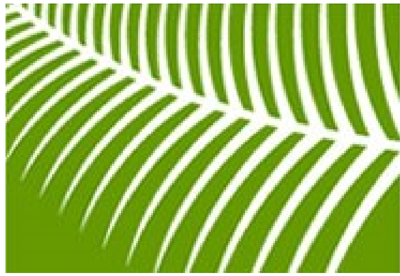

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Innovative Forms of Care for Seniors in Rural Areas of Poland

Abstract: Ageing is an issue faced by the majority of the European countries, including Poland. Due to their dissimilarity there is a need to apply different approaches to ageing in urban and rural areas. The population aged 65+ is expected to increase by nearly 60% by 2035, and the percentage of that group within the total population is estimated to grow from the current 14% to 22%. These demographic changes will bring new challenges to social welfare system. The need for social care and healthcare services will grow. In order to limit the consequences of this phenomenon action must be taken to allow elderly people to continue their careers, ensure that they are active members of their communities and that the quality of lives does not worsen. This article identifies new and innovative solutions in rural areas to support the elderly inhabitants whose independence is limited and keep them actively involved in community activities, and in order to ensure quality of life. The authors provide a detailed description of two non-standard solutions to deal with the ageing issue. These include social farms and rural hospices at home, both of which have already been implemented in some rural areas in Poland.

Keywords: elderly people, demographic changes, home hospice, social farms, Poland.

1. Introduction

The demographic ageing that is currently being observed in the majority of the European countries, including Poland, has been a topic of interest for researchers in various fields, including economists and sociologists. The ageing process is a result of a decline in the death rate and an accompanying decline in birth rate, which contributes to a growing proportion of the elderly in the population as

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a whole.[1] Sociologists and gerontologists often talk about a greying population, when Peter G. Peterson (1999) calls this process "gray dawn".

In the literature, old age is most often treated as a certain stage of life (static state), which is related to changes in the human body. Ageing, on the other hand, is a process (dynamic phenomenon) of progressive loss of function accompanied by a progressive loss of ability to adapt to the environment due to the increasing probability of death (Kirkwood 1996). According to Anthony Giddens (2006, p. 185) ageing processes are no longer treated as something obvious and natural; progress in medical and nutritional sciences has shown that the majority of ageing symptoms, once regarded as inevitable, may be either avoided or significantly reduced. Thanks to a better diet, hygiene and healthcare, on average people reach a much older age than they did a hundred years ago. Ageing is a natural physiological process, which is why it is difficult to determine a specific age in which this stage of life begins. Polish law defines an elderly person[2] as one who reached the age of 60 (Journal of Laws 2015). This marks the onset of old age also according to the World Health Organisation. The elderly population can be divided into three life-stage subgroups: the young-old (ages 60–75), the middle-old (ages 75–90), and the old-old (90+).

Population ageing has resulted in the development of a silver economy concept. This is a broadly understood economic system targeted at making use of the elderly people's potential and accounting for their needs (Rudnicka and Surdej 2013). Actions taken in this respect aim to encourage people aged 60+ to engage in various activities and in particular to continue their careers. Ageing appeared as a subject of social discourse as early as in the 1960s, when the UN General Assembly commissioned a report on population ageing. Initiatives taken by the United Nations became an inspiration to European Union projects. In 1999, the International Year of the Seniors, the European Commission (EC 1999) identified four dimensions of the phenomenon, with the focus on the ageing work force (a need for continuous training), the increasing burden on pension systems and state budgets (a need to develop pension systems which take account of demographic changes), increasing demand for medical services and healthcare for the elderly, increasing diversity of the elderly people's needs (increased risk of social exclusion).[3] In Poland, actions aimed at engaging the elderly in social

[1] So called demographic ageing (Rosset 1967; Okólski 2005, p. 154).

[2] The elderly are also called the seniors, golden-agers, retired persons, 55+, 60+ age group.

[3] In order to mitigate the adverse effect of these factors, the EU adopted the Lisbon Strategy, which included the aim to increase the employment rate to 70% by 2010, and in the category of employees aged 55–64 – to 50%.

activities and improving their quality of life are implemented by public sector institutions as well as by the tertiary industry.[4]

If ageing is considered from the point of view of residence, it is important to apply a different approach for urban and rural areas,[5] as these two environments feature major differences, for people in rural areas retirement may not necessarily involve a change in lifestyle. These people often continue to work on their farms. Thus it is difficult not to agree with Daniel Zarębski (2005), who claims that old people in rural areas experience living at that stage of life differently than their counterparts in cities. One also has to underline that the elderly people in rural areas form a very diverse group. On one hand, they include healthy elderly adults who have not yet stopped working and who live busy social lives. On the other hand, there are also people who are no longer fully independent and who are reluctant to change. Such people require a broad range of support, including health and social care. Dispersed settlement, low income or limited access to infrastructure are the non-demographic factors which influence the situation of the elderly in rural areas. The above-mentioned ageing issues are not exclusive to the Polish rural areas; they are also a challenge for governments of other European countries (the 2015 Report). The desired social security model should take account of the specific character of rural areas.

