels of social support, death of loved ones, reduction or weakness in fulfilling social roles and maladaptation to old age. **Impaired ageing** is the least desirable course of the ageing process, characterised by so-called multimorbidity, running in a pathological manner. The most common comorbidities in older people include joint and spinal disorders, hypertension, ischaemic heart disease, diabetes, chronic lung and eye diseases, atherosclerosis and mental disorders associated with the ageing process. Among the most significant risk factors are genetic and environmental factors: inappropriate lifestyle, poor diet, harmful working conditions, pollution in a place of residence, and past illnesses and injuries.

Probably everyone would like to grow old successfully, but most people experience a loss of health as they age. Older people suffer from multimorbidity, (co-morbidities of a chronic nature), which requires complex medical care. In 2021, 98 million consultations were provided as part of outpatient healthcare to people aged 65 years and over, accounting for almost 31% of total consultations provided (Kamińska-Gawryluk 2022). In primary care this was 59.5 million consultations, in specialised care 33.5 million, and in dental care the number of consultations provided to people aged 65 and over amounted to 5 million.

The *PolSenior 2* report indicates the main health problems reported by people in the 65+ age group to primary care physicians (PCPs) and GPs and describes the main reasons for hospitalisation in 2018 (Kostka 2021). The 10 most common reasons for a visit to PCPs and GPs included cardiovascular disease, hypertensive disease, osteoarticular disease, diabetes, ischaemic heart disease, chronic gastrointestinal diseases, peripheral nervous system diseases, chronic respiratory diseases, thyroid diseases, and cancer.

People aged 60 and over constituted nearly half of all hospital admissions in 2018 (Kostka 2021). Older people were most often hospitalised due to cardiovascular diseases – this comprised ¼ of all hospitalisations in this age group (with slightly higher prevalence among men than women). The second most common reason for hospitalisation was malignant and benign neoplasms, accounting for 16% of hospital admissions in 2018 (17.9% for men and 14.4% for women). Other causes of hospitalisation mentioned by the authors of the report include mention eye diseases (mainly cataracts), diseases of the respiratory, digestive and genitourinary systems, trauma, and poisonings.

The co-occurrence of several conditions requires specialised care of multiple physicians, who treat a condition only from their area of expertise and often lack insight into the elderly patient's overall health. Geriatric care is becoming an effective solution. In 2021, there were 156 geriatric outpatient clinics in Poland, with the highest

availability per number of older people in the Łódzkie and Śląskie voivodeships, and the lowest in the Warmińsko-Mazurskie Voivodeship. A total of 73.1 thousand consultations were provided in these clinics in 2021 (Kamińska-Gawryluk 2022). In 2021, there were 51 geriatric wards in Poland with a total of 1,048 beds, where 21.3 thousand people were treated during the year (Kamińska-Gawryluk 2022). The largest number – 12 geriatric wards – was in the Śląskie Voivodeship.

Ageing inevitably leads to death. Analysis of data on deaths among the elderly shows that for years the leading causes of death have been cardiovascular disease and cancer (Kamińska-Gawryluk 2022). Due to cardiovascular diseases, 37.6% of people aged 60+ died in 2021 (34.8% in the general population), more often women (41.2%; a 33.7% mortality rate among men). 19.6% of the elderly population died from cancer (similar to the general population), more often men (21.6%) than women (17.6%). In 2019, older people were most likely to die from tracheal, bronchial and lung cancers (19,923 people in total), colorectal cancer (7032 people), urinary tract cancers (6313 people) and female genital cancers (5685 people) (*Demographic Yearbook 2021*, 2021). It is worth noting that the number of deaths resulting from colorectal cancer, urinary tract malignancies and female genital malignancies increases with age. These data are relevant to the development of prevention and health programmes targeting older people.

Since 2020, a new cause of death, COVID-19, has been observed. The epidemic is more likely to threaten the elderly, which is reflected in the death statistics – in 2021, 18.6% of people over 60 years of age died from coronavirus (17.9% in the general population), while the death rate was 8.6 and 2.4 respectively.

