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TO GIVE WHAT IS REALLY NEEDED

RESEARCH REPORT

IRWIR PAN
Polish Academy of Sciences
Institute of Rural and Agricultural Development

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Introduction: The Problem and the Proposed Solution

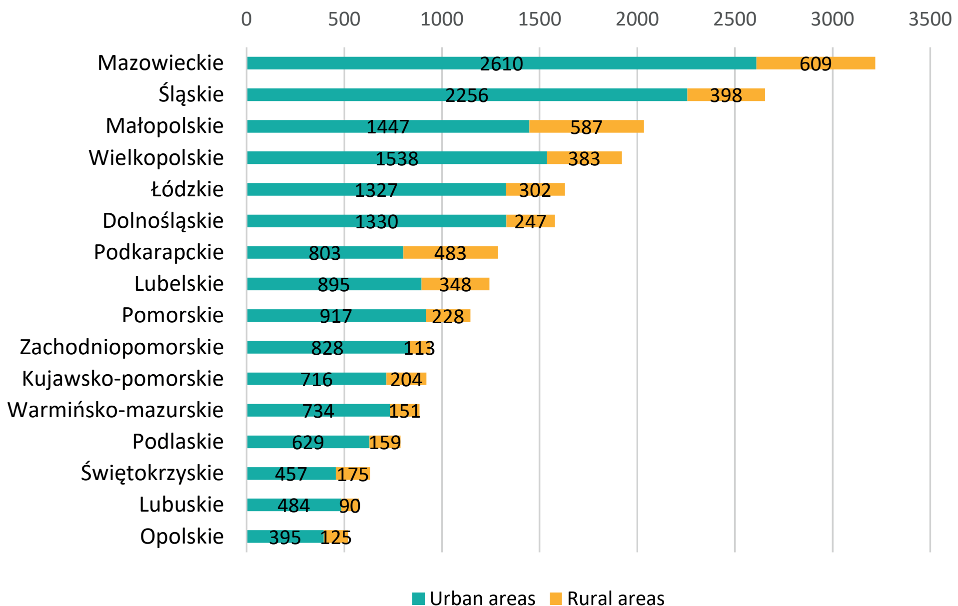
The demographic changes taking place in the European Union indicate that the ageing of the population has been a steady trend for some time. It is due to many factors: people starting a family later than they used to, a smaller number of children being born, and progress in medicine extending life expectancy. Some regions of the EU are ageing faster than others, due to factors including the migration of young inhabitants and the related exceptionally low birth rate. These are also places where we observe the decline of commercial services as a result of decreasing profitability as well as public ones due to diminishing tax revenues (Łuków et al. 2021; Bem, Ucieklak-Jeż, Prędkiewicz 2015, 2014, 2013; Krawczyk-Sołtys 2014; Bennett, Probst, Vyavaharkar, Glover 2012; Williams, Carter, Spencer, Solovieva 2005; Frączkiewicz-Wronka 2004; Guagliardo 2004; Casey, Thiede Call, Klingner 2001). In the face of these changes, the situation of older people living in areas affected by the processes described above seems especially difficult (Roksandrić, Sikoronja 2021; Watts et al. 1999). They are being deprived of access to services that may be crucial for their health or quality of life. The problem is becoming so urgent that the necessity to find means of dealing with the effects of these processes has become the focus of the European Commission's attention. Announcing the *Call for Proposals on Social Innovation and National Reforms – Long-Term Care*, the EC sought initiatives that might become model solutions promising to respond to existing needs. The call for proposals, launched in 2019, yielded several dozen submissions of innovative initiatives, seven of which were chosen for testing. Among these was one initiative from Poland: the project *To Give What Is Really Needed*, carried out by a consortium of four partners.

According to the Polish national population and housing census (NSP 2021), today approx. 60% of the population of the Republic of Poland lives in urban areas and 40% lives in rural areas. Demographic forecasts up to 2050 predict that the urban population will decrease by as much as 17.4%, while the rural population will drop by just 1.8%. The reason lies mainly in migration from urban to rural areas (the spread of cities),

from peripheral rural areas to suburban areas classified statistically as rural as well as a slightly higher fertility rate. Rural population growth is not uniform across the country. Looking at microregions (*powiat*/county units), the population will grow in counties surrounding province capitals and decrease in peripheral ones.

Let us juxtapose this with rural areas' preparedness for the challenge before them. According to the Statistics Poland (GUS) report *Rural Areas in Poland 2020*, there were 4,600 health centres/outpatient departments in these areas, which accounted for 21.5% of all such centres in Poland. Their number had increased by 440 since 2010. In urban areas in 2020, there were 16,900 health centres, their number having grown by 4,500 over 10 years, i.e. 10 times more compared to rural areas. This means that there are three health centres per 10,000 rural residents, whereas this index is close to 6.5 per 10,000 residents in urban areas. Even taking into account that the great majority of specialist health centres/clinics are located in cities, access to basic health care is by no means equal (cf. also Ucieklak-Jeż, Bem 2017).

Figure 1. Health centres/outpatient departments in 2021, by locality and province character (status as of 31 December).



Source: *GUS „Outpatient Health Care in 2021" news release of 24 June 2022.*

As regards highly specialised hospital care, understandably it would be irrational to disperse resources, equipment and the small number of specialists (cf. e.g. Siedlecki Bem, Ucieklak-Jeż, Prędkiewicz 2017), and the better solution is to concentrate these

services in cities, given that highly specialised centres operate there. However, it is important to ensure everyone access to such services. Meanwhile, it is worth looking at the data on primary health care provided at health centres, which should be located close to patients' place of residence. People living in small localities should be able to get to these centres easily, both for medical help and to obtain a referral for further treatment by a specialist.

Rural residents have to deal with multiple problems caused by many years of neglect, compounded by the effects of unfavourable demographic processes: population ageing, migration of young people to urban areas, single-generation families, the singularisation of old age. The oldness of the population is connected with an increased incidence of incurable diseases that restrict older people's fitness and independence. The crisis of the 1980s and the post-communist transformation led to the degradation of the system of rural health centres built in Poland after World War II (Jarosz, Kosiński 1995; Jastrzębowski 1994), causing the conditions of health care for rural residents to become unsatisfactory. This crisis situation is deepened by the decline of public services, the high cost of private services, and the concentration of these services in urban areas. The lack of convenient public transport, especially in peripheral areas, further exacerbates the crisis (Ciechański 2021; Wolański et al. 2016).

Caring for people at the end of life is a special type of medical care. The predominant opinion today is that the best solution, both from the viewpoint of an older person's well-being and in terms of the cost of care, is the longest possible functioning of older people in their home environment and not in a nursing home. This was also the approach announced in 2021 by the Polish government, which called for giving up care at large institutions in favour of providing support in the local environment where people lived. This is the main premise of the *Strategy for the Development of Social Services*.[1] At the same time, long-term in-home nursing care, in which patients receive help at home[2] and which is important for chronically ill and dependent patients, is less often available in rural municipalities. Many rural health centres lack the staff to provide such services. Among other things, this is due to the imperfection of the law regulating the remuneration for such employees: it does not provide for any payment for using their own means of transport to get to patients, nor does it make allowances for the fact that reaching patients in rural areas takes much longer due to dispersed housing. The system for financing medical or care services fails to take into account the unique conditions sometimes found in rural areas. In this situation, employees can make fewer visits or (against the regulations) shorten their visits, counting the travel time as

1 https://isap.sejm.gov.pl/isap.nsf/DocDetails.xsp?id=WMP20220000767 (accessed 12 February 2022).

2 Health Minister's 22 November 2013 Regulation on Guaranteed Nursing and Care Services in Long-Term Care (*Dziennik Ustaw/Journal of Laws* 2015 item 1658, as amended).

part of the time assigned to the service. For similar reasons, in-home hospice care is not readily available to patients living in rural areas, either. The results of a study from 2012 (Dziechciaż et al. 2012) suggest it is essential to improve older people's access to long-term care and comprehensive geriatric care focused on the diverse needs of older patients and their caregivers.

The aim of the project *To Give What Is Really Needed* was to test an innovative approach to providing long-term care to older and dependent, chronically and terminally ill people in already tough rural areas, i.e. areas strongly affected by depopulation and rapid population ageing. The proposal was developed by the Prophet Elijah Hospice Foundation,[3] which has 10 years of experience in providing in-home hospice services in five municipalities in eastern Poland, in Podlaskie province. The innovative approach in question, aimed at ensuring an effective care system, was based on the assumption that in-home hospice care should be available to everyone who needs it (WHO standard) and not just to those with specific illnesses.[4] To provide such care to this wider group, the following was assumed to be necessary:

- setting up an interdisciplinary team for such a hospice, comprising doctors, nurses, physiotherapists, hospice caregivers, a dietician and a psychologist. The team should be based on locally available resources as much as possible, and the range of services offered should be tailor-made to respond to the needs of a specific patient;
- building a collaboration/support network of local institutions/formal and informal organisations able to provide relevant services;
- creating the job position of Dependent Care Coordinator (KOOZ). This person's task would be to identify the needs of the hospice's patients and support their families, and then apply for necessary help for them to the relevant institutions on their behalf.

The project was implemented by a consortium of four partners, namely:

1. the Prophet Elijah Hospice Foundation (FHPE), founded in May 2009[5] and

3 The foundation gained its first experience in building the innovation model as a participant in a project of the Shipyard Foundation – Laboratory for Social Research and Innovation called *Innovations on a Human Scale: Supporting the Development of Micro-Innovations in Dependent Care Services*, co-funded under the POWER programme. In the project, the Shipyard Foundation provided funding for the ideas of the prospective innovators. The project implementation became the basis for designing methods of action that the FHPE is currently testing in the hope of implementing them across the country with time. Another project related to the same subject matter was the Pro Hospiz initiative in the Erasmus+ European programme, in which partners that included the FHPE shared their experiences during four international training programmes and an exchange connected with best practice in providing palliative care.

4 For adults, the list of illnesses entitling a patient to receive hospice care in the National Health Fund (NFZ) system includes: diseases caused by the human immunodeficiency virus (HIV), cancer, the outcomes of inflammatory diseases of the central nervous system, systemic primary atrophies affecting the central nervous system, cardiomyopathy, respiratory failure, decubitus ulceration.

5 It was called the Podlasie Oncological Hospice Foundation at the time.

headed by Paweł Grabowski MD, which provides care to terminally and chronically ill adult patients from five municipalities in Podlaskie province: Michałowo, Gródek, Zabłudów, Narew and Narewka. The foundation became the leader of the consortium. In 2020 (before the innovation's implementation) the FHPE team comprised four doctors, six nurses, a psychologist, three physiotherapists, a dietician, and six hospice caregivers. In that year, 119 patients were in the foundation's care programme. The patients received a different package of services from the one offered by the NFZ; it was more flexible, adjusted to the patients' changing needs. The employment situation changed during the implementation and testing of the innovation. As of 2023, the foundation has also been running a residential hospice in the village of Makówka, Narew municipality.

2. The Regional Centre for Social Policy in Białystok (ROPS-B), which is a local-government organisational unit operating in the form of a state administrative entity. The aim of the centre is to carry out the Podlaskie Province Local Government's tasks connected with social policy, especially social services, preventing and solving alcohol-related problems, drug addiction, preventing social exclusion, supporting families, and the foster care system. Fulfilling its tasks, the centre works with national and local-government administration bodies, nongovernmental organisations (NGOs), and other entities.

3. The Institute of Rural and Agricultural Development of the Polish Academy of Sciences (IRWiR PAN) is a research institute. The purpose of the institute is to conduct interdisciplinary research on issues connected with rural and agricultural development involving economic sciences, social sciences and humanities. In particular, the institute's tasks include conducting research projects within the disciplines of the aforementioned and related sciences, and disseminating the results.

4. The Nongovernmental Organisations Support Centre (OWOP) in Białystok is an association that aims to support and foster the development of the activity of citizens and their organisations. OWOP supports local and supra-local initiatives, supports the development of NGOs, stimulates and supports collaboration between NGOs and the national and local government administration, supports initiatives serving to build civil society, stimulates, supports and promotes self-help and civic activity, creates conditions for inter-sector cooperation, promotes and organises volunteering projects, supports and develops the social economy and corporate social responsibility, supports the development of local government units and their organisational components, and fosters social, career-related and educational integration and reintegration. In particular, the association pursues its goals by initiating collaborations and joint activities.