This is why any initiative specially tailored to the needs of elderly rural inhabitants in Poland should be encouraged. A call for action for elderly rural inhabitants is directly expressed in a programme called Solidarity of 50+ Generations.[6] The programme postulates adjusting the proposed actions to the needs, abilities and limitations of rural inhabitants. Other objectives include adjusting competencies and increasing the qualifications of people aged 45+ so that they are not excluded from the job market, developing corporate culture and environments which are more suited to workers aged 50+, increasing the effectiveness and efficiency of actions promoting employment and career development, supporting the idea of active and healthy ageing, developing cooperation in order to increase the employment of workers aged 50+, and enabling social transfers aimed at keeping the elderly employed until they decide to retire. In Poland, older people can use services in hospices, outpatient clinics, hospitals, care and treatment institutions, as well as

[4] These actions include: Objectives of the Strategy for Long-Term Care for the Elderly 2014-2020, Government Initiative for Social Inclusion of the Elderly 2014-2020 (ASOS Programme) and „Vigorous Seniors" Multi-annual Programme 2015-2020 (MRPiPS 2015, RM 2013a, 2013b, 2013c).

[5] A rural area is a multifunctional space, taking into account the features of diversification of the functional structure of the local economy, as and human communities (Rosner 2007).

[6] Solidarity of Generations Programme. Actions for supporting career opportunities for people aged 50+, Attachment to Resolution No. 239 of the Council of Ministers of 24 December 2013 (item 115).

in nursing homes, municipal day care homes, support centres for the elderly and home care, social farming and specialist care services at home.

The aim of the article is to identify new and innovative solutions to be implemented in rural areas in order to support elderly inhabitants whose independence is limited and keep them actively involved in community activities, and in order to ensure the quality of life. The authors provide a detailed description of two non-standard solutions to deal with the ageing issue. They include social farms and rural hospices at home, both of which have already been implemented in some rural areas in Poland. The article is based on secondary data sources provided by Central Statistical Office (*Główny Urząd Statystyczny, GUS*) and primary data gathered for the study by direct interviews.

2. Ageing of rural inhabitants in Poland

According to the 2014-2050 demographic forecast, the population of Poland will decline steadily (from 38.4 million in 2013 to 33.9 by 2050), and the number of people aged 65+ may increase from 5.67 to 11.09 million (from 14.7% to 32.7% of the whole population) (GUS 2014, pp. 133–134). For urban areas, the population aged 65+ will increase from 3.64 to 6.53 million (from 15.7% to 34.7% of the whole population) and in case of rural areas – from 2.02 to 4.56 million (from 13.3% to 30.2% of the entire population). This process will be accompanied by "double ageing", defined as a rapid increase of the proportion of the old (aged 75–89) and the oldest (90+) people in the elderly population.

Currently, 15.2 million people live in Polish rural areas, of whom more than 2.1 million are over 65.[7] The largest elderly population live in rural areas of five regions: Podlasie, the Lublin area, Mazovia, the Łódź area and Świętokrzyskie (cf. Stasiak 1992, Rosner 2012). The geographical distribution of this group is shown in Figure 1.

Greater Poland, Pomerania and Western Pomerania include the youngest municipalities in demographic terms. They have less than 10% of population of retirement age. These are chiefly suburban municipalities such as Kołbaskowo, Wejherowo, Komorniki, Pruszcz Gdański. In the "oldest" municipalities, the group of people in retirement age accounts for a third of the population. Those municipalities belong to Podlasie region and include Narew, Michałowo, Krynki, Milejczyce, Bielsk Podlaski, Czyże, Kleszczele, Orla and Dubicze Cerkiewne. The population aged 65+ is expected to increase by nearly 60% by 2035 to exceed 3.4 million and is estimated to grow from the current 14% to 22% of the total

[7] GUS 2016.

population.[8] These demographic changes will bring new challenges for the social welfare system. The need for social care and healthcare services will grow.