Health deteriorates with age and an ageing population is becoming a challenge for the health system. It therefore makes sense – in addition to treatment-oriented remedial actions – to take action to strengthen health, promote individual responsibility for it and to encourage research aimed at early detection of disease.

Tasks and objectives of health promotion and prevention in the context of demographic challenges – a scientific perspective

"Prevention is better than cure", the famous words of Hippocrates emphasise the importance of taking action directed at avoiding illness before it occurs. The dominance of the biomedical model of health and disease has led to the fact that for many decades health issues have been sidelined, prioritising disease and its effective treatment only. This model is still dominant in medicine, hence resulting in ambivalence towards health promotion (Puchalski 2011). A turning point in broadening the perspective on human health was a report by Marc Lalonde in 1974, in which he described the concept of "health fields", emphasising the influence of environmental

and lifestyle factors on the health of the population and attributing much less importance to genetic factors and health services than was commonly assumed. However, this concept, now seen as oversimplified, has influenced a shift in health policies and allowed the development of new models of health – including the socioecological model, which makes the category of health a central concept in the considerations and actions taken by and for individuals and communities.

Health as described in the concept proposed by the World Health Organization (WHO) is considered:

- normative – it is a value through which individuals and groups can achieve their goals, satisfy their needs, and modify their living environment;
- tangible – it is a resource (a type of good) through which social development and quality of life are made possible;
- instrumental – it is a tool used in everyday life; it is not life's purpose;
- evaluative – it is a positive category emphasising the benefits of "being healthy" (Woynarowska 2017).

In the context of demographic challenges, health understood in this way goes beyond the framework of medical institutions and activities, instead becoming the subject of socio-health policies (Golinowska 2016).

Attempts to reorient health and consider it a central category contributed to the development of the idea of health promotion, which in the Ottawa Charter classical study ("Ottawa Charter for Health Promotion" 1986) was defined as "a process that enables people to control and enhance their own health", thus becoming "not only a responsibility of the health sector, but extending beyond lifestyles to well-being". Health, in turn, was defined as "a resource of everyday life, not its goal; health is a positive concept emphasising social and personal resources as well as physical potential" ("Ottawa Charter for Health Promotion" 1986). The Ottawa Charter identified six basic lines of action in the area of health: 1) defining a national health policy, 2) creating a health supportive environment, 3) enhancing social action, 4) developing personal skills of individuals, 5) reorienting health services from treatment to prevention and education, 6) long-term strategy placing care and the holistic perspective as well as ecology at the centre ("Ottawa Charter for Health Promotion" 1986).

Health promotion activities are aimed at the general public, so no group should be left out of their planning and implementation. Often, however, specific programmes are targeted at a narrowly defined audience (children, blue-collar workers, etc.) as there are legitimate reasons (health, economic, psychosocial) for doing so.

In that case, what is the situation of older people as recipients of health promotion and prevention programmes? Is it at all reasonable to talk about the issue and take action of this nature in a group of people in which – as shown above in the analysis of the health of the elderly – the incidence of diseases and limitations is widespread, and multimorbidity and dependence increase with age? To put it

bluntly, is it not too late for prevention and health promotion among those who have reached the age of 60 and over? Can such measures maintain the current state of health of older people or even improve it? Can discrimination against older people be found in such programmes?

Until 1990, many European countries perceived older people as not amenable to lifestyle change, so health promotion among them was unwarranted and they were neglected in such programmes (Golinowska et al. 2016; Heszen-Celińska and Sęk 2022). Today, many studies confirm that older people are inclined to keep themselves healthy, both physically and mentally, by remaining active and maintaining social contacts (European Union 2019). In addition, older people, precisely because of increasing ailments and limitations, begin to attach more importance to their own health in old age; it constitutes an autotelic value for them. They thus become more receptive to health education and to taking specific actions to maintain or improve their own health (Golinowska 2016). Targeting them with health-promoting content and activities therefore seems to be justified and necessary. However, the intrinsic diversity of the elderly population in terms of, for example, health status and related limitations should be taken into account, which is important when defining promotion and prevention goals and tasks. As Golinowska writes, "health promotion addressed to older people is, to some extent, an alternative to programmes focused on increasing financing of costly treatment services for an ageing population" (Golinowska 2016: 33). Elsewhere, the author also draws attention to the fact that many activities promoting health and health-related activities among the elderly focus on younger seniors, while in the group of older seniors (85+) the focus is placed on the appropriate level of medical care (infrastructure, accessibility, services) and satisfactory relations with medical staff, and to a much lesser extent on health behaviours (Golinowska et al. 2016).