The implementation/testing of the innovation lasted three years (with a six-month break caused by restrictions introduced due to the COVID-19 pandemic): it began in

2020 and will end in 2024. The present publication offers a synthetic presentation of the results of observation and research conducted during the innovation's implementation and at the time of activities aimed at propagating its implementation as an element of social policy at the national level. Detailed results and analyses were presented to the consortium members in partial working reports drawn up in the course of the research.

1. Social Innovations and Methods of Studying Them

1.1. Social Innovations: Between Theory and Practice

The notion of innovation was initially tied to technology (Utterback 1971), but over time it also started being used with respect to activity in the social sphere (Nicholls, Murdock 2012; Murray, Caulier-Grice, Mulgan 2010; Mulgan, Tucker, Ali, Sanders 2007; Mulgan 2006; Cloutier 2003). The possibility of such usage of the term became the subject of theoretical reflection by many authors (Marques, Morgan, Richardson 2017; Wronka-Pośpiech 2015; Mothe, Thi 2010; Pol, Ville 2009; Phills, Deiglmeier, Miller 2008; Maruyama, Nishikido, Iida 2007). The term "social innovation" was used in relation to activities in many different areas, including education (Loogma, Tafel-Vila, Umarik 2012), fostering the sustainable transformation of marginalised areas (Spacek, Perlik, Brnkalakowa, Kluvankova, Valero, Nijnik, Melnykovych, Lukesch, Sarkki 2021), health issues (Benaire, McCarthy 2012, Calsyn 2003), and combatting domestic abuse (Sullivan 2003). In Poland, research on various entities' role and collaboration in the implementation of social innovations was conducted by Katarzyna Zajda (Zajda 2022a, 2022b; Zajda, Mazurek 2022).

Social innovation is such a complex issue that no single definition of it exists (Caulier-Grice, Davies, Patrick, Norman 2013; Moulaert, Martinelli, Swyngedouw, Gonzalez 2005). On the website of the European Social Innovation Academy,[6] Grigorios Balamatsias has posted eight popular definitions of social innovation, developed up to the end of the 2010s on the basis of various approaches, including pragmatic, systemic, managerial, critical, economic and universal. To put it briefly, a social innovation is an innovation that is social both in its ends and in its means. It is most often a response to many crisis changes observed in Europe and the developed North, to mention examples

6 https://www.socialinnovationacademy.eu/author/greg-balamatsias/page/3/ (access 10 October 2023).

such as the refugee crisis, growing social disproportions and marginalisation, problems of young people, unemployment, poverty, and demographic problems. The European Commission (2013) states that "social innovations can be defined as the development and implementation of new ideas (products, services, models) that respond to social needs and create new social relationships or collaborations" (Zajda 2022, p. 20). The EC also adds that they are open, social in their ends and their means, and take place in social processes.

Social innovations have garnered interest from various groups – starting with politicians, through experts, to researchers – that create definitions for their own particular purposes. Hence the confusion in discourses, which proceed on different levels: at the level of public policies, where they concern various aspects of economic and social development; at the level of social actors, who undertake various activities when faced with different problems; at the level of scientific research, where their characteristics are analysed, and at the level of the innovation addressees (stakeholders) (Penven 2015). This discourse changes over time, because social innovations respond to emerging social problems that are the effect of consecutive crises of the capitalist world in the second half of the 20th century. Benoît Lévesque (2018) distinguishes four generations of social innovation. The first one developed in the 1960s on the wave of "counterculture". That was when the idea emerged to "work and produce differently", and "alternative enterprises" were set up. The second generation came in response to the problems caused by the crisis of Fordism. The innovations of this generation were mainly related to labour and the democratisation of relations within enterprises. The third generation of innovation responded to the crisis in public services guaranteed by the "welfare state". This crisis created an extremely favourable context for social innovations to emerge (Harris, Albury 2009), which ultimately led to the reconfiguration of the model of the state (new public management). Innovations appeared in four areas: personal services, employment and labour market entry, local development, and governance. This was accompanied by a wave of social economy projects, which led to the hybridisation of innovation, where the actions of public functionaries and users of services were interwoven (Heiscala 2007). In the second decade of the 21st century, in response to the climate crisis, a new – fourth – generation of social innovation emerged, because that crisis required changes in the relationships between the economy, society, and nature. This meant it was necessary to change the way that production, consumption and management were conducted, and also the global relationships between present and future generations, the North and the South.

In Poland research on social innovations in rural areas is pursued from diverse perspectives. On the one hand, as in Zajda's research (Zajda 2022), social innovations

may be analysed in terms of the diversity of actors involved in their implementation, in particular including the involvement of non-profit organisations and their types (e.g. NGO, LAG). On the other hand, researchers dealing with activities that are part of smart village initiatives (Kalinowski, Komorowski, Rosa 2021) focus on the potential of motivating local communities. Both these perspectives will be considered further on in the description and analysis of the innovation discussed here, i.e. a new model of care for ill and dependent people and their families in rural areas. It is worth pointing out that this particular innovation was chosen by the EC because it responded to an important, actually existing and acute problem, impossible to solve using traditional methods, experienced by the community where the innovation is being implemented.

1.2. „To Give What Is Really Needed" Project: The Innovation According to Various Research Approaches

Descriptions of social innovations mention many different features. The Young Foundation (2012) lists: (1) novelty; (2) the possibility of implementation in practice; (3) meeting a social need; (4) effectiveness; (5) enhancing society's self-organisation. Innovations can be implemented bottom-up or top-down. They also differ with respect to territory, in which case we can distinguish: (1) innovations developed locally and implemented supra-locally; (2) innovations that are sustainable locally and supra-locally; (3) supra-local innovations that are implemented locally (Zajda 2022, p. 27). The description of an innovation is also complex. According to Julie Cloutier (2003), it should include: (1) the subject of innovation; (2) the field of innovation; (3) the subject of change; (4) the aim of change; (5) the process of change; (6) results.

We propose that the above theoretical findings serve as guidelines for the description of the innovation called *To Give What Is Really Needed*. It belongs to the third generation of innovations, being a response to a crisis in public services guaranteed by the state, in this case: medical and care services for ill and dependent people. It has all the main features of a social innovation: (1) it proposes a broader range and profile of care services, new elements in the organisation and management of the care system; (2) medical and social services; (3) it is targeted at people in need of such care living in five municipalities of Podlaskie province; (4) the aim is to make care more effective; (5) by creating a collaboration network, it assumes the consolidation of local communities' self-organisation. It is an innovation created locally and its implementation is also a grassroots activity. Based on the matrix presented by Cloutier (2003), it can be described as shown in Table 1.

Table 1. Innovation analysis matrix in the project „To Give What Is Really Needed".

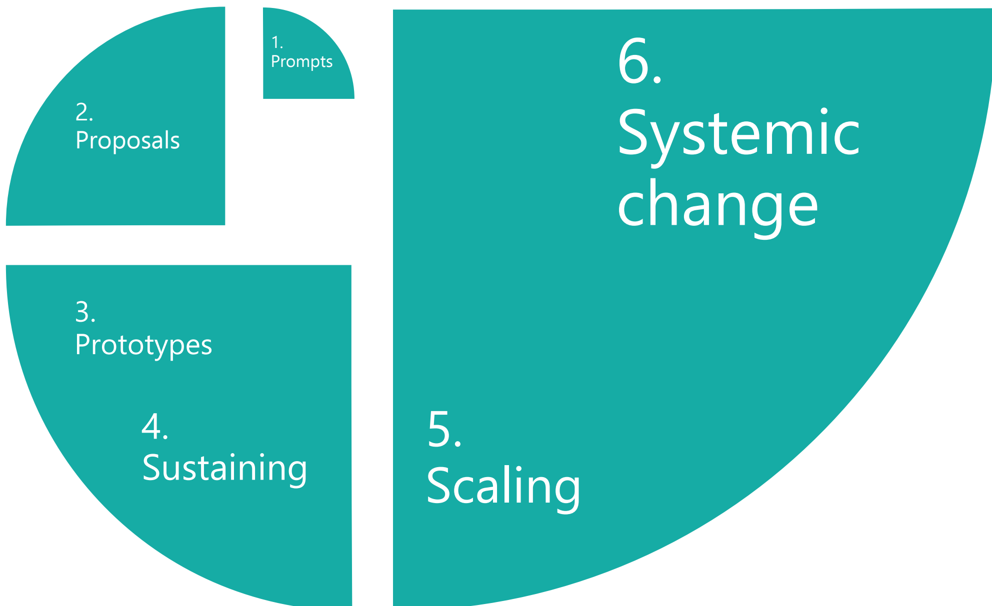
Subject of the analysis	Features
Subject of innovation (what?)	• Innovative character of services offered to terminally and chronically ill people and their families: • tailor-made and flexible care, • expanded list of illnesses qualifying someone for hospice care, expanded group of beneficiaries, • building a support network, • establishing the KOOZ • Procedural and organisational change
Field of innovation (where?)	• Health and welfare sector • New health and social services • Hospice management model • Building social capital
Subject of change	• Treatment and care service, local community, in-home palliative care system, existing system of legal norms
Aim of change (why?)	• Improved well-being (through more effective care) of chronically and terminally ill people and their caregivers • Improved welfare solutions in rural areas in connection with population ageing, unavailability of services, inefficiency of the current system
Process (how?)	• Actors: individual and institutional, contracted and volunteers • Making residents and local institutions aware of the problems and the possibility of a different (alternative) solution, by identifying and pointing out the problem, creating a model of the alternative solution
Results	• "An innovation is a proposed version of the future" (Zajda 2022). It is the aspiration of its actors to change the care system in Poland, provide (better) care to those in need of it, and better use the resources earmarked for this purpose

Source: Own work based on the template provided in Cloutier 2003, p. 42.

Innovations – not only according to the EC – are treated as social processes and analysed accordingly. The EC distinguishes four stages in this process: identifying new or not fully met needs; preparing new solutions in response to these needs; evaluating the effectiveness of these solutions, and the scaling of effective social innovations. Analyses most often refer to the six-stage innovation spiral from *The Open Book of Social Innovation* (Murray, Caulier-Grice, Mulgan 2010). The stages are: (1) prompts, or uncovering a need for social innovation, identifying social problems/needs; (2) proposals, or preliminary suggestions of solutions to problems, coming from different entities; (3) prototyping, or developing a prototype of a solution and testing it; (4) sustaining, or

ensuring lastingness and support for the innovation, popularising and implementing it: the model should provide for sources of steady financing; (5) scaling, or expanding the scale of the innovation, its expansion and diffusion to other groups or communities interested in the change; (6) systemic change, or when putting the innovation into practice causes a lasting social change, changing ways of thinking and the functioning of various social systems (Wronka-Pośpiech 2015; Komorowska, Wygnański 2019).

Figure 2. Innovation as a process: spiral of innovation.



Source: Komorowska, Wygnański (2019); adapted from Murray, Caulier-Grice, Mulgary (2010).

The innovation *To Give What Is Really Needed* was at the prototype implementation stage during our research. At the time of editing of the present report the "sustaining" stage has not been planned yet. We hope that the results of the analyses presented here will serve to increase interest in the problem and the innovation itself, thus helping the proposed solution to find the necessary stable funding and leading to the systemic change sought by the innovation's author. Meanwhile, the Regional Centre for Social Policy in Białystok (ROPS-B) has taken action towards carrying out this stage: during two conventions of the directors of Regional Centres for Social Policy (ROPS) and the heads of Marshal's Office Health Departments, it conducted consultations on recommending that the innovation be incorporated into national policy and on filing such recommendations with the institutions responsible for policy planning and implementation.