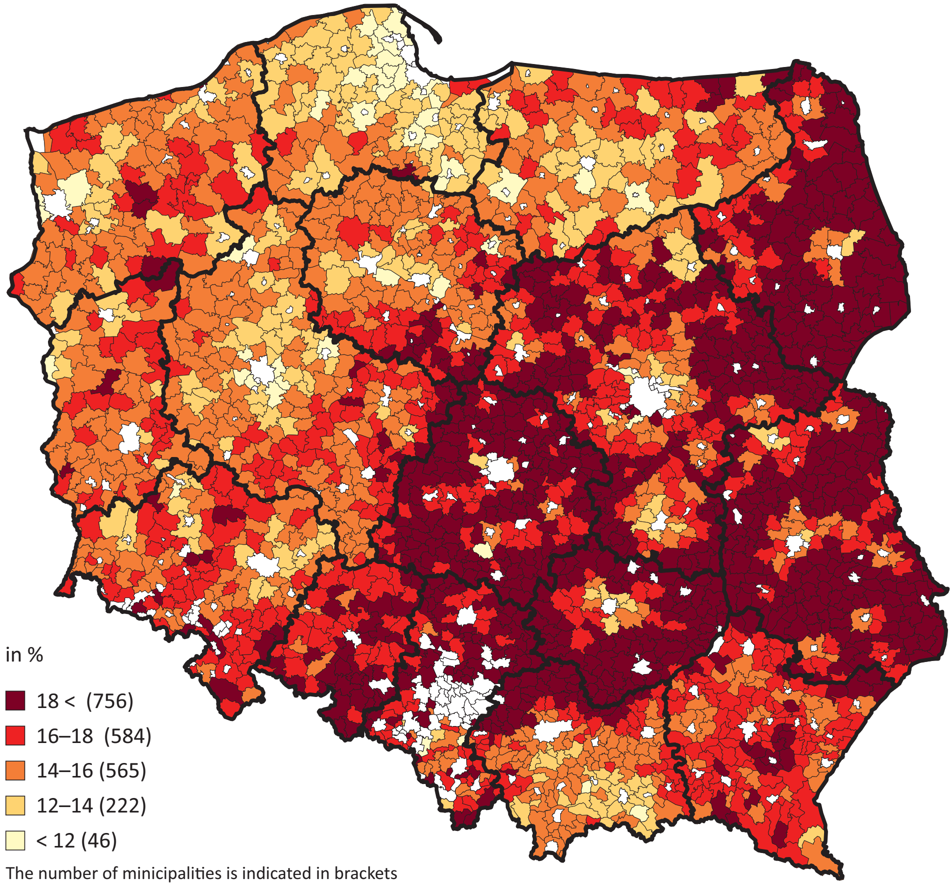

Figure 1. Percentage of people of retirement age

Source: Stanny, Rosner and Komorowski (2018).

The problem of ageing was noticed in the developed countries as early as in the 1970s, as a result of which institutionalised care models for the elderly were developed. In Eastern Europe the situation looks different; institutionalised care for the elderly is only starting to develop. The situation in rural areas is especially

[8] GUS 2014.

difficult. While the institutionalised care model is universally accepted in Western European countries, in Eastern and Central Europe the model of family care still prevails and putting an elderly person into an institution may be perceived negatively by the community. The rural community has long been associated chiefly with farming. In a traditional farming family the elderly enjoyed honour and the esteem of other community members due to their experience and knowledge to be passed on to the young. On the other hand, the absence of an institutionalised care system made the sick, handicapped or frail almost entirely dependent on family support after they were no longer useful on the farm. Until the 1970s Polish farmers were not covered by the social insurance system, and care for the elderly in the final stages of their lives was entirely left to families. It was similar with healthcare, which, until 1970s, was not easily available to farmers and had to be paid for. Hospitalisation or long-term treatment could be so expensive that the whole family could face financial problems. Pension or disability benefits and farmers' healthcare insurance were introduced gradually. Until 1962 the only way of securing life in old age was for parents to transfer their farm to the next generation (descendents) in exchange for support based on a caregiver contract.[9] By signing such a contract, the descendants undertook to provide food and accommodation to their forebears. Social insurance for farmers was developing in stages and by sectors. Initially it was introduced to cover the workers on state farms in 1946, followed by members of agricultural production cooperatives in 1962. Later, in exchange for waiving their title to land, individual farmers could also be covered with the state insurance (subsequent changes followed in 1973, 1977 and 1982). An important role in the government action for farmers was that of the Ordinance of the Minister of Health and Social Care (1971) concerning healthcare benefits. Farmers and their families were covered with free medical care. However, a property tax was imposed in order to offset the cost of these benefits[10] (see: Matysiak and Michalska 2016).