It should also be remembered that older people face not only health problems, but also material (low income) or psychosocial problems (loneliness and isolation), so effective strategies should involve the cooperation of many professionals and institutions (psychologists, sociologists, physicians, health educators, nurses; medical institutions, NGOs, state institutions, informal groups), and should emphasise non-medical determinants of health and be more individualised.

The following strategic objectives of health promotion for older people are distinguished: maintaining and enhancing functional capacity, maintaining and enhancing self-care, stimulating an individual's social network, enhancing social participation and integration (Golinowska et al. 2016). The first goal refers to the physical health dimension and the remaining to the psychosocial dimension. At the operational level, health promotion programmes take into account (Golinowska 2016):

- the functional criterion – the action is intended to perform a specific function:

- the informative function is carried out through the production and dissemination of health information on health and risks of specific diseases;
- the educational function – its purpose is health education, the aim of which is to raise awareness among older people by providing knowledge about correct and incorrect health behaviour and its consequences, and about risk factors;
- the diagnostic (and partly informative) function – realised through screening, the results of which serve as information not only for those concerned (the patients), but above all for those responsible for shaping health policies;
- the preventive function carried out as part of primary prevention, taking the form of information, prevention activities, promoting correct lifestyles, aimed at preventing a specific disease;
- the socio-technical function realised through advocacy, i.e., raising the value of health at the individual and societal level by influencing society;

- the place of health promotion criterion – refers to the place in the physical or environmental sense where activities of a health-promoting and health-protecting nature are undertaken (place of residence, workplace, home, care units [hospitals, nursing homes], media, community);
- the criterion for the type of activities that are indicated as conducive to health (physical activity, good nutrition, vaccination, avoidance of health risks associated with smoking, alcohol consumption, loneliness, among others; mental health care, sexual health).

The shaping of health programmes in Poland is the responsibility of the relevant ministries and the local government units. So what does the right to health look like in the light of strategic documents? These issues will be discussed in the next part of the article.

Health policy and health programmes in the light of strategic documents

The right to health and its protection is guaranteed to every person under international documents (Declaration of Human Rights) and national documents (Constitution of the Republic of Poland of 2 April 1997). Four categories of persons have the right to special care: children, pregnant women, persons with disabilities and the elderly. An elderly person in Poland is anyone over 60 years of age (Rada Ministrów [Council of Ministers] 2015a). Precise guidelines for the

implementation of tasks related to the protection of citizens' health are contained in other, specific laws. They indicate the entities, tasks, responsibilities, monitoring of results and also the manner and sources of financing of activities. One such key document is the Act of 27 August 2004 concerning the Public Funding of Healthcare (Rada Ministrów [Council of Ministers] 2004). The Act sets out the tasks regarding health programmes, prevention and health promotion for two state entities with legal personality – the National Health Fund (NHF) and the Agency for Health Technology Assessment and Tariff System (AHTATS). The National Health Fund is responsible for health programmes (in terms of their development, implementation, realisation, financing and monitoring), pilot programmes (in terms of their implementation, realisation, financing and evaluation), performs tasks within the framework of health policy programmes and is the body responsible for health information and promotion activities. AHTATS is responsible for the preparation of materials necessary for the development of maps of health needs and is the body producing opinions on draft health policy programmes prepared at the ministerial level or below.

Another important document that defines the tasks and the rules for their financing and describes institutions involved in them is the Public Health Act of 2015 (Rada Ministrów [Council of Ministers] 2015b). Public health tasks are described in Article 2 of the cited Act and include, among others, monitoring and evaluation of the health status of the population; health education adapted to the needs of different population groups, in particular children, adolescents and the elderly; health promotion; prevention of diseases; activities aimed at elimination of risks; analysis of the health services provided; carrying out scientific activities; development of human resources; reduction of health inequalities, and activities in the area of physical activity (Rada Ministrów [Council of Ministers] 2015b).