1.3. The Innovation *To Give What Is Really Needed* as the Subject of Scientific Observation and Analysis

In the project described here, the multifaceted, systematic and critical observation of the innovation's implementation, its local determinants and social effects was the task of IRWiR PAN, or, more precisely, a three-person team of sociologists from the Department of Rural Sociology.[7] The observation was planned to encompass the local conditions (contexts) of the innovation's implementation, actions implementing the innovation that were undertaken by the innovation team (consortium), and the effects of implementing individual elements of the innovation. The implementation gave the greatest number of tasks to the FHPE, because the foundation had to:

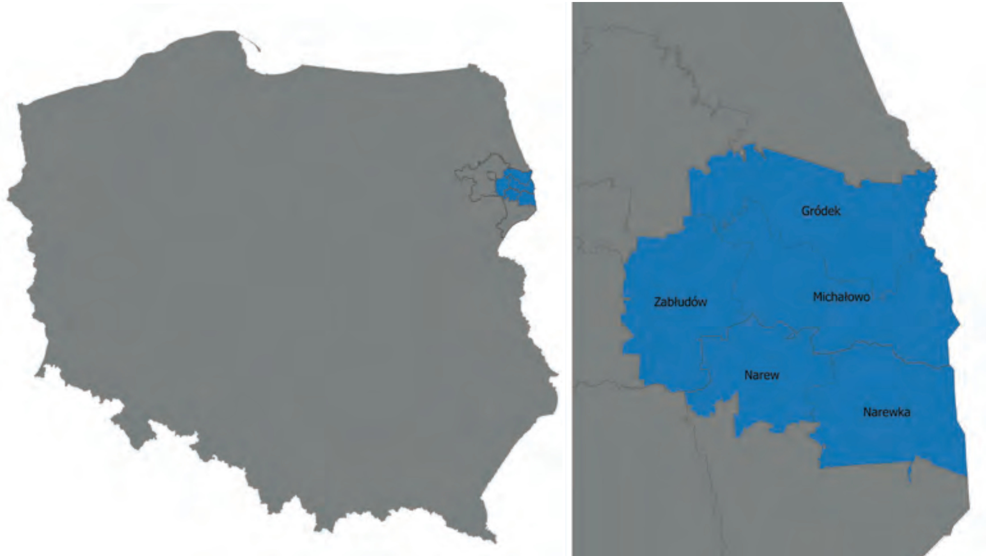
- build the necessary interdisciplinary team of employees,
- contribute (with ROPS-B) to creating a support network comprising local formal and informal institutions/organisations,
- create the position of Dependent Care Coordinator (KOOZ) and define this person's responsibilities.

The study examined the team implementing the innovation: FHPE staff, the psychologist working with the foundation team, and the appointed KOOZ. Also included in the study – in the area covered by the foundation's work, i.e. five municipalities in Podlaskie province – were local institutions that had formed a collaboration network as well as local leaders in the municipalities. Direct studies involving people in the care of the institution implementing the innovation were not pursued because it was deemed unethical to talk to them directly about the innovation. Information on their condition and needs was obtained from other sources, of which the most important was data gathered by the KOOZ (using a specially conceived questionnaire).

Designing the study, the researchers planned to use the comparative method to identify the effects of the innovation. This method involves seeking, describing and explaining similarities and/or differences between two appropriate units. In our case, this meant two institutions: one implementing the innovation, the other, the control unit, pursuing its standard operations. Each has its unique features. The context of the innovation is defined by the territorial units within the area covered by the Prophet Elijah Hospice Foundation (FHPE). These are five *gmina*/municipality units within Podlaskie province: Gródek (rural municipality, Białystok *powiat*/county), Michałowo (urban-rural municipality, Białystok county), Narew (rural municipality, Hajnówka county), Narewka (rural municipality, Hajnówka county) and Zabłudów (urban-rural municipality, Białystok county).

7 The authors of the present report; the team was headed by Sylwia Michalska, PhD hab., IRWiR PAN professor.

Figure 3. Municipalities where the FHPE operates: Gródek, Michałowo, Narew, Narewka, Zabłudów.

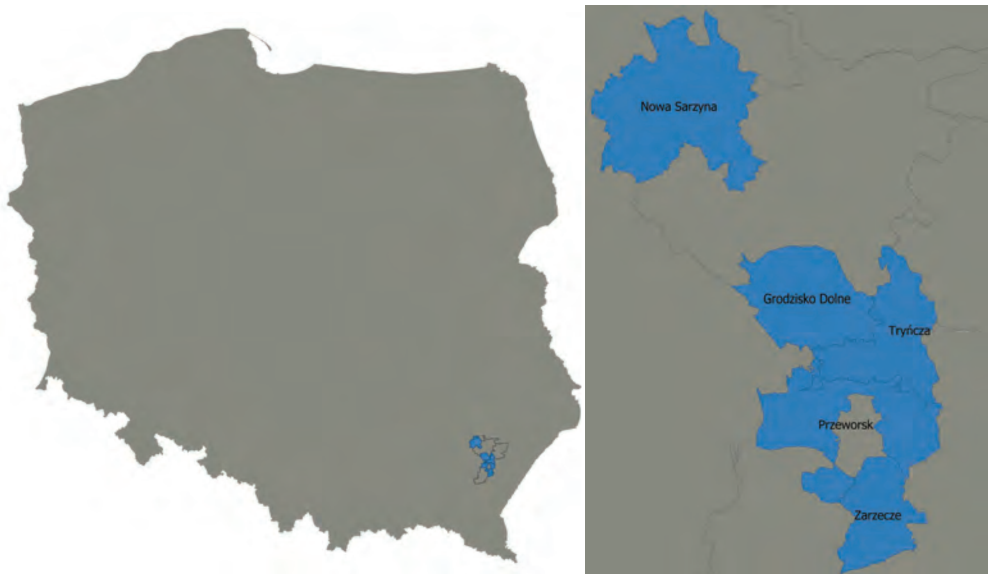


Source: Own work.

Since Podlaskie province did not have another in-house hospice operating in rural areas, an institution from Podkarpackie province was chosen for the control institution: the Nadzieja [Hope] Non-Public Health Care Facility, hereinafter NZOZ Nadzieja. It runs an in-home hospice that provides care to cancer patients and those with progressive illnesses that do not respond to causal treatment. The facility accepts patients based on medical indications and a significantly advanced stage of the illness. It was founded by Janina Jaroń and employs a doctor, nurses, a psychologist, a welfare worker, a physiotherapist and a chaplain. NZOZ Nadzieja's operations are based on providing services (medical, nursing, psychological and rehabilitation) to adults as part of in-home palliative care. The staff treat pain in accordance with WHO guidelines, support the family during the patient's illness, and teach patients and their families how to care for a patient and maintain hygiene by themselves (self-care and personal hygiene). The facility also pursues educational activities and provides health advice. A similar set of observations/research as that carried out at the FHPE was conducted here. NZOZ Nadzieja operates over a larger area than the FHPE hospice and has more people in its care: around 100 patients on average in rural areas (status as of 2021). It operates in six counties: Leżajsk, Jarosław, Przeworsk, Mielec, Kolbuszowa and Ropczyce-Sędziszów, which comprise a few dozen municipalities. It was impossible to include them all in the study, so the researchers obtained an anonymised list of NZOZ Nadzieja's patients indicating their place of residence. This was the basis for selecting five municipalities

with a large number of the facility's patients. Moreover, the municipalities were chosen to be similar in type (urban-rural and rural) to the municipalities where the FHPE is implementing the innovation, the aim being to improve the comparability of contexts of the two facility's operations. The following municipalities were ultimately selected: Grodzisko Dolne (rural municipality, Leżajsk county), Nowa Sarzyna (urban-rural municipality, Leżajsk county), Przeworsk (rural municipality, Przeworsk county), Tryńcza (rural municipality, Przeworsk county) and Zarzecze (rural municipality, Przeworsk county).

Figure 4. Municipalities where NZOZ Nadzieja operates: Grodzisko Dolne, Nowa Sarzyna, Przeworsk, Zarzecze, Tryńcza.



Source: Own work.

Designed like this, the study was able to yield a detailed description of the way the innovation was being implemented as well as an indication of the problems and difficulties that emerged as the project progressed. The present report, in which we have gathered the main results of the research, could be considered a monograph on innovation implementation in the project called *To Give What Is Really Needed*.

1.4. Research Methods and Techniques

The study thus planned required the use of many research techniques analysing existing sources or activating/creating sources. There are no research tools tested in diverse cultural contexts, and the researcher faces a great many methodological challenges (Zajda 2022, p. 37). Our study was based on elements of participatory action research, which recommends techniques like (1) describing/documenting reality and (2) its contextualisation, and on the social innovation biography, whose recommendations include network analysis and interviews/questionnaires involving different actors. Our analyses took advantage of the triangulation of research techniques so as to analyse and then describe the elements of the innovation as comprehensively as possible. This is presented synthetically in Table 2.

Table 2. Research methods and techniques.

A. Forming an interdisciplinary team of doctors, nurses, physiotherapists, hospice caregivers, a dietician and a psychologist within the in-home hospice care system	• Desk research • Surveys of hospice staff • Individual in-depth interviews with hospice staff • Individual interviews with health care and social policy experts • Participant observation
B. Building a collaboration network of local, formal and informal institutions/organisations providing services to older, terminally ill and dependent people	• Desk research • Individual interviews with local leaders • Surveys of hospice staff • Individual interviews with health care and social policy experts • Sociometry • Participant observation
C. Creating the position of Dependent Care Coordinator (KOOZ).	• Desk research • Surveys of hospice staff • Interviews with the appointed KOOZ • Individual interviews with health care and social policy experts • Participant observation

Source: Own work.

a) Desk Research

Desk research is a research technique in which existing and available data are analysed in detail. This enables data previously scattered across various sources to be consolidated, processed and analysed. In this case, the technique was mainly used to describe the social context in which the innovation was being implemented.

Analyses of social innovation, especially localised social innovations closely tied to a specific territory, underline the importance of the context, or “the set of factors existing together, bound to something” (Encyklopedia PWN).[8] This is “an area of social life in which an important social function is fulfilled” (Sztompka 2003, p. 264). A context is made up of many elements, some of which are more and others are less important.

In our view, these are the most important factors influencing the implementation of the social innovation under consideration:

- **the demographic context**, described by features of the local population such as its size, density, age structure, natural and migration movement;
- **the economic context**, describing the condition of the local economy, i.e. the condition of roads and public transportation, the budgets of territorial units and their structures, entities within the local economy, revenue and spending;
- **the social context**, described with social capital indices: the state and structure of NGOs, social participation, the degree of integration of local welfare institutions;
- **the health and welfare context**, described through the local infrastructure and how it is used.

Benoit Lévesque (2018) points to the influence of conditions existing in different countries. Considering the European scope of the project, the characterisation of the contexts will be preceded – whenever possible – by a brief characterisation of the status at the macrosocial level (Poland – NUTS 0), and then these areas will be characterised at the regional level (provincial – NUTS 2). These two levels in turn will serve as the background for the most detailed characterisation, at the local level – counties and municipalities (NUTS 4 and 5, respectively). Further on, the report will consider the state of the areas mentioned earlier at moments in time closest to the launch and the end of the innovation's implementation, and also – wherever possible – will present the dynamics of the indicators in the years preceding the implementation of this innovation. The characterisation presented here is a dynamic analysis of the situation on three levels: national, regional and local. The indicator values at the national level constitute the point of reference for the values of corresponding indicators describing the contexts at the regional and local levels.

The authors have done their best to use the latest data. For statistical data, in most cases these are data for 2019 (a year before the innovation was launched) and 2022 (the last year of the innovation's implementation for which mass statistical data are available). To show the tendencies of change, especially in the case of quantitative indicators based on existing data from Statistics Poland describing the individual contexts, data

8 https://encyklopedia.pwn.pl/haslo/kontekst;3925329.html.

from 2010 have also been used in order to demonstrate the direction of demographic, social and economic change.

Desk research was also used to analyse data elicited during the study, in particular those gathered by the KOOZ (see questionnaire in the Appendix). These data yielded information on the FHPE's patients who were in the hospice's care as part of the innovation. This was information about their state of health, living conditions, welfare, medical and social needs, and forms of assistance received as well as the actors of the support network used by the KOOZ when working for a patient and his or her caregivers.

b) (Semi-)Structured Interviews

The interviews were semi-structured, which means that instructions prepared in advance were used, but the option of starting new threads was allowed in the course of the conversation/interview. The interview guidelines may be described as issues matching the agreed aims of the interview along with loosely formulated topics that the researcher could discuss with the interviewees in any way they liked. It is a virtue of this technique that you can adjust the course of the conversation to the needs of the interviewee.

- **With local leaders.** These were interviews conducted with representatives of municipality authorities (rural and urban mayors) and representatives of social services centres operating in the municipalities. In the municipalities covered by the FHPE's activities, the interviews were conducted before the innovation implementation began. The aim was to identify how the municipality authorities and people responsible for welfare assistance in the municipalities perceived the problem of population ageing and all that it entailed. The pretext for the interviews was the municipality's development, because when carrying out research on an innovation affecting ill and older people, the authors did not want to direct the conversation towards the problems this involved, but aimed to allow the interviewees to rank existing problems in order of importance from the municipality's point of view. The studies in the municipalities covered by the social innovation implemented by the FHPE were carried out in October 2020. Interviews (a total of 10) were conducted in each of the five municipalities – Gródek, Michałowo, Zabłudów, Narew and Narewka – based on previously designed free interview instructions.