[9] Mariusz Ludwiński for Wydawnictwo Naukowe PWN, http://www.bankier.pl/wiadomosc/Wiedza-o-finansach-jak-powstal-KRUS-2261456.html [accessed: 10.02.2016].

[10] Property tax must be paid by land owners and perpetual usufructuaries. It also has to be paid by managers of property owned by municipality or state. The level of property tax is fixed by the municipal authorities with jurisdiction over the area on which the land is located. The amount due from a given owner/keeper is a product of land area and tax rate. Land intended for residential development is taxed at a lower rate. Land on which business activity is pursued has a higher tax rate.

3. The long-term care (LTC) system in Poland and case of the first home hospice in rural areas

Long-term care in Poland is provided by two types of institution: nursing care (support in everyday activities) is provided by welfare institutions and medical and healthcare services are provided by healthcare institutions. The services may be provided at home or at a specialist service facility (Golinowska 2006, p. 16).

Nursing care is offered to people who live alone and need support due to their age, illness or disability. It can be provided also to a person who has a family, but where family members, including a cohabitating spouse, are unable to provide care.

Institutional support and care are provided by small and large nursing homes as well as by day-care centres. Support and care at an old-people's home includes help with cleaning, cooking, shopping, running administrative errands, showering and bathing, dressing, administering medications, making the bed, preventing bedsores and blisters, feeding, keeping company and providing contact with the neighbouring community if possible.

Payment for a stay at a nursing home covers an average monthly maintenance cost. A resident of a nursing home pays no more than 70% of their income. The balance is covered by a spouse, descendants or parents, and in the case of a single person by a municipality (Ministerstwo Rodziny, Pracy i Polityki Społecznej etc.).

Healthcare services are provided to the elderly by long-term care institutions and convalescence and rehabilitation facilities. The task of a long-term care facility is to provide 24h care to chronically ill patients and to those who, following hospitalisation as a result of surgery or intensive treatment, no longer need a 24h stay but require care due to their health condition, disability, inability to care for themselves and a need for professional nursing and rehabilitation. In such facilities healthcare services are provided by doctors, nurses, psychologists and physiotherapists. The services include group therapy, pharmacological treatment, dietary treatment, provision of medical devices as well as health education to prepare a patient to care for themselves at home (Kujawska 2015, p. 714).

A resident of a long-term care facility pays the cost of board and accommodation. A monthly fee is fixed as an equivalent of 250% of the lowest retirement benefit, however, this amount may not be higher than 70% of the resident's monthly income defined by welfare legislation (Journal of Laws 2004). In 2013 there were 474 long-term care facilities (excluding mental health facilities); in addition there were 57 mental health facilities, 73 hospices and 57 palliative care wards at hospitals. Old people account for approx. 60–80% of LTC facilities and approx. 50% of nursing home residents (Kujawska 2015).

Healthcare services provided at home are targeted at mechanically ventilated patients. These are patients who require continuous or periodic ventilation by means of a mechanical ventilator (as a form of invasive therapy by means of a tracheal tube) or non-invasively through a mouthpiece, mask or helmet, which does not require hospitalisation at ICU or other 24h medical facility.

In addition, the services may be provided in the form of long-term nursing care at a patient's home. In such cases a nurse visits a chronically ill patient who does not require hospitalisation, but who requires systematic nursing care at home due to their health problems (Błędowski et al. 2012, pp. 71–75). Apart from the above-mentioned forms of institutional care, old people are frequently cared for by their families. There is also private-sector old people's care, where services may be bought at market prices. While in the Western European countries the institutionalised care model is universally accepted, in Eastern and Central Europe, for economic and especially cultural reasons, the family care model still prevails.

There are no specific figures concerning the cost of healthcare and social care for the elderly. They are included in the total cost of long-term care services. However, there is a general belief that healthcare funding in Poland is inadequate, also for the elderly. Mieczysław Gałuszka (2013) notes that the organisation of the healthcare system is not adapted to seniors' needs. Their needs are marginalised and healthcare services for old age are limited (Gałuszka 2013, p. 89). Poland features a hybrid model of long-term care financing, also in terms of care for the elderly. This involves financing with state funds (local budget, central budget, National Health Fund (*Narodowy Fundusz Zdrowia*, *NFZ*), i.e. with taxes and obligatory health insurance, as well as from private sources (pension funds, family savings, private insurance). The state budget funds dedicated to long-term care are very low.