In order to effectively implement public health policies, the Ministry of Health periodically approves the National Health Plan. The National Health Plan (NHP) for the period 2021–2025 is currently in force (Rada Ministrów [Council of Ministers] 2021a). According to the document, the aim of the NHP is to increase the number of healthy life years (HLY) and also to reduce social inequalities in health. The latter objective in particular appears to be extremely important in the context of the considerations made so far. The operational objectives are aimed at dealing with the health impacts of the COVID-19 pandemic and include: prevention of obesity; prevention of addiction; promotion of mental health; environmental health and infectious diseases; and demographic challenges (Rada Ministrów [Council of Ministers] 2021a).

At the local government level, there are many prevention and health promotion activities resulting from the above-mentioned provisions of national laws, but many initiatives are own tasks resulting from the provisions of relevant local laws,

e.g., the Act on Commune Self-Government, the Act on County Self-Government and the Act on Voivodship Self-Government.

In view of the general situation of older people, actions aimed at strengthening and maintaining health should be interdisciplinary and take into account not only the category of health in a strict sense, but also other actions that indirectly affect the well-being of older people. Therefore, the following documents should be mentioned. The first of these is "Social Policy for Older Persons 2030: Safety – Participation – Solidarity" (Rada Ministrów [Council of Ministers] 2018b). As the document states, "the goal of social policy towards older people is to improve the quality of life of seniors by enabling them to remain independent and active for as long as possible and to ensure safety; the activities undertaken should take into account the recommendations of the World Health Organization and the activities of the European Commission on healthy and active ageing" (Rada Ministrów [Council of Ministers] 2018b). The document identifies seven main areas that take into account actions for older people, including strengthening positive attitudes towards old age, actions aimed at the inclusion of older people, creating conditions that enable them to realise their potential, increasing their physical safety by countering violence; intergenerational integration; educational actions and health promotion; and disease prevention as well as access to diagnosis, treatment and rehabilitation (area IV) (Rada Ministrów [Council of Ministers] 2018b). Among the specific tasks in the latter area, the most important are: strengthening individual responsibility for health, its promotion, disease prevention and strengthening health-promoting attitudes among the elderly as well as access to health care services, including rehabilitation and prevention of physical and mental health disorders (Rada Ministrów [Council of Ministers] 2018b). The second document is the "Active+" Multiannual Programme for Older Persons for 2021–2025 (Rada Ministrów [Council of Ministers] 2020), which aims to increase the participation of older people in all areas of social life. The priority areas include: social participation, social activity, digital inclusion and preparing for old age. The last programme is the "Senior+" multi-annual programme for 2021–2025, which aims to develop a network of "Senior+" Day Care Centres and "Senior+" Clubs and support economically inactive people over 60 by enabling them to participate in various social, physical, educational, cultural and caring activities within the framework of the aforementioned facilities (Rada Ministrów [Council of Ministers] 2021b).

As can be seen from the aforementioned review of scientific literature and strategic programmes, the health of the elderly appears to be one of the most important values towards which multidirectional, interdisciplinary measures are taken to enhance the well-being of individuals and the population as a whole. Health is also a central category for many strategic documents of the state, determining the directions of specific policies (especially health and social policies).

Results of the analysis of health programmes in the context of an ageing population

Methodological note

The following are the results of an analysis of nationwide health policy programmes, health programmes, prevention programmes and pilot programmes from 2015 to the present. A search was performed using online resources by entering the keywords "health programme" and "prevention programme" into the Google search engine in the Chrome browser, version 112.0.5615.138. The obtained records were then searched for documents meeting the predefined inclusion criteria: 1) the nationwide nature of the programme, 2) the start of the programme no earlier than 2015, 3) the availability of programme documentation allowing verification of the objective, target group and analysis of activities. Out of an initial pool of approximately 150 programmes found, 40 national programmes from 2015 onwards meeting the criteria listed above were finally analysed. Table 1 details them in a chronological order – title, period of implementation and whether the programme included older people. The analysis carried out took into account the health problem, the purpose of the programmes, the way they were implemented, their duration and addressees as well as the inclusion criteria. The analysis had two objectives. First, to examine which health problems the programmes addressed in order to see what proportion of them included conditions suffered by older people. Second, the aim was to see what proportion of all programmes constituted those that could benefit older people. In this case, the intention was to verify whether the programmes applied exclusionary age criteria.