  In the municipalities where NZOZ Nadzieja operates, individual interviews with local leaders were conducted in 2023. They concerned the situation existing at the time of the study as well as the most important issues from a few years back. The latter was relatively easy, as in practice it meant the time "before the pandemic" that caused changes in the work and priorities of many local governments. Wherever it

was impossible to conduct an interview for some reason, the websites of the municipality and its institutions were analysed to find out what groups were the addressees of activities undertaken in the municipality and what social problems such actions responded to.

- **With health care and social policy experts.** These interviews were conducted throughout the innovation implementation period. The most numerous group was that of the directors of Regional Centres for Social Policy (ROPS) and directors of the Health Departments of Province Marshals' Offices, or specialists designated by them. They were consulted on the recommendations for incorporating the innovation into activities at the national policy level; within the partnership carrying out the project, this area was the responsibility of the Regional Centre for Social Policy in Białystok (ROPS-B). The interviews were conducted in 2023 with nine people from the following provinces: Lubuskie, Małopolskie, Pomorskie, Kujawsko-Pomorskie, Łódzkie, Podlaskie, and Wielkopolskie.

  Interviews were also carried out with the staff and management of other hospices in medium-sized cities, and also at an in-home hospice operating exclusively on the basis of rules set down by the National Health Fund (NFZ) and located in a big city with a population of over 500,000. We also received expert assistance from researchers studying issues connected with social policy, public policies, health care systems, and the law.
- **With hospice staff**, individual interviews were held to expand the information obtained in the questionnaire survey. This yielded detailed opinions and information from specific people who were experts in a given area. In 2020 at the organisation implementing the innovation, individual interviews were conducted with the FHPE's president and the Dependent Care Coordinator (KOOZ). The psychologist hired as part of the innovation to support the FHPE team was also interviewed. At NZOZ Nadzieja, an in-depth individual interview with the director was conducted in 2022.

c) Questionnaire Survey

A cyclic questionnaire survey was conducted among FHPE hospice and NZOZ Nadzieja staff. The survey was based on a form that the respondents filled in by themselves. In such a situation, the researcher delivered the questionnaire to the people selected for the survey, without conducting an interview with each respondent in person and limiting the interaction to stating the aim of the survey and offering technical remarks on filling in the form. In the case of the FHPE staff, this was an auditorium questionnaire, its asset being that it limited the interviewer effect, i.e. the influence that the interviewer (who in this case would be representing the consortium carrying

out the project) has on a respondent during an interview. Another asset is that a hundred percent of questionnaires are returned. This type of survey was also chosen for practical reasons – the possibility of having the whole team surveyed at the same time, during their usual monthly meetings. This form of survey was not possible at NZOZ Nadzieja because such meetings were not the custom there. Instead, a self-return form was chosen. The questionnaire was short, simple and required no extra explanations. The survey questionnaire is provided in the Appendix to the report. Four rounds of the survey were conducted at the FHPE hospice, and two at NZOZ Nadzieja. Below is the number of questionnaires collected in both cases.

Table 3. Number (N) of questionnaires collected.

	2021	2022	April 2023	September 2023
Number of questionnaires completed at the FHPE	19	11	18	20
Number of questionnaires completed at NZOZ Nadzieja	X	19	15	

Source: Own work.

d) Sociometry

Sociometry is a research technique that studies the structures of collaboration and communication between individuals or organisations. This technique was used to gather data for the social network analysis in each of the municipalities, during the questionnaire survey carried out during the first series of networking meetings, in summer 2021. The aims of these meetings included informing representatives of local governments and communities about the innovation. The survey conducted during these meetings included a question about which institutions from the list of those invited to the meeting a given person's institution collaborated with most often. This was then the basis for reconstructing the cooperation networks in the individual municipalities.

e) Participant Observation

Participant observation is when the researcher "enters" a given community or group and observes it from within, i.e. as one of its members. In this case, the researchers were project team members tasked with describing how the innovation (the new model of an in-home hospice) was implemented and how its translation into elements of care policy progressed. The observation was carried out during the cyclic networking meetings for local institutions involved in the support network in each municipality covered by the

FHPE's operations, during the conventions of Directors of Regional Centres for Social Policy (ROPS) as well as numerous field visits.

This means that two types of source were used to produce the present report: secondary and primary. The former – secondary sources – were mainly: (i) raw mass statistical data, chiefly those gathered in the Statistics Poland Local Data Bank (BDL GUS), (ii) documents drawn up and binding at the local and provincial level, and (iii) the websites of the municipalities involved. The primary sources included: (i) materials gathered by the Dependent Care Coordinator (KOOZ), (ii) information gathered in the individual interviews, and (iii) information from the questionnaire surveys.

1.5. Time of the Innovation's Implementation: Pandemic, Refugee Crisis, State of Emergency, Russia's Attack on Ukraine

The implementation of the innovation in the project *To Give What Is Really Needed* was disrupted by external factors that need mentioning before we move on to describing any actions in the project. Some of these factors, like the COVID-19 pandemic, affected everyone, while others, like the refugee crisis on the Polish-Belarusian border, were specific to part of the region where the innovation was implemented. These events had an impact on the implementation and the possibilities for observing this process.

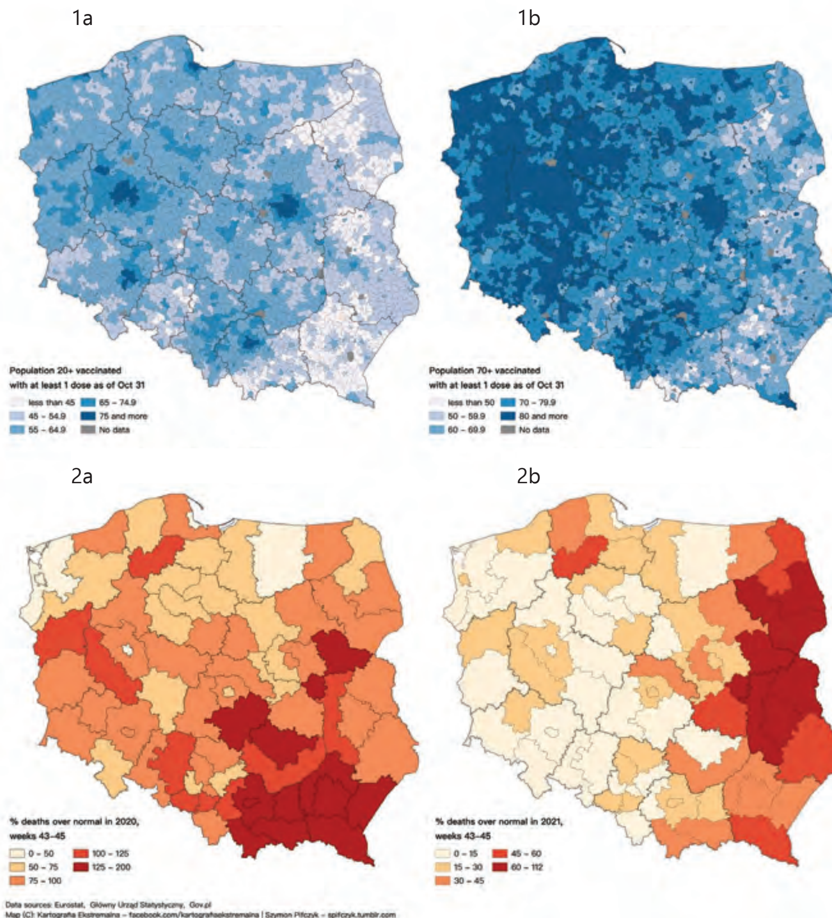
a) The COVID-19 Pandemic and Its Consequences

In Poland the first case of a COVID-19 acute respiratory infection caused by the SARS-CoV-2 virus was reported on 4 March 2020 at a hospital in Zielona Góra. A state of epidemic threat was in force in Poland between 14 and 20 March, and as of 15 March a cordon sanitaire was introduced on the Polish border, significantly reducing border traffic. Based on a Minister of Health order, a state of epidemic was in force in Poland from 20 March 2020 until 1 July 2023. The sanctions and constraints connected with sanitary restrictions changed over time in response to successive waves of COVID incidence.

Up to 25 February 2022, Poland reported 5,637,646 COVID cases, and 111,056 deaths were registered (see maps below). At first, Podlaskie province was one of the provinces least affected by the pandemic, as opposed to Mazowieckie province where the number of cases was very high from the start. This made it difficult to carry out field studies due to the risk that the researchers, who lived and worked in Warsaw, might spread the disease. On the other hand, COVID-19 vaccinations progressed slowly in Podlaskie province, which had its consequences for the number of cases and deaths.

During this time the researchers from IRWiR PAN tried to find units on which to carry out the control study, but the need to provide the best possible patient care as well as restrictions imposed by the Ministry of Health meant that none of the hospices asked to take part in the study agreed to do so.

Figure 5. 1a Vaccination rate for adults and 1b senior citizens in October 2021 by municipality, and 2a "excess deaths" in 2020 and 2b in 2021.



Source: Kartografia ekstremalna, https://www.facebook.com/kartografiaekstremalna/.

Data from 26 February 2022 showed infection with the SARS-CoV-2 virus in a total of 140,629 residents of Podlaskie province, compared to the province's total population of 1,181,533. This means that 11.9% of the province's population was infected. Each person diagnosed with SARS-CoV-2 infection corresponded to eight residents not found to be infected with this coronavirus.

Poland did not handle the pandemic well, the effect being some alarming December 2021 data on excess deaths. Impeded access to health care would affect the number of people in need of help, including hospice care, in the near future. This had an impact on the implementation of the medical part of the innovation. Because some hospitals were turned into isolation hospitals, patients' access to regular health care deteriorated, which delayed the treatment of diseases other than COVID-19. The availability and quality of services of primary care physicians worsened. Many clinics provided remote consultations. Preventive testing and treatment possibilities were limited, which is already reflected in national statistics. The maps (Fig. 5, maps 1a and 1b) present the vaccination rate nation-wide – status as of 31 October 2021, as well as data on excess deaths by county in the years 2020 and 2021 (Fig. 5, maps 2a and 2b). The data shown on the maps indicate that the place of implementation of the innovation had the country's lowest vaccination rates (both for the general population and for senior citizens) as well as the highest excess death numbers in both 2020 and 2021.

The pandemic generated substantial cost growth in many areas, with a sudden increase in protective equipment use, and higher prices of medications, medical materials and equipment due to growing delivery costs (e.g. the several-fold increase in maritime transport prices), for which it was impossible to compensate with deliveries from the Material Reserves Agency or other government agencies. It is estimated that medical materials went up by about 30% during the pandemic, which also affected the costs incurred by centres like in-home hospices. On the other hand, the rate paid for patient care under NFZ contracts was not changed.

During the pandemic it became more noticeable than before that hiring medical workers in an in-home hospice facility as their second, third of further place of employment was a weakness of the system. The issue was not just the risk of the staff spreading the virus between facilities, but also a serious staff shortage when a staff member had to go into isolation or fell ill. The solution planned by the Ministry of Health, i.e. allowing medical staff to be employed at only one health care facility, would have meant that the FHPE would only have had one doctor caring for all the patients. Everyone else, including all the nurses, worked at more than one facility.