Tertiary medical care for the elderly is insufficient in Poland. In the majority of regions, geriatric clinics can be found only in big cities and they are too few of them. For example, there is no such clinic in the whole Warmia and Mazuria region. Poland also suffers from a lack of doctors specialising in geriatric medicine. Their overall number is estimated at 275, but only 140 practise as geriatric physicians. According to the statistics, Poland has 0.36 geriatric physician per 100,000 population and only 2.5 specialist doctors per 100,000 population aged 65+ (Derejczyk at al. 2008).

The situation is equally difficult in the area of palliative care. The beginnings of palliative and hospice care in Poland date back to 1976, when, on Halina Bortnowska's initiative, volunteers were organised in Nowa Huta. The first organisation to provide palliative care at home was established in 1984 in Gdańsk. Since 1998 it has been possible for a doctor to specialise in palliative medicine. Nurses may also specialise in palliative care. In 2017 there were 476 palliative care doctors

and – according to the estimates of the Central Consultant in Palliative Care Wiesława Pokropska – there should be 1000 doctors more to fulfil the target of providing 0.3 palliative care doctors per 10,000 population. Currently there is a shortage of 500 doctors. Every year from 20 to 40 doctors specialising in palliative care join the system, which is not enough to achieve the estimated targets. In Western Europe 12 palliative care beds are assumed to be needed per 100,000 population. In Poland it is currently 6.5 beds per 100.000, and in some regions there are only 2.6 beds (Western Pomerania) or 4.7 (Mazovia). In Poland there are 450 hospices at home, approx. 150 out-patient clinics and 160 hospital wards (Analysis of Palliative and Hospice Care in Poland).[11] According to specialist doctors, the waiting time for admission to a palliative care facility ranges from three to seven days (according to the ministry) or several weeks, to even three months (according to specialist doctors).

In this respect, elderly inhabitants of rural areas suffering from depopulation are in a particularly difficult situation. Depopulation processes are highly visible in eastern Poland, where the population has been ageing, the birth rate is negative, younger inhabitants emigrate and the villages are increasingly populated by excluded and lonely people. Due to increasingly limited services, including public transport, their access to (disappearing) infrastructure, including medical services, is quite limited. The Prophet Elijah Hospice at Home[12] has been operating in such an area where chronically ill people have difficulty reaching a doctor, a clinic, a hospital or a pharmacy, where old age frequently means loneliness and lack of support, or where a caregiver is also old and ill. On its establishment it was the only one, and currently it is one of a few institutions operating in rural areas and providing palliative care at home. It has been run since 2009 by the Prophet Elijah Hospice at Home Foundation based in Michałowo in Podlasie region. It has been operating in five municipalities. In order to reach some patients, the doctors must sometimes travel up to 40 kilometres. The foundation provides care for about 40 patients, but less than 20 of those are financed by the National Health Fund. There are no big urban centres in the region, and there are no other institutions providing similar services. The hospice provides free care to terminally ill people so that they can live the last months of their lives in dignity. Psychological support is also provided to families of the sick people as well as to people working with the terminally ill, namely to medical personnel and volunteers. Since July 2017 care for approximately half the patients is funded by the National Health Fund, and the rest are maintained thanks to individual and institutional donors.

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[11] http://www.mpz.mz.gov.pl/wp-content/uploads/sites/4/2018/06/opiekapaliatywnahospicyjna_polska-1.pdf [accessed: 11.07.2019].

[12] https://hospicjumeliasz.pl/ [accessed: 11.07.2019].

The Hospice at Home personnel include three doctors, four nurses, a nurse coordinating the rent of medical equipment, four physiotherapists, a psychologist, administrative workers and volunteers. Patients may rent medical equipment, such as hospital/rehabilitation beds, mattresses, portable oxygen concentrators, walkers, rollators etc. Under a social innovation introduced by the hospice, the personnel was increased to include carers. Their job is to help in everyday situations if a patient cannot be left all by themselves at home and a family member who cares for them has to go out and cannot deliver the patient to a day-care centre. Carers' (mostly female) tasks involve helping with household chores and nursing. Practice shows that these new team members are highly valued simply because of the time they spend with the patient just being with them and talking to them.

In order to raise funds for its operation, the foundation has taken various initiatives to promote its activity. These include the Elijah Run, organised every year since 2012, or a charity ball and a charity auction. The hospice also takes part in the Field of Hope campaign, started by the Marie Curie Cancer Care Charity in Edinburgh, UK, which, thanks to the St. Lazarus Hospice in Krakow, has now been promoting hospice organisations for 18 years. During fund raising events in spring, donors are given daffodils planted in autumn – a symbol of rebirth after winter – which are also symbols of hope for victorious end of a battle with cancer. During the campaign conferences are organised to integrate hospice workers from all over Poland.