Formal characteristics of programmes in the light of definitions

A health policy programme constitutes "planned, broad health care activities that are effective, safe and justified" (Ministerstwo Zdrowia [Ministry of Health] 2023). The aim of such programmes is usually to detect and address a specific health need and, consequently, to improve the health status of the target group. **Health programmes** face similar aims and objectives. The difference between them concerns the type of entity that is responsible for them – in the case of health policy programmes, it is the Ministry of Health and local government units, while in the second case the responsible entity is the National Health Fund. **Pilot programmes** test new health solutions before they are implemented as part of larger programmes or strategies. A **prevention programme** is an action aimed at preventing the occurrence of a health problem, but considering the levels of

prevention, programmes are also created to minimise the effects of diseases and dysfunctions that have already occurred.

Table 1. National health policy programmes, health programmes and pilot programmes since 2015

PROGRAMME TITLE	PERIOD OF IMPLEMENTATION (ascending)	TARGET GROUP – OLDER PEOPLE (+/-)
Ensuring Poland's self-sufficiency in blood and blood components for 2015–2020	2015–2020	(+) the programme did not specify an upper age limit for the donor
National programme to reduce mortality from chronic lung diseases through the establishment of non-invasive mechanical ventilation rooms 2016–2019	2016–2019	(+)
Monitoring the oral health status of the Polish population 2016–2020	2016–2020	(+) older people were included as a 65–74 age category and were subject to the 2019 survey (962 respondents in total)
National antibiotic surveillance programme 2016–2020	2016–2020	(+)
Programme for the prevention of depression in Poland 2016–2020	2016–2020	(+)
Prevention programme for early detection of rheumatoid arthritis	2016–2023	(+/-) discriminatory age criteria
Health policy programme to implement the "Za życiem" comprehensive support programme for families for 2017–2021	2017–2021	(-)
POLKARD Cardiovascular Disease Prevention and Treatment Programme 2017–2021	2017–2021	(+)
ABCDE of nevus self-monitoring – nationwide skin cancer prevention programme	2017–2023	(+/-) discriminatory age and other criteria (labour force participation)
National Programme for the Prevention of Cerebrovascular Diseases (ICD10: I60–I69)	2017–2023	(+/-) discriminatory age criteria
Osteoporotic fracture prevention coordination programme	2017–2023	(+/-) discriminatory age criteria
Prevention programme for tick-borne diseases	2017–2023	(+)
Improving access to dental services for children and young people in schools in 2018	2018	(-)

PROGRAMME TITLE	PERIOD OF IMPLEMENTATION (ascending)	TARGET GROUP – OLDER PEOPLE (+/-)
Government programme for comprehensive intrauterine therapy in the prevention of sequelae and complications of developmental defects and diseases of the unborn child – as part of improving the health of unborn children and newborns for 2018–2023	2018–2023	(-)
Breast cancer prevention programme	2018 to date*	(+/-) discriminatory age criteria
Cervical cancer prevention programme	2018 to date*	(+/-) discriminatory age criteria
Prenatal screening programme	2018 to date*	(-)
Smoking-related diseases prevention programme (including COPD)	2018 to date*	(+/-) discriminatory age criteria
Orthodontic care of children with congenital defects of the craniofacial region	2018 to date*	(-)
Treatment of children in a coma (ICD-10 principal diagnosis: R40.2)	2018 to date*	(-)
Treatment of adult patients in a coma (ICD-10 principal diagnosis: R40.2)	2018 to date*	(+)
Postnatal depression prevention programme	2018–2023	(-)
Head and Neck Cancer Prevention and Early Detection Programme	2018–2023	(+/-) discriminatory age criteria
National programme for the prevention of arteriosclerosis and heart disease (KORDIAN)	2019–2022	(+)
Pilot programme for prevention of liver cancer through early detection of chronic HCV and HBV infections in adults in Poland	2019–2023	(+)
National chronic back pain prevention programme	2019–2023	(-!) discriminatory criteria (labour force participation)
Tuberculosis prevention programme	From 2019 to date**	(+)
National programme for the prevention of lymphoedema after breast cancer treatment	2020–2023	(-!) discriminatory criteria (labour force participation)
Prevention of colorectal cancer	2020–2030	(+/-) discriminatory age criteria
E-addiction treatment in children – a pilot	2021–2023	(-)