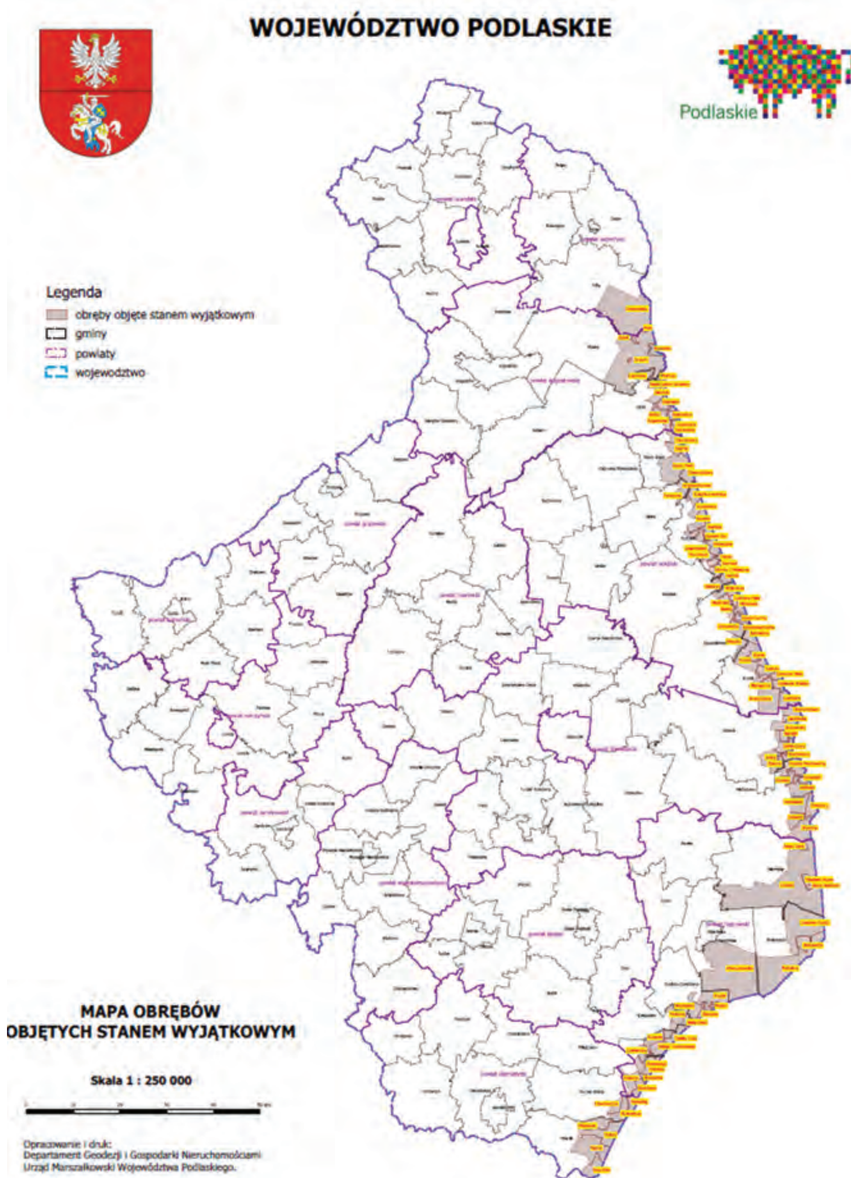
b) Refugee Crisis, State of Emergency, Russia's Attack on Ukraine

The next event that affected the innovation's implementation and the possibility of conducting observations to monitor the effectiveness of any actions, was the refugee crisis that emerged on Poland's border with Belarus in summer 2021. Large and numerous groups of migrants from Asian and African countries, organised by the Lukashenko regime, appeared at the border, their main planned destination being the

western countries of the EU. The Polish government's decision to undertake measures preventing the migrants from initiating asylum procedures as well as growing protests from lawyers and society caused the Polish president, upon a motion from the government, to impose a state of emergency on a part of Poland's territory on 2 September 2021. This entailed a number of acute restrictions that encompassed 115 localities in Podlaskie province and 68 in Lubelskie province, along the entire Polish-Belarusian border. The list of localities where the state of emergency was imposed also included those within the Gródek, Narewka and Michałowo municipalities. The government's motion to impose a state of emergency was explained by a threat to public security and order on part of Poland's territory in connection with the migration crisis and the Russian-Belarusian military exercises, codename ZAPAD, taking place next to the Polish border. The state of emergency was imposed for 30 days, and extended for another 60 days as of 1 October 2021.

Further restrictions imposed in selected municipalities were regulated by the Minister of the Interior and Administration's order dated 30 November 2021 on the temporary ban on staying in a specific area within the border zone adjacent to the state border with the Republic of Belarus. These were in force until 1 July 2022. By that time work had finished on the construction of a controversial barrier on the Polish-Belarusian border that split the globally unique Białowieża Forest National Park. The refugee crisis in this part of Poland continued until the study discussed here was completed, antagonising local communities and involving numerous activists, including locals, in helping the refugees, which also had an impact on how actively people took part in the support network being built by the KOOZ.

Figure 6. Area covered by the state of emergency.



Source: https://www.wrotapodlasia.pl/pl/wiadomosci/komunikaty/mapa-pogladowa-obszarow-obje-tych-stanem-wyjatkowym-na-gis-podlasia.html.

The state of emergency also affected the implementation of the innovation's medical part. The restrictions on movement required the hospice's employees to obtain passes and surrender to checkpoint procedures as they travelled to their patients living in villages within the state of emergency zone. Local health centres and the ambulance

service were additionally burdened with sick calls to people trying to get into Poland. The migrant crisis coincided with the fourth wave of coronavirus infections. Due to these factors, attempts to estimate the extent to which the innovation relieved or replaced the existing system were doomed to fail from the start.

Groups of volunteers trying to help migrants were active in the municipalities where the innovation was being implemented. The local community also became involved in assistance. This was particularly noticeable in the municipality where the FHPE is based, i.e. Michałowo municipality, which became a precursor and model of the assistance that a local community can offer at a time of crisis, even against official policy at the national level. This commitment, which necessarily continues to this day, meant that the option to get involved in other local initiatives, like the support network being built by the FHPE, was limited for many potentially active people living in the municipality. The state of emergency, which restricted access to the area for people from outside it, practically cut off the territory it covered from the possibility for the researchers to monitor the innovation's implementation.

On 24 February 2022 Russia attacked Ukraine. Millions of refugees from Ukraine arrived in Poland, mobilising local authorities, community activists as well as citizens who were usually less active. At the start of the conflict the strongest mobilisation and commitment – from both the local authorities and community activists – was observed in areas near Poland's border with Ukraine, including the area where NZOZ Nadzieja operates. This undoubtedly affected how they perceived and judged current social problems in their municipalities. At the same time, the war has had a negative impact on economic processes, causing new perturbations in the Polish economy. These elements, mentioned in passing here, had to affect the social activeness of the residents in the municipalities in our study (three of them border directly on Belarus) and the priorities of the local authorities.

2. Context for the Activity of the Institution Implementing the Innovation and the Control Institution

For it to be possible to compare whether the innovation came up to expectations and actually ensured better care for the elderly, the chronically ill and their caregivers in rural areas, it was necessary to determine the initial conditions in which the implementation began. That is why multidimensional "portraits" were produced of the "innovation" municipalities and those used for comparison when assessing the innovation's effectiveness.

2.1. Demographic Context

For many years now, Poland has been in the first 30 demographically old countries of the world. Both in Poland and in Podlaskie province, the population has been shrinking as the percentage of people of post-retirement age grows. Taking into account existing demographic trends is essential in the context of future demographic dynamics. As Statistics Poland forecasts show, in 2030 one in three residents in Poland will be aged 60 and over, and in 2050 a little over 40% of the Polish population will be people of post-retirement age.

Similar tendencies are observed in the municipalities where the innovation was implemented ("innovation municipalities"). The population is shrinking in all of them except Zabłudów. The percentage of people of post-retirement age is growing everywhere, but again, it is the lowest in Zabłudów municipality. All the municipalities report negative natural population growth – it is the lowest in Zabłudów and the highest in Narew. These negative demographic tendencies are compounded by population migration. A positive migration balance is only observed in Zabłudów municipality, which has become popular among people moving out of Białystok. It should also be noted that the direction of change in the municipalities was stable in the years 2019–2022; the main tendencies already noticeable in the past decade intensified.

Table 4. Demographic context in the "innovation municipalities".

	Similarities	Differences
Demographic context	• Depopulation (except Zabłudów municipality) • Low population density • Growing percentage of people of post--retirement age • Decreasing natural population growth • Decreasing migration balance in Gródek, Narewka and Narew	• Different population change dynamics (Zabłudów – increase, the others – decrease (highest in Narew municipality)) • Different population ageing dynamics (smallest decrease in Narew, highest in Narewka) • Positive migration balance in Zabłudów

Source: Own work based on BDL GUS data.

Most of the "innovation municipalities" show an accumulation of negative demographic tendencies – the greatest being in Gródek and Narewka municipalities. Relatively the best situation – as mentioned – is in Zabłudów municipality. Things are a little different in the municipalities covered by the operations of NZOZ Nadzieja, i.e. the control municipalities. Among them, only Grodzisko Dolne shows a greater accumulation of negative demographic processes. On the other hand, similarly to Zabłudów, the situation is relatively good in the municipalities of Przeworsk, Tryńcza and Zarzecze.

Table 5. Demographic context (2010–2022): "innovation" vs. control municipalities. Pink areas show where the trends from the first column occur, white areas show where they do not.[9]

	Gródek	Michałowo	Narew	Narewka	Zabłudów	Grodzisko Dolne	Nowa Sarzyna	Przeworsk	Tryńcza	Zarzecze
Decreasing population										
Low population density*										
Negative migration balance										
Higher percentage of people of post-retirement age*										
Negative natural population growth										

Source: Own work based on BDL GUS data.

**The reference units for population density and for the percentage of people of post-retirement age are the national-level index values.*

9 In the tables, the municipalities are arranged alphabetically.

Table 6. List of demographic indices selected for analysis (1).

	Population (in thousands)			Population density			Migration balance per 1,000 residents		
	2010	2019	2022	2010	2019	2022	2010	2019	2022
Poland	38 529,9	38 382,6	37 766,3	123	123	123	-0,1	0,2	0,1
Podlaskie province	1 203,5	1 178,4	1 143,4	60	58	57	-1,3	-1,7	-1,0
Białystok county	142,6	149,6	156,4	48	50	53	6,9	9,8	10,7
Michałowo	7,3	6,6	6,0	18	16	15	0,3	2,7	4,3
Zabłudów	9,0	9,3	9,9	27	28	29	14,6	10,0	11,9
Gródek	5,7	5,1	4,9	13	12	11	-0,2	-0,4	-4,0
Hajnówka county	47,2	42,6	39,4	29	26	24	-4,1	-4,4	-2,6
Narew	4,0	3,5	3,3	16	14	14	-3,8	-3,5	3,1
Narewka	3,9	3,6	3,2	12	11	9	-1,0	-8,0	-3,7
Podkarpackie province	2 128,0	2 127,2	2 079,1	119	119	117	-0,9	-1,4	-1,0
Leżajsk county	70,2	69,4	67,0	120	119	115	-2,8	-3,6	-4,2
Grodzisko Dolne	8,1	8,0	7,8	103	102	99	-2,7	-3,4	-3,6
Nowa Sarzyna	21,8	21,6	21,0	152	150	146	-2,7	-3,6	-5,1
Przeworsk county	79,5	78,4	76,1	114	112	109	-0,9	-2,2	-2,5
Przeworsk	14,7	14,9	14,6	162	164	161	-3,1	-2,8	1,6
Tryńcza	8,4	8,5	8,5	119	121	121	2,6	0,6	-2,7
Zarzecze	7,2	7,2	7,0	146	147	141	2,4	-1,7	2,4

Source: Own work based on BDL GUS data.

Table 7. List of demographic indices selected for analysis (2).

	Percentage of people of post--retirement age (65+)			Natural population growth per 1,000 residents		
	2010	2019	2022	2010	2019	2022
Poland	13,5	18,1	19,5	0,9	-0,9	-3,8
Podlaskie province	14,6	17,8	19,3	0,1	-1,0	-3,8
Białystok county	14,4	16,5	17,3	-0,5	-0,5	-2,3
Gródek	21,2	23,1	25,4	-6,5	-11,4	-10,5
Michałowo	23,2	23,9	25,9	-5,9	-12,3	-14,0
Zabłudów	16,6	17,0	17,2	-2,7	-2,3	-3,4
Hajnówka county	21,3	24,3	26,5	-7,4	-8,8	-13,0
Narew	27,2	27,9	28,6	-16,3	-10,6	-15,9
Narewka	23,3	25,5	27,6	-11,9	-9,6	-15,0

	Percentage of people of post--retirement age (65+)			Natural population growth per 1,000 residents		
	2010	2019	2022	2010	2019	2022
Podkarpackie province	13,1	16,9	18,4	1,7	0,3	-2,5
Leżajsk county	12,5	16,6	18,0	1,1	0,5	-2,1
Grodzisko Dolne	14,7	16,6	17,5	1,2	1,3	-2,4
Nowa Sarzyna	12,0	15,9	17,2	1,7	1,1	-0,3
Przeworsk county	13,8	16,6	18,0	1,2	0,1	-2,2
Przeworsk	14,1	15,7	16,5	2,1	0,7	-0,5
Tryńcza	13,6	14,8	15,2	1,3	2,0	-1,8
Zarzecze	12,8	15,4	16,5	2,8	-0,6	0,0

Source: Own work based on BDL GUS data.

2.2. Economic Context

In the years 2010–2022 the municipalities under analysis reported growing revenues and spending – both in overall sums and per resident. One significant factor describing the economic context from the viewpoint of individuals is unemployment. The counties where the "innovation municipalities" are located are characterised by a higher unemployment rate than that reported in Podlaskie province and in Poland. The agricultural sector and the industrial sector continue to be important in the local economies of Gródek, Michałowo, Zabłudów, Narew and Narewka. The share of businesses operating within these sectors reaches a half of all the entities operating within the municipalities. The remaining share belongs to services.