Apart from providing medical services, the Hospice at Home has become an important institution in its area of operation, as it engages and integrates representatives of various communities: the patients, their families, individual donors and local businessmen. Actions under the Field of Hope campaign involve local school students as well as people from the neighbouring regions. Its activities go far beyond healthcare, and its importance, especially because of its active participation in the local community life, can be compared to the role of institutions which used to integrate rural communities in the past. Collaboration with local authorities, churches of various denominations (Podlasie is an atypical region of Poland – populated by people of many religious denominations), schools, local business representatives, mass media, makes the hospice an important actor prompting changes in rural areas. First and foremost, however, the hospice staff provide such help to patients and their families, which makes their lives in rural areas easier. To address vast needs of the population in respect of long-term care, in 2019 the construction of a hospice building started in order to provide 24h care to patients who can no longer be taken care of in their homes and have to be transferred to a specialist facility.

4. Social farming (green care)

The social farming concept goes back to the Middle Ages. One of the best known examples of a social farm is described by Eugeen Roosens and Lieve Van de Walle (2007). The farm was in Ghel in Flanders – now part of Belgium. Support was provided to needy people who – while following a specific therapy – were included in daily work on a farm. More social farms operated in the second half of the 19th century, when mentally handicapped or sometimes physically handicapped people were placed in specialist institutions in the country and on enclosed areas adjacent to parks, forests or on the outskirts of big cities (Bird 2007, p. 102). The most important reason for placing handicapped people in such locations was the wish to isolate them from the rest of the society, because they were regarded a shameful social problem. Then, however, it was noticed that the natural environment has a calming effect on the inmates of such institutions. It was common for these facilities to establish one or several farms producing staple food, which helped lower the cost of the inmates' maintenance. Where it was advisable, the inmates could participate in farm work. Apart from significant financial benefits, the positive influence of work on the inmates was observed. In the mid-20th century the first specialist therapeutic communities were formed, known as Camphill Movement or Camphill Communities,[13] in which handicapped children underwent therapy, nature being regarded as the key element of the therapy.

In 21st-century Europe, care provided on farms is a part of a broader idea of farming (EC 2013), which combines two concepts: multi-functional farming and social services – healthcare at local level. Agricultural production contributes to improving the well-being and social integration of people with particular needs. The term **social farming** comprises a number of activities known throughout Europe as **farming for health**, **care farming**, **green care** or **green therapies**. These terms relate to various actions in the area of care, social reintegration, social and vocational training and rehabilitation of people who find themselves in difficult predicament, as well as training people with particular needs. Taking such actions contributes to improved well-being of people who are in a difficult situation, by improving their health and by social inclusion. Sometimes – through contact with nature and the act of production – such activities contribute to improved learning skills, improve self-esteem and facilitate participation in social life.

[13] Formation of the first Camphill communities was related to an Austrian doctor Karl Konig, who was inspired by the ideas of Rudolf Steiner. In 1940 Konig emigrated from Nazi Austria to Great Britain (near Aberdeen in Scotland) where, together with other doctors and students, he established the first community that provided therapy to handicapped children and ran a farm. http://www.camphill.org.uk/about/camphill-history [accessed: 3.04.2015].

Analysing the systems of social farming in Europe, Jan Hassink (2009) points to a certain differentiation of approaches across countries (Figure 2). In the Netherlands the dominant model is one which puts emphasis on the care function provided on a farm. Similar mechanisms are popular in Flanders – the Flemish part of Belgium. Public institutions and healthcare institutions in social farming predominate in Germany, France and Ireland. In Italy there are both private farms as well as very common social cooperatives, which is why the system is often referred to as mixed.