Government programme for comprehensive protection of procreative health in Poland in 2021–2023	2021–2023	(-)
National Programme for Early Detection of Lung Cancer by Low-Dose Computed Tomography	2021–2023	(+/-) discriminatory age criteria
40+ prevention programme	2021–2023	(+)
Ensuring Poland's self-sufficiency in blood and its components for the period 2021–2026	2021–2026	(+/-) 18–65 years age criteria for the donor
Cardiovascular disease prevention programme	2022 to date***	(-!) discriminatory age criteria
Government Health Policy Programme for the antiretroviral treatment of people living with HIV in Poland for the period 2022–2026	2022–2026	(+)
Health policy programme to implement the "Za życiem" comprehensive family support programme for 2022–2026	2022–2026	(-)
Tooth decay prevention programme for adolescents	n.a.–2023	(-)

* provided as part of the guaranteed benefits of health programmes (Rada Ministrów [Council of Ministers] 2018a) (Dz. U. [Journal of Laws] 2018, item 188)
** provided as part of the guaranteed services of a primary care nurse (Rada Ministrów [Council of Ministers] 2019) (Dz. U. [Journal of Laws] 2019, item 736)
*** carried out within the framework of guaranteed services in the field of primary health care (Rada Ministrów [Council of Ministers] 2022) (Dz. U. [Journal of Laws] 2022, item 1355)
(-!) older people were not included, although the health problem addressed by the programme concerned older people
(-) older people were not included as the health problem addressed by the programme did not concern older people
(+/-) older persons included only up to a certain age (e.g., 59, 65 or 74 years)
(+) older persons included in the programme without an upper age limit

Source: own study.

Results

Of the programmes analysed, 12 were aimed at a target group other than the elderly due to the nature of the health problem that was being addressed (prenatal screening, developmental defects, dental care for children and adolescents, treatment of children in a coma, e-addictions in children, postnatal depression, etc.). In the table, these programmes are marked with a (-) symbol.

14 programmes included older people as addressees – in most of these programmes there was no upper age limit or age was not an inclusion criterion (it was

a specific health problem, e.g., HIV, which may potentially also affect older people). Health problems addressed in this group of programmes are not common among older people, so it can be assumed that they have not constituted a very large group of beneficiaries. These programmes are marked in the table with a (+) symbol. On the other hand, descriptions of two programmes clearly state that older people are the target group and the health problems they address are widespread among the elderly – these are the Programme for the Prevention of Depression in Poland 2016–2020 and the POLKARD Programme for the Prevention and Treatment of Cardiovascular Diseases 2017–2021. In the case of depression, the population included people over 65 years of age as a high-risk group, while the POLKARD programme included people over 65 years of age with at least three cardiovascular risk factors.

Another group is made up of programmes with discriminatory age criteria. There were a total of 11 such programmes and they are marked in the table with the (+/-) symbol. Most often, these programmes accept the age of 65 as the upper age limit (e.g., Rheumatoid Arthritis Early Detection Prevention Programme, Colorectal Cancer Prevention), but there are some where this limit is lower, e.g., the Cervical Cancer Prevention Programme targets women aged 25–59.