Table 8. Economic context in the "innovation municipalities".

	Similarities	Differences
Economic context	• Revenue and spending growth in municipality budgets (2010–2022) • Similar level of entrepreneurship expressed in the number of businesses • Decreasing unemployment rate (2010–2022)	• Different per capita revenues and spending (highest in Narewka municipality, lowest in Zabłudów)

Source: Own work based on BDL GUS data.

Comparing the economic situation, for which the indicators in the present analysis are the level of entrepreneurship and per capita revenues and spending, it should be noted that the "innovation municipalities" are characterised by a better financial situation, i.e. higher per capita revenues and spending. On the other hand, both municipality groups show a low level of entrepreneurship.

Table 9. Economic context (2010–2022): "innovation" vs. control municipalities. Pink areas show where the trends from the first column occur, white areas show where they do not.

	Gródek	Michałowo	Narew	Narewka	Zabłudów	Grodzisko Dolne	Nowa Sarzyna	Przeworsk	Tryńcza	Zarzecze
Lower level of entre-preneurship*										
Lower per capita revenues*										
Lower per capita spending*										

Source: Own work based on BDL GUS data.

**The reference units for the above indices are the national-level index values.*

Let us also note how the municipalities are equipped with infrastructure. As it turns out, the "innovation municipalities" are very poorly equipped in water supply, sewerage and gas supply systems. In the other group (control municipalities), only Grodzisko Dolne municipality shows similarly low values of the relevant indices – lower than the national values. However, when we look at the infrastructure availability indicator values more closely, even the worst results of the selected Podkarpackie province municipalities are similar or even better than those in the best Podlaskie province municipalities chosen for the study.

Table 10. Infrastructure (2010–2022): "innovation" vs. control municipalities. Pink areas show where the trends from the first column occur, white areas show where they do not.

	Gródek	Michało-wo	Narew	Narewka	Zabłu-dów	Grodzisko Dolne	Nowa Sarzyna	Prze-worsk	Tryńcza	Zarzecze
Lower percentage of people using a munici-pal water supply system*										
Lower percentage of people using a munici-pal sewerage system*										
Lower percentage of people using a munici-pal gas supply system*										

Source: Own work based on BDL GUS data.

**The reference units for the above indices are the national-level index values.*

Table 11. List of economic indices selected for analysis.

	Number of business entities per 1,000 residents			Revenue per capita (PLN)			Spending per capita			Unemployment rate		
	2010	2019	2022	2010	2019	2022	2010	2019	2022	2010	2019	2022
Polska	8,2	7,2	7,2	3 022,1	5 240,0	6 757,9	3 025,3	5 246,1	6 902,9	13,4	5,2	5,2
Podlaskie province	5,9	5,3	5,4	2 871,8	5 180,9	7 045,9	2 827,7	5 060,2	7 054,2	14,7	6,9	7,3
Białystok county	4,8	4,6	4,6	2 663,5	5 266,6	6 345,9	2 630,9	5 168,3	6 537,3	18,4	7,6	8,0
Gródek	6,3	5,4	5,3	3 171,8	5 245,7	7 294,7	3 267,3	5 801,4	7 061,2	-	-	-
Michałowo	4,4	5,5	4,2	3 534,6	5 539,3	8 500,1	3 370,4	5 313,6	9 822,7	-	-	-
Zabłudów	4,5	4,9	5,0	2 618,6	5 753,6	7 303,3	2 508,3	5 833,5	7 006,4	-	-	-
Hajnówka county	5,5	5,0	5,3	2 830,5	4 992,0	7 731,8	2 928,0	4 982,4	7 473,3	13,6	6,8	8,1
Narew	11,1	4,3	4,6	3 246,0	5 461,9	9 412,4	3 751,5	5 439,7	8 780,2	-	-	-
Narewka	3,8	3,3	3,8	3 759,5	6 727,3	10 659,7	3 698,8	6 331,0	11 064,0	-	-	-
Podkarpackie province	6,1	5,6	5,6	2 891,3	5 126,6	6 412,1	2 875,3	5 157,5	6 566,0	16,4	7,9	8,8
Leżajsk county	4,7	4,2	4,2	2 733,2	5 025,6	6 171,9	2 781,9	5 063,1	6 262,1	19,4	12,4	15,4
Grodzisko Dolne	2,1	1,7	1,8	2 940,4	5 705,8	5 897,7	2 983,0	5 526,5	6 264,0	-	-	-
Nowa Sarzyna	4,4	4,3	4,3	2 750,4	5 051,8	6 316,7	2 645,9	5 118,2	6 321,4			
Przeworsk county	4,7	4,1	4,1	2 782,5	5 159,9	7 067,4	2 836,9	5 126,6	6 908,0	18,4	11,7	15,0
Przeworsk	2,5	1,5	1,6	2 264,0	4 537,6	6 551,5	2 471,6	4 533,9	6 783,1	-	-	-
Tryńcza	3,6	2,7	1,4	3 212,9	5 189,2	7 103,2	3 013,9	4 918,2	6 712,5	-	-	-
Zarzecze	4,9	4,0	4,2	2 754,1	6 202,1	8 053,1	2 718,8	6 035,2	8 062,6	-	-	-

Source: Own work based on BDL GUS data.

Table 12. List of infrastructure indices.

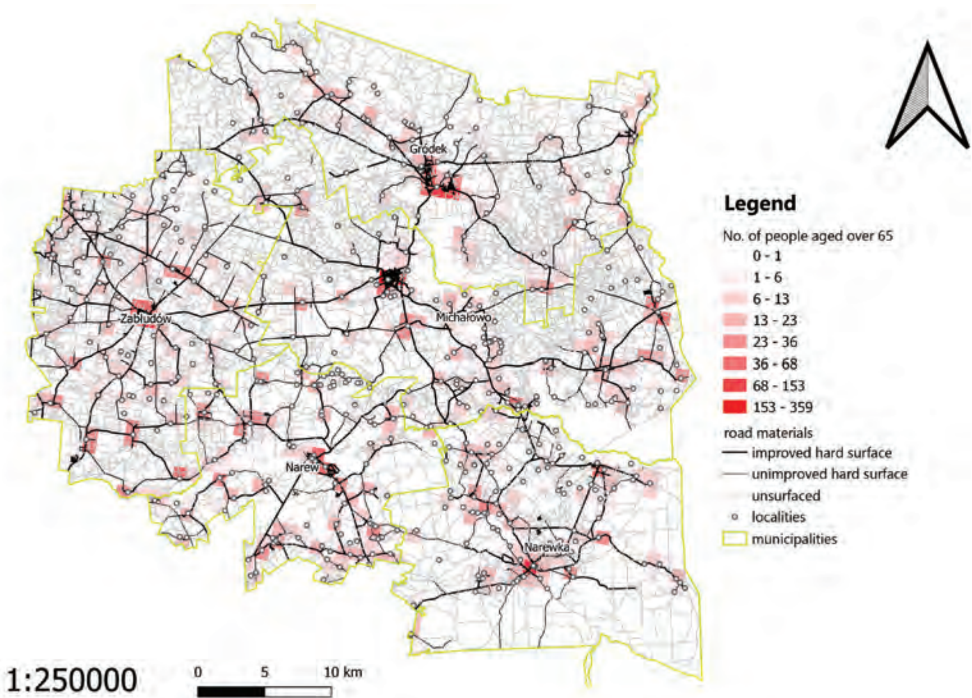
	Percentage of people using a municipal water supply system			Percentage of people using a municipal sewe-rage system			Percentage of people using a municipal gas supply system		
	2010	2019	2022	2010	2019	2022	2010	2019	2022
Poland	87,8	92,2	92,4	64,3	71,2	71,9	52,4	52,9	55,9
Podlaskie province	88,0	90,8	91,1	61,5	64,8	65,4	27,7	29,2	31,2
Białystok county	86,2	89,3	89,7	55,2	61,5	62,6	15,6	23,5	33,6
Gródek	70,2	71,4	71,6	44,7	46,6	46,9	0,0	0,0	0,2
Michałowo	84,8	94,0	93,6	50,4	53,0	49,8	0,0	0,0	0,7
Zabłudów	56,1	59,6	60,8	21,5	24,1	25,0	4,6	5,7	13,4
Hajnówka county	91,5	92,4	92,5	59,3	62,9	63,7	0,1	0,1	0,3
Narew	70,9	72,8	73,3	22,0	24,4	25,4	0,1	0,0	0,1
Narewka	92,5	95,0	95,0	45,4	50,4	51,8	1,0	1,0	0,2
Podkarpackie province	75,9	81,2	81,4	61,5	71,1	72,4	72,6	72,7	77,6
Leżajsk county	90,8	95,2	95,4	56,4	66,9	68,9	61,9	61,2	71,4
Nowa Sarzyna	86,6	96,6	96,6	56,1	65,1	66,2	66,1	64,9	75,6
Grodzisko Dolne	96,8	96,9	97,0	50,5	57,6	58,5	39,8	40,3	49,4
Przeworsk county	85,4	89,0	89,2	66,8	78,2	79,6	65,5	65,1	73,2
Przeworsk	92,3	92,5	92,7	71,3	87,8	88,1	71,4	69,4	76,7
Tryńcza	92,5	95,4	95,6	59,9	83,2	83,7	60,2	58,5	67,7
Zarzecze	93,8	95,9	96,0	82,0	85,3	85,8	76,3	75,4	93,7

Source: Own work based on BDL GUS data.

A characterisation of the transport infrastructure in the municipalities was also included in the description of the context of the FHPE's operations and the innovation's implementation. This is important for analysing the possibility of getting to (or even undertaking) work, e.g. in the care sector, but also from the point of view of patients looking for medical help. It turns out that within the municipalities under analysis, many roads are of low quality. There are also problems with travelling due to the fact that transport infrastructure runs mostly along the main transport routes and does not cover more remote localities. This is shown in the maps below (Fig. 7 and Fig. 8).

The first map shows how many residents aged 65 and over do not have access to a hard-surface road or an improved hard-surface road. This means problems with moving around during intensive rainfall or thaws, and makes snow removal in winter more difficult.

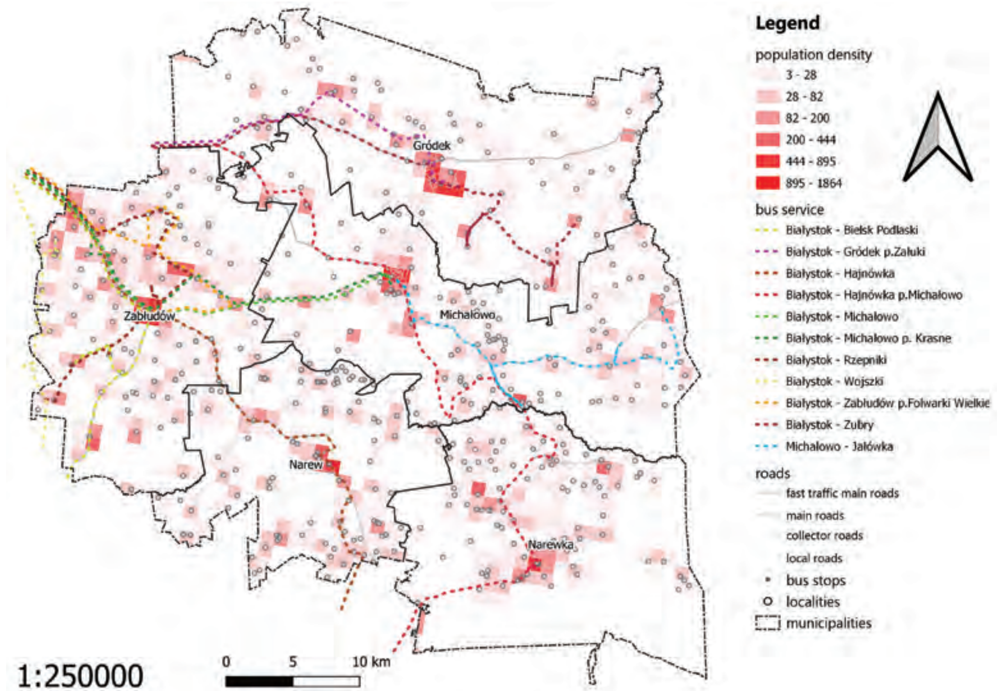
Figure 7. Road condition map for the municipalities where the innovation was implemented.



Source: Own work based on BDL GUS data.