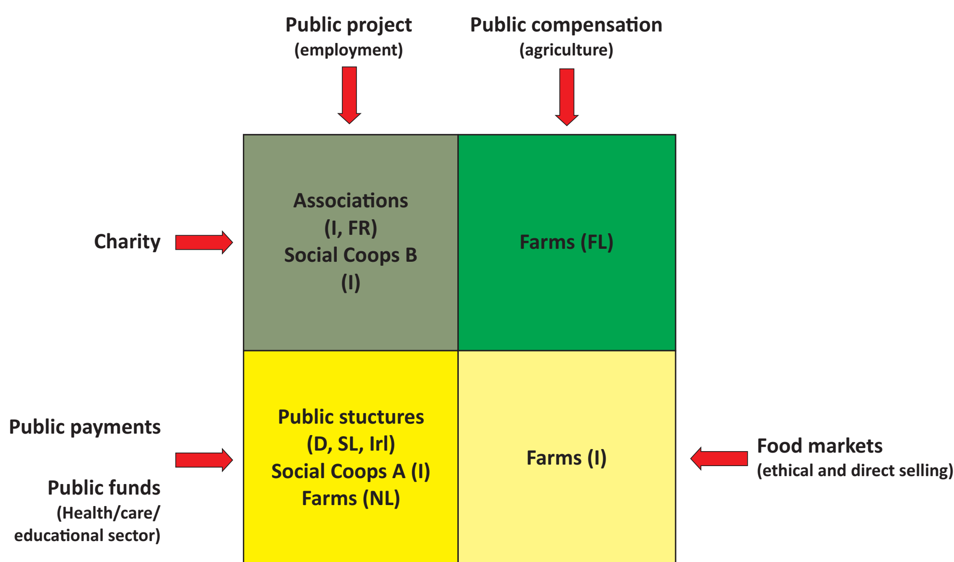

Figure 2. Various regulations of social farming in Europe

Source: own studies based on Hassink 2009, p. 32.

Social farming in the Netherlands is the closest to the healthcare system, while in Italy and France it is chiefly linked to the social sector and welfare system, and in Germany, Britain and Slovenia it can be put between the social sector and healthcare sector.

From the point of view of funding, in Italy and France public projects and charity campaigns organised by social associations and cooperatives (chiefly in Italy) predominate. In the Netherlands, where agricultural holdings predominate, funding comes in the form of state money dedicated to healthcare and caregiving sectors. In Germany, Ireland or Slovenia social farming is funded by public institutions with state budget funds earmarked for healthcare or education (Hassing 2009).

Social farming as a new trend related to socially engaged farming has so far been little known in Poland. As a practically not yet discovered idea for running a private farm in Poland, social farming is at the experimental stage. The issue is reflected in the Responsible Development Strategy (RDS) adopted by the Council of Ministers on 14 February 2017 (MED 2017), which is a key governmental document in the area of medium and long-term economic policy. The issue of developing non-agricultural functions of farms (including caring, healthcare and educational services), has been raised several times in the RDS. This is one of the actions to be implemented by 2020 under Rural Development Programme (Objective: Sustainable territorial development), as well as under improvement of accessibility to social and healthcare services (Objective: Social cohesion). The proposed goals are also reflected in strategic projects highlighted in the RDS. Under a strategic project "(Not)independent" (which provides for a set of various social services for handicapped people to ease the burden for informal carers), the Ministry of Agriculture and Rural Development has been implementing a measure called "Farm open to people".

5. The experience of establishment and development of social farming in Kujawy and Pomerania region (Central Poland)

Actions to develop social farming in Kujawy and Pomerania were inspired by similar ones taken in the period 2002–2004 in Podkarpackie and Lublin regions (Ordyczyński 2004, p. 30). In 2013, the Kujawy and Pomerania Agricultural Advisory Centre Minikowo started discussions with a group of holiday farm holders in the area of Bory Tucholskie (Tucholskie Forest) unified in the Bory Tucholskie Rural Tourism Union to extend their operations to include caring for people in need (Kamiński 2015). During several meetings the farmers were presented with the concept of social farming in the Netherlands. Apart from farmers running holiday farms, the participants in the meeting also included representatives of Tuchola County (*powiat*) Authorities, the local action group Bory Tucholskie and other local leaders. A group of seventeen holiday-farm owners or members of their families participated in an intensive two hundred hour-long training on how to care for elderly and handicapped people. The training included theoretical and practical part (minimum 100 hours of practical training) at the old people's home in Wysoka locality in Tuchola County. The participants learned about the specific type of work as carers and held direct discussions with the inmates. Thanks to practical training and experience acquired they were able to assess whether they were ready to provide care to the elderly and the handicapped. The participants were very much interested in the training.

In 2014 the implementation of the international component of the project began. Liaisons were made with a Dutch partner – DLG Government Service for Land and Water Management – and a concept of establishing social farms in Bory Tucholskie was prepared based on the Dutch experience (Kamiński 2014). In the beginning a Dutch expert paid a visit to the site[14] and workshops were held with the participation of farmers interested and other stakeholders from Tuchola County. Further actions were effected with the support of funds from the European Social Fund of the Regional Operational Programme for Kujawy and Pomerania Region. Between 2016 and 2018 under the "Green Care" project, support was provided to 225 people in need of care. They were offered day-care at 15 social farms. Finally, 75 day-care places were established in five countries in the region. In the 2018-2020 period a subsequent project has been implemented ("Care on a Farm") which includes 14 other social farms that provide support to further 225 people in need. It is worth underlining that although the EU funding has expired the vast majority of the farms still operate. Some of the farmers have officially registered their farms as caregiving establishments, a few others have registered "social economy" entities, for example in the form of foundations.[15] Farm owners have also established a regional association. Theoretical support is still provided by the Kujawy and Pomerania Agricultural Advisory Centre in Minikowo. Systemic solutions at a central level are provided by the Agricultural Advisory Centre in Cracow, which has been cooperating with the Jagiellonian University and the Ministry of Agriculture and Rural Development in the establishment of legislative and administrative framework for social farms in Poland under the GROWID Project.[16]