Among the programmes analysed, there were 3 in which the elderly were not included, although they may have been affected by the health problem addressed by the programme. They are marked in the table with the (-!) symbol. These were:

- Cardiovascular disease prevention programme, which targeted people aged 35, 40, 45, 50 or 55;
- A nationwide programme for the prevention of lymphoedema after breast cancer treatment, which targeted professionally active post-mastectomy women;
- A nationwide programme for the prevention of chronic back pain, which targeted professionally active people.

Health policy programmes are also implemented by the Local Government Units, following their approval by the Agency for Health Technology Assessment and Tariff System. The 2018–2021 report shows that the Agency received 437 final reports on the implementation of these programmes (AHTATS 2021). The largest number of programmes concerned the Mazowieckie Voivodeship (62) and the smallest number concerned the Warmińsko-Mazurskie Voivodeship (6). Among the programmes, the most frequent were those for influenza vaccination among people aged 65 and over, caries prevention, pneumococcal infections prevention and papilloma virus infections prevention. The largest number of programmes that included older people were regional flu vaccination programmes.

In summary, about one-third of the analysed programmes dealt with health problems affecting the elderly and included older people as the addressees. One

in three programmes was targeted at other population groups due to the health problem tackled by the programme, while 3 programmes concerned conditions occurring in old age, but were addressed to recipients other than seniors. The last group, which also constitutes one third of the analysed programmes, consists of those whose criteria excluded older people due to exceeding a certain age threshold or being economically inactive, although the problem addressed in the programmes concerns them.

Conclusions and discussion

The analysis of health programmes in the context of the tasks and objectives of health promotion and prevention allows several important conclusions to be drawn. First, the elderly constitute a distinct group of addressees of the analysed health policy and health programmes in Poland. It is reasonable to state that the provisions of health policy with regard to older people are not only formulated at the declarative level, but are also translated into the design and implementation of specific programmes.

Second, the analysis revealed that some of the programmes apply discriminatory criteria (usually age or activity-related), which limit older people's access to the programmes. This is quite a big problem, as it indicates that the state's health policy does not fully take into account the current demographic trend and demographic projections in its planning. In 2008, a review was prepared at the request of the Ombudsman, which revealed similar conclusions – it was found that discriminatory age criteria (e.g., age up to 65 years) were used in prevention programmes and that older people were very often not referred for preventive examinations (Szatur-Jaworska 2008). The problem of ageism in this respect is still present. Informal signals from older people indicate that they feel left out of some health programmes. However, there is a lack of systematic research in this area, thus conclusions could not be drawn regarding the actual evaluation of the offer by those concerned.

Increasing longevity not only means a numerical increase in the number of older people in the general population, but also an increase in health risks, a rise in the number of diseases of old age, increasing dependency, and withdrawal from activity. In the light of the demographic forecasts described above, the inclusion of increasingly older groups of seniors in health and prevention programmes appears to be a justified and necessary measure. Good examples of this include inclusion in prevention programmes concerning colorectal cancer, malignant tumours of the urinary tract, and female genital malignancies, which are the most common causes of death in the elderly, and the number of deaths increases with age. In light of the statistical data, if health programmes were to be set up to address these specific

problems, they should include all older people, without limiting accessibility to, for example, only those under 65 or 70 years of age.

Third, the above analysis shows a gap between the health problems targeted by the programmes and those actually found in the elderly population. While cardiovascular diseases are reflected in the programmes, some of them use discriminatory criteria. Osteoarticular diseases, diabetes mellitus, ischaemic heart disease, chronic digestive diseases, peripheral nervous system diseases and thyroid diseases are the health problems most frequently reported by seniors to the PCP. These are not reflected in the programmes, similar to the case with the aforementioned types of cancer that represent the second most common cause of death among people aged 60+.