The next major element for describing mobility in the municipalities under consideration is their internal transport network. The next map shows the public transport network run by PKS Nova, comprising 11 bus lines. Bus stops, population densities as well as major roads, localities and municipality boundaries are also marked. The data indicates that many villages do not have access to mass transport. They include Ciełuszki, Tyniewicze Duże, Siemianówka, Bobrowniki and Kołodno. It is also worth noting (in conjunction with the data presented in the tables above) that localities such as Żednia, Planty, Lewkowo Nowe and Narewka only have access to one pair of transport services per day.

Figure 8. Public transport map for the municipalities where the innovation was implemented.

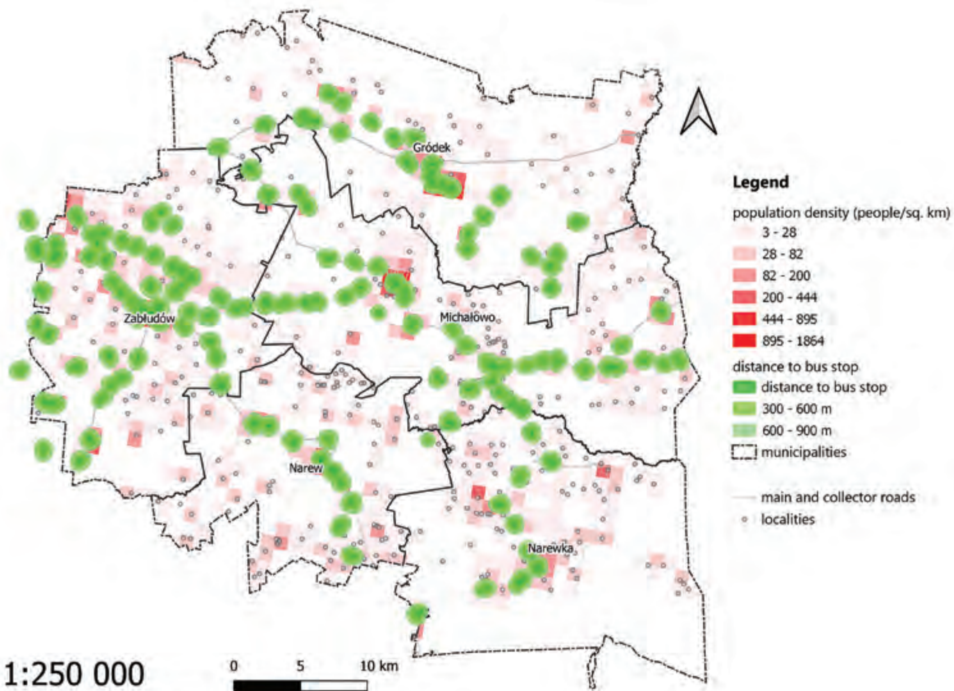


Source: Own work based on BDL GUS data and data obtained from local transport companies' websites.

The 11 bus lines operated by PKS Nova run through the municipalities where the innovation was implemented. They mainly provide links to Białystok as well as Hajnówka and Bielsk Podlaski. The bus company runs high-floor vehicles, and although it offers free transport of wheelchairs, the structure of the buses makes it difficult for people with mobility issues to use them, especially older people who may have problems mounting the steps.

The next map (Fig. 9) shows the average time it takes to walk to the nearest bus stop, with isochrones of 10, 20 and 30 minutes. It should be noted that a 20- or 30-minute walk is not attractive or possible for many people, especially older people with mobility problems or returning home with shopping. In the reality of working in the field, a half-hour walk also extends the time it takes a hospice employee to reach a patient if they are using public transport. Since the time spent getting to a patient is work time, it increases the costs the hospice incurs per patient. In such a situation, the most rational option is for hospice staff to travel by car. However, this means that the hospice would have to maintain an appropriate number of company cars, or that having a car and a driving licence would be a necessary condition of employment at the hospice.

Figure 9. Accessibility of bus stops in the municipalities where the innovation was implemented.

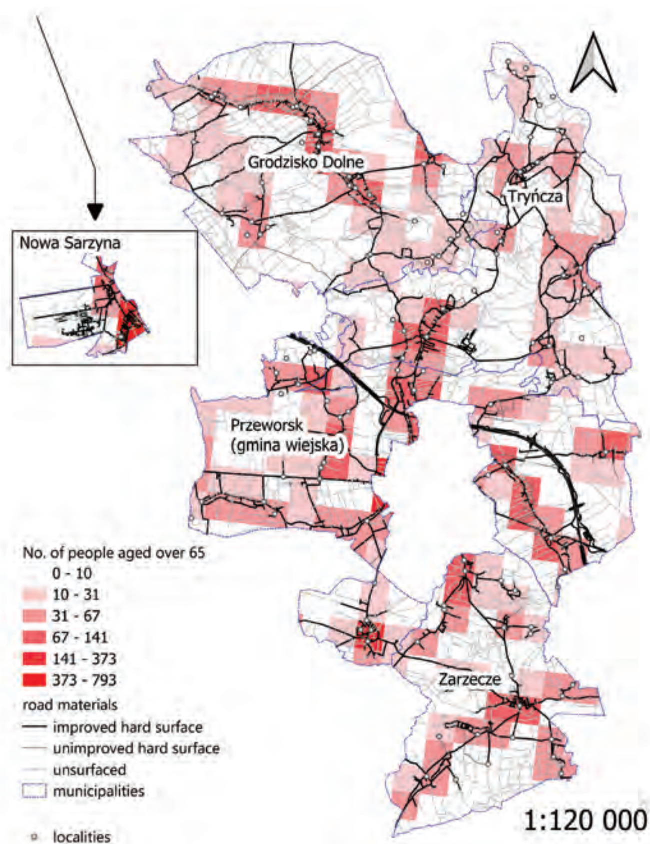


Source: Own work based on BDL GUS data.

The same analyses of road and transport infrastructure were conducted for the selected municipalities where NZOZ Nadzieja operates. However, the situation there was different.

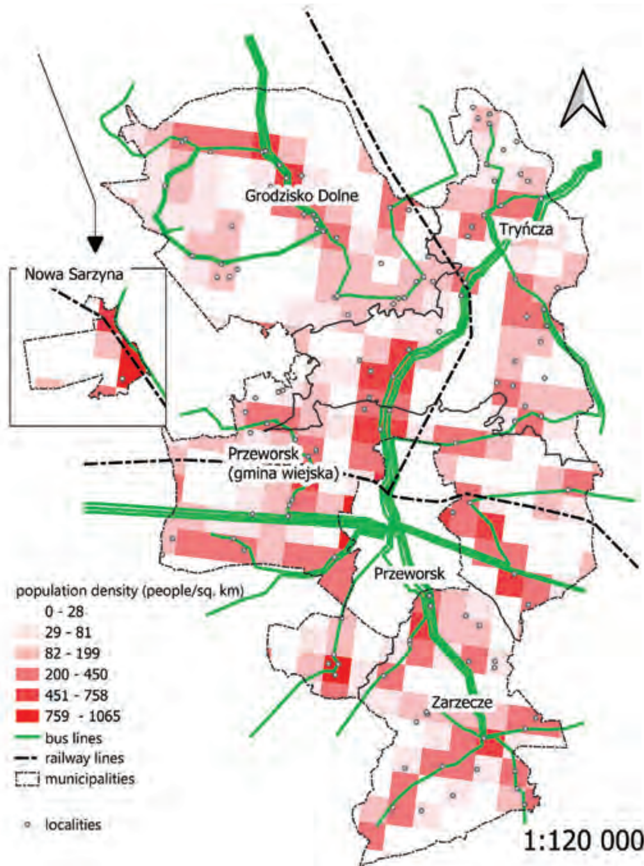
Due to the well-developed road system as well as locations along transport routes of regional and interregional (and even provincial and national) importance, some of the localities have good access to long-distance buses and trains, which also ensure speedy travel between larger towns in the region under analysis, e.g. between Przeworsk and Rzeszów. The network of local links is strengthened by minibuses running to places like Leżajsk, Lublin, Tarnobrzeg, Przemyśl and Biłgoraj.

Figure 10. Road condition map for the ("control") municipalities in Podkarpackie province.



Source: Own work based on BDL GUS data.

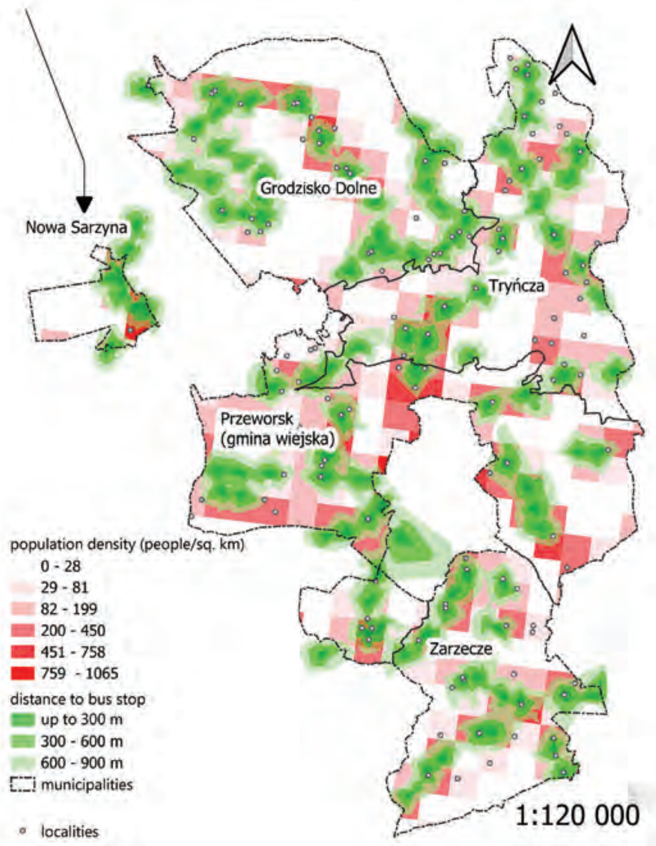
Figure 11. Public transport map for the ("control") municipalities in Podkarpackie province.



Source: Own work based on BDL GUS data and data obtained from local transport companies' websites.

Bus transport in these municipalities is provided by several companies, both private and local-government-run: PKS Leżajsk, PKS w Rzeszowie, Grzesiek Bus, Jan Bus, Eurobus, Usługi Przewozowe Pola Artur Bar (POLA). Transport between the biggest towns (e.g. between Przeworsk and Rzeszów) is also provided by long-distance carriers, e.g. Flixbus. The only regional bus company running vehicles with low floors (along the whole bus or only part of it) is PKS w Rzeszowie. It has 87 all or partially low-floor buses, accounting for 65% of the company's fleet. Regional transport is strengthened by Polregio regional trains. In addition, on some routes it is possible to take a PKP Intercity train. Similarly to what was shown for the innovation implementation municipalities, the map below (Fig. 12) presents the average time it takes to walk to the nearest bus stop, with isochrones of up to 300 metres, between 300 and 600 metres, and over 600 metres.

Figure. 12. Accessibility of bus stops in the ("control") municipalities of Podkarpackie province.



Source: Own work based on BDL GUS data.

2.3. Social Context

The description of the social context in the place of the innovation's implementation is based on the results of interviews conducted with two groups of subjects: representatives of local authorities and the staff (wherever possible – managers) of municipality (GOPS) and town-municipality (MGOPS) social welfare centres. To avoid directing the subjects' attention to the problem of dependent care in which we were interested, the pretext for the interview was investigating what challenges and opportunities a given person saw in connection with development, management and working in peripherally located municipalities. The aim of the interviews conducted on this pretext was to check whether local authorities noticed problems related to the large population of older, chronically ill and dependent people living in their area. We wanted this topic to emerge during the unstructured interview in the order indicated by the interviewees,

which would suggest how high the problems to which the innovation responded were on the list of priorities of local authorities and social welfare institutions. Taking place at the start of the innovation, before testing began, the interviews were also a valuable source of knowledge about the problems in the municipalities under consideration, the initiatives undertaken there, and the strategies of coping in a crisis situation, i.e. another wave of the pandemic that occurred during the study.

In each of the municipalities in the study, issues connected with providing care to older and dependent people were mentioned in the course of the conversation at the initiative of the subjects, but at different moments of the interview. All of the municipalities also took steps to respond to emerging needs and problems, but it is interesting just how varied these response attempts were. Similarly, the interviewees' answers varied with regard to the next aim of the study – checking the recognisability of the leader (FHPE) that has been active in the municipalities for many years. In some of the municipalities, it was mentioned almost immediately as the main or a major partner in solving dependent care problems. In others it was not brought up until a direct question about the leader had been asked. In such cases it turned out to be a recognised organisation, but one that – according to the local leaders – did not play as great a role as in the other municipalities.