6. Conclusions

Ageing requires taking appropriate action and must be taken account of in the central socio-economic policy. A change of population age structure has an impact on a change of the structure of the population's needs. An analysis of this phenomenon is necessary as it may help to adjust actions in order to mitigate the adverse effects of ageing. In Poland a number of initiatives have been taken in order to improve seniors' lives by offering various forms of education, social activities and career opportunities. This is necessary because ageing may lead to

[14] The expert was Mr Kees Manintveld, who in the 2002-2004 period helped to develop the concept of social farm in the Podkarpackie region.

[15] See as an example: http://www.toskaniakociewska.pl/ [accessed: 14.07.2019]

[16] See: https://www.cdr.gov.pl/projekty-i-wspolpraca/2898-growid-gospodarstwa-opiekuncze-w-rozwoju-obszarow-wiejskich-wobec-wyzwan-demograficznych [accessed: 14.07.2019]

an increasing gap in satisfying job demand and increased demand for healthcare and social care services at the same time.

One has to underline that ageing in Poland is not equally distributed across regions or in terms of urban and rural areas. Seniors in rural areas are more dependent on their families, which can help them if the old people's health deteriorates to the extent that they find it difficult to live on their own.[17] Although rural areas are known as homes to more multi-generational families, in recent years this situation has been changing, because of the frequent migration of youth to big cities and abroad. This is an unfavourable phenomenon from the point of view of caring for the elderly family members and for a family as an institution to fulfil the carer role. The diminished role of the family in caring of its senior members increases the demand for external help of specialist facilities. In a time of a growing need for care services for more and more elderly people the number of facilities which can offer this type of service in rural areas is still insufficient.

Social farms and hospices mentioned in this article are unconventional undertakings which provide therapeutic services, care and inclusion for the elderly and are oriented especially on this group of people. Social farming is a new form of care used in many Western European countries. Not previously used in Poland, it is innovative and complementary to public services. This environmental care is carried out near the place of residence of dependent elderly people and is cheaper than all-day stays in social welfare homes or hospitals or care and treatment centres.

One should praise actions taken in Poland (under a number of adopted and implemented supranational, national and regional strategies) which are dedicated to supporting innovations in rural areas and which establish framework and systemic solutions in order to increase accessibility to care services to the elderly inhabitants of rural areas.

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[17] In the general opinion of society, it is the family which is primarily responsible for providing care and help to an elderly person (Dyczewski et al. 1999).

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Innowacyjne formy opieki nad osobami starszymi na obszarach wiejskich w Polsce

Streszczenie: Starzenie się populacji to proces, przed którym stanęła większość krajów europejskich, w tym Polska. Konieczne jest stosowanie odmiennego podejścia do problemu starości w mieście i na wsi, ze względu na zróżnicowanie obu środowisk. Prognozuje się, że na obszarach wiejskich w Polsce do 2035 roku liczba osób po 65. roku życia wzrośnie o niemal 60%, a ich odsetek wobec ogółu populacji z obecnych 14 do 22%. W związku z tymi zmianami demograficznymi pojawią się nowe wyzwania dla systemu zabezpieczenia społecznego. Wzrośnie przede wszystkim zapotrzebowanie na pomoc społeczną i opiekę zdrowotną. Konieczne jest więc podejmowanie działań mających na celu podtrzymanie aktywności społecznej oraz zawodowej i poprawę jakości życia osób po 60. roku życia. Celem artykułu jest identyfikacja nowych i innowacyjnych rozwiązań organizacyjnych, które wspierają na wsi osoby starsze o ograniczonej samodzielności i podtrzymują ich aktywności, a także zapewniają im dobrą jakość życia. Autorzy szczegółowo zaprezentowali dwa niestandardowe rozwiązania radzenia sobie z problemami starzejącego się społeczeństwa. Są to gospodarstwa opiekuńcze i wiejskie hospicjum domowe, które działają na terenach wiejskich w Polsce.

Słowa kluczowe: osoby starsze, zmiany demograficzne, domowe hospicjum wiejskie, gospodarstwa opiekuńcze, Polska.