Fourth, there is an apparent lack of health promotion and primary prevention programmes targeted at older people. Promoting individual responsibility for health, strengthening health resources and encouraging health-seeking attitudes among older people are not translated into specific national programmes as objectives formulated in health policy. This can lead to inappropriate attitudes among older people towards their own health, characterised by low awareness of health-enhancing activities and passivity in terms of health responsibility, which is contrary to the idea of active, healthy and successful ageing at the heart of the national health policy. Issues concerning the importance of taking informed action directed at strengthening one's own health potential and avoiding risk factors among older people are widely reported in the literature. A distinction is made between physical health-related behaviours, psychosocial health-related behaviours, preventive behaviours and avoidance of anti-health behaviours. (Muszalik et al. 2013). Health-promoting behaviours enhance individual and population health, with the goal of successful ageing and active old age (Zamorska and Makuch 2018). Health status among older people is also influenced by factors such as physical activity, proper nutrition, prevention and the living environment. Another important factor is the individual's resources to effectively cope with stress.

Health-promoting practices among the elderly in Poland are determined by educational level, family situation (being in a relationship) and participation in Universities of the Third Age. Particularly the latter factor seems to be important from the point of view of preventive measures (Muszalik et al. 2013). Physical activity is age-determined – in light of data from the *PolSenior 2* survey, the level of activity indicated by respondents was stable until the age of 70–74, after which it decreased significantly. The most common activities performed by the older people were walking and working in a garden. The research cited above also shows that the physical activity of older people is determined by their level of education, while some forms of activity are determined by the size of their place of residence. Most often, older people indicated that they participated in these activities for health, for pleasure, and out of a need to relax (Kostka et al. 2021). The diets of

older people depend on their financial situation, education, place of residence and age. The greatest dietary disturbances are present among the oldest seniors, residents of small towns and cities, and among those with low material status (Wernio et al. 2021). Health behaviours also depend on social support and psychological factors such as sense of coherence, personality, life optimism, mental resilience, sense of control, and spirituality (Zadworna 2012; Zadworna-Cieślak and Ogińska-Bulik 2012; Mędrela-Kuder and Bogacka 2017; Rembecka, Sztuba and Łakomska 2020). It seems reasonable to strengthen the health of older people by implementing health promotion campaigns.

Summary

The article achieves two stated objectives. It presented the tasks of health policy in the field of prevention and health promotion in relation to the elderly, both from a scientific perspective and on the basis of existing strategic documents. It also analysed nationwide health programmes in order to verify how the implementation of health programmes functions in practice in the light of the tasks and goals assumed in the health policy of the ageing society. The analysis made it possible to verify the hypothesis concerning too little consideration of the elderly as addressees of these programmes. The results indicate that:

- older people are a distinct group of addressees of the analysed health policy and health programmes in Poland;
- some programmes apply discriminatory criteria that prevent older people from accessing the programmes;
- there is a mismatch between the health problems targeted by the programmes and those actually utilised by the older population;
- there is a lack of health promotion and primary prevention programmes targeting older people.

The above conclusions allow for a cautious confirmation of the hypothesis posed at the beginning of the article, stating that nationwide health programmes take too little account of older people as addressees. Although many programmes are addressed to older people, some of them use discriminatory criteria, mainly age-related. As the population ages, morbidity rates change and the age at which certain conditions are acquired is delayed, but health programmes do not take these changes into account, excluding people who have reached a certain age. Additionally, the health issues addressed by the programmes only partially address the health problems of old age.

The final recommendations derived from the article for the purpose of scientific theory and practical health policy actions can be outlined as follows:

- it is necessary to design research studies aimed at analysing older people's experiences of utilising the health programmes on offer. Such research should include not only the evaluation of programmes in terms of inclusion/exclusion criteria, but also address perceptions of programmes offered in general, awareness of the role of prevention and health promotion among older people, and individual practices undertaken by seniors to strengthen health;
- it is necessary to revise the inclusive age criteria in existing programmes and to design further programmes taking into account the longevity perspective and the changes in the incidence of certain diseases among seniors whose longevity is increasing;
- it is recommended that programmes be designed to take greater account of the relevant health problems of the elderly;
- it is essential to take action to raise awareness of the importance of health-oriented activities rather than disease management, and to promote active, informed choices and lifestyles among older people that will foster the strengthening and maintenance of health.

The right to health is guaranteed to everyone, but securing it in old age requires comprehensive measures combining scientific knowledge of the ageing process with government and local authority decisions stemming from the specific policies adopted and from an active attitude towards one's own health among those concerned.

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