Table 13. Summary of the main problems in the municipalities where the innovation was implemented.

Gródek municipality	Among the most important problems, the wójt (mayor) mentioned the municipality's geographical size, which generates large financial outlays on infrastructure (gas and water supply, roads and transport etc.), and also underlined the unique situation and challenges stemming from the municipality's location on the border and the fact of having a border crossing within it. It was only during a conversation with just the GOPS manager that issues involving older and dependent people emerged as important problems. The municipality is home to associations having proposals for such people. The municipality does its best to offer courses, e.g. vocational, to train people who could then start working with older or dependent people, but there is a shortage of applicants to take part and to take this kind of job. There are four welfare caregivers in the municipality who, similarly to other municipalities, alongside skills connected with dependent care also have to have a driving licence and a car, which is an additional requirement unique for this labour market. The FHPE was mentioned in the interviews, but mainly in connection with the interviewees' personal experience, not as an organisation that the municipality collaborates with to meet the needs of its residents.

Michałowo municipality	The local authorities' opinions on the municipality's most important problems were presented differently than those of people involved in social welfare in the municipality. The town's deputy mayor listed depopulation, defined as a shortage of young people and not an excess of older people, as the municipality's most important issue. This definition of the problem affects the type of action taken by the local government, which focuses on attracting new, young residents and getting local young people to stay in the municipality. Measures undertaken in the municipality include investing in housing, saving the local school, promotion through the school's stage performance class, tax breaks, the municipality's 2000 extra welfare programme, investing in building modernisations, setting up NGOs, investing in cultural life, the Village Centres programme (which, it needs mentioning, does include elements targeted at older people). Among activities aimed at senior citizens, the Senior Ball was mentioned as an example. The FHPE only appeared in the interview after a question about it was asked. It was not perceived as an institution that could be a partner in solving the problems of older people in the municipality. In the interview with the MGOPS manager, problems of older and dependent people were mentioned as the main area of activity for the centre's employees, requiring significant outlays and expanding all the time.
Narew municipality	In this municipality, separate interviews were conducted with the mayor and GOPS employees. In both cases, demographic issues were mentioned as the most important problems. However, whereas the mayor speaking about depopulation and a demographic disaster in the municipality underlined migration and a shortage of young people, leading to the municipality's low social potential, the GOPS employees indicated the problems of older people as the most important thing in need of solving. Paying care home fees for older, lonely people without family to take care of them was mentioned as a significant burden on the municipality budget. As the GOPS employees underlined, although neighbours often react and notify the welfare service of older people's problems, they are unwilling to get involved in helping, they don't want to formalise things and pledge regular help, even though they do spontaneously help older people around them. This could suggest a lack of social trust, which is an important indicator of social capital. In both interviews, the interlocutors mentioned the FHPE operating in their area, but mainly underlined the planned opening of the residential hospice being built within this municipality.
Narewka municipality	In this municipality, the municipality secretary and the GOPS manager were interviewed together. The representatives of both institutions had similar things to say about the municipality's problems. The problems of older people were spontaneously mentioned as one of the fundamental and most urgent issues. The authorities point out that the growing elderly and dependent population means a greater burden on the municipality budget because spending on services for older people grows. Loneliness was suggested as an important problem, but both interviewees underlined that this group's problems were complex, from health, through social, to financial and mental issues. Other problems mentioned included the municipality's large area and its settlement structure – the location of villages requires any helpers, whether family members or institutional caregivers, to have both a car and a driving licence. The municipality is taking measures to improve the situation of older people; daily life assistants affiliated with the GOPS (previously with the Red Cross) are financed from the municipality budget. The municipality office staff spontaneously pointed to the FHPE as an important partner in caring for older people in the municipality.

Zabłudów municipality	The interviews conducted with the mayor and with the MGOPS manager and team revealed differences in the perception of the most important problems in the municipality. Whereas for the mayor the most important challenges for the municipality were infrastructural issues in a broad sense (chiefly technical: water supply, sewerage, roads, internet), the MGOPS employees in their interview indicated issues connected with older and dependent people as the most important problems that required solving. Demographic issues in the mayor's interview were viewed in terms of the necessity to attract young people, encourage them to settle in the municipality, which would result in tax revenue for the budget. The demographic problem was understood as a deficit of young people, not an excess of older residents. At the same time, it seems that the position of the MGOPS does translate into the municipality authorities' activity, as they carry out tasks aimed at providing older and dependent people with access to quality services. The municipality takes part in competitions for investment projects involving dependent care; for example, a Community Self-Help Home was opened recently. The FHPE was not mentioned by the mayor as a partner in the municipality's activity; the MGOPS knew about the FHPE's operations but had not collaborated with them in helping dependent people in the municipality.

Source: Own work based on interviews and a review of the websites of municipality offices and local institutions.

Due to the difficulties mentioned earlier, obtaining control units for the study was delayed. Although all effort was made to ensure that the research procedure was as similar as possible to that used in Podlaskie province, it had to be partially modified. Wherever possible, interviews were conducted, just like they had been in Podlaskie province, but it was only possible to talk to representatives of one of the institutions in some municipalities, and in the case of Tryńcza municipality the procedure had to be limited to an analysis of budgets, strategic documents, statistical data and the municipality's website and social media. Strategic documents, budgets, websites and social media were analysed for all the municipalities.

The Podkarpackie province municipalities in which the control institution – NZOZ Nadzieja – operates showed a radically different perception of the local communities by their leaderships compared to Podlaskie province. In all of the units considered, demographic issues manifested in population ageing already emerged at the beginning of the interviews. It is also worth noting that the local authorities and social welfare staff were unanimous in pointing to the most urgent problems in their particular municipality, something that only happened in Narewka municipality in the case of Podlaskie province. Each of the Podkarpackie province units takes action to counteract these unfavourable trends. These strategies usually include strengthening the social welfare system within which services are provided to dependent, older and ill people. If possible, municipalities also invest in social infrastructure – adult day care centres, residential care homes, and meeting places for older residents.

Table 14. Summary of the main problems in the municipalities where the control institution operates.

Grodzisko Dolne municipality	An interview was conducted with the social welfare centre (OPS) manager, who listed negative demographic trends – the growing number of older people requiring care and support – as the most important problem for the municipality. The centre offers care services, which are provided in collaboration with Caritas. The municipality's social welfare centre also runs a day care home where 30 people receive support in the form of a therapeutic activation programme, rehabilitation, and meetings with a psychologist. Neighbourly assistance also works very well in the municipality, providing care services. The interview also revealed that there was a community self-help home and an education and rehabilitation centre in the municipality.
Nowa Sarzyna municipality	Interviews were conducted with the mayor and the director of the social welfare centre (OPS). Both interlocutors devoted a lot of attention to social issues. The mayor said that from the point of view of local finance, education was the greatest burden due to the decreasing number of children and thus limited resources from the government education subsidy. However, the education of the youngest residents was a priority: the municipality runs creches, preschools, primary schools and a secondary school, actively working with local entrepreneurs to ensure funding and development opportunities. The population is shrinking – a greater number of deaths are being reported after the pandemic. Symptoms of suburbanisation are also noticeable: the population is growing in the rural part of the municipality, with about 100 new buildings appearing every year. The interviews also showed that the municipality pursued an active seniors policy, driven by the fact that there were more and more older people in need of care (which was once the duty of families). The municipality provides care services, collaborating with Caritas on this. It also has coordinators who support the oldest residents. The municipality takes advantage of the Senior Plus programme. It has two day care homes (a third one is under construction). A housing centre is being set up in the municipality – intended for people from the community self-help home. There is also a social cooperative and a vocational rehabilitation facility in the municipality.
Przeworsk municipality	The conversation with the municipality secretary and the social welfare centre (OPS) manager spontaneously covered issues connected with negative demographic trends. Firstly, the interviewees pointed to the decreasing number of children, which makes running educational facilities a big burden on the municipality budget due to reduced government education subsidies. Secondly, they mentioned the problem of the ageing of society, which is noticeable in the municipality. Numerous activities are undertaken, e.g. within the seniors integration centre, to support the municipality's oldest residents. In this, the municipality collaborates, for example, with NGOs (e.g. the Sołuński Brothers Foundation and farmers' wives' associations) as well as village community centres (which exist in all of the municipality's villages). Additionally, the secretary pointed out that the local authorities devoted a lot of attention to infrastructural issues – building new facilities and modernising existing ones. In this context, the elimination of infrastructural barriers and supporting people with mobility problems was also mentioned.

Tryńcza munici-pality	The situation of older people in this municipality was described on the basis of secondary sources: documents from Municipality Councils, analyses of GOPS and CUS (Social Services Centre) budgets and reports, analyses of the municipality's website, analyses of local media, and analyses of the social media of the municipality and the CUS operating there. This means that we infer the importance of the problem of older people not from the declarations of those governing the municipality but on the basis of their actions. However, these show that issues connected with the elderly population are important to the local authorities, who are doing a lot to improve the situation of the municipality's older residents. There are three day care homes for seniors in the municipality – in Tryńcza, Wólka Małkowa and Jagiełła, and another, in Gniewczyna Łańcucka, is scheduled to resume operations from January 2024 (after a several-year break). In collaboration with village administrators, CUS employees visit older and lonely people, creating opportunities for conversations, providing fresh bread to those in need and, during the Christmas season, Santa Claus also takes part in the visits, bringing Christmas poppyseed cakes. Birthday visits are made to the oldest residents in the municipality. Free English courses are offered to seniors, and St. Andrew's Day parties, trips to the cinema and excursions are also organised. One interesting initiative involves workshops for two generations: seniors and children (e.g. photography, olden-day games, and cooking). Respite care giving short-term relief to primary caregivers is also provided in the municipality. In the course of the study, the municipality carried out a project involving the creation and operation of a facility renting out rehabilitation, nursing and aid equipment, as well as a programme of courses for 25 participants who are caregivers for people in need of support in daily life in terms of care and rehabilitation. The CUS-affiliated rental facility rents out equipment free of charge.
Zarzecze munici-pality	An interview was conducted with the social welfare centre (OPS) manager. Among the most important aspects of the municipality's activity, she mentioned assistance for older and lonely people – this is connected with the intensifying ageing of the population. The municipality provides assistants to people with disabilities, offers respite care, and has a rehabilitation and nursing equipment rental facility. Specialist services for people with mental disorders are provided as well. The municipality has a community help home and a social integration centre. Steps are being taken to set up a seniors club and generally expand the range of services offered. Help in the form of extra meals is provided. The municipality collaborates with Caritas and the Sołuński Brothers Foundation on welfare matters. Alongside all this, the interviewee mentioned care and education problems among young people and children as well as behavioural addictions – the municipality is also taking action to deal with them.

Source: Own work based on interviews and a review of the websites of municipality offices and local institutions.

The information obtained in the interviews is supplemented by the results of the analysis of strategic documents in force in the municipalities. These documents have a specific structure. Their first, diagnostic part indicates what problems, potentials and resources characterise a given municipality. The next, strategic part outlines the vision, mission, objectives and tasks that need to be undertaken in order to take maximum advantage of existing potentials and minimise the negative consequences of the difficulties diagnosed.

In order to produce the strategic documents for the municipalities under consideration, detailed diagnoses were carried out, covering the social, economic, environmental and infrastructural spheres. None of the documents in Podlaskie province – except Narewka municipality – points directly to demographic problems connected with population ageing. However, the strategies underline that the municipalities are seeing problems with access to social services in a broad sense, due to their lack or poor quality as well as the dispersed settlement network. The strategic parts of the documents usually do not directly suggest the necessity to undertake actions aimed at older and dependent people and those with disabilities as well as their caregivers and families. However, it is possible to identify directions of activity indirectly connected with the needs of this group. In the social aspects, Gródek municipality focused on the need to improve the quality and availability of social services, Michałowo municipality – on preparing detailed documents addressing the problems of marginalised people and groups, and Narewka municipality – on the development of social infrastructure. Only Zabłudów municipality virtually ignored welfare and social issues in the strategic part of its document.

Sector documents – the municipalities' Strategies for Resolving Social Problems – were also analysed. Four out of five of these strategies stated that one of the key problems was that of the ageing of society; Narew municipality was the exception. The Michałowo Municipality Strategy for Resolving Social Problems for the years 2016–2024 underlined that the municipality experienced insufficient access to specialists and the problem of population ageing in a broad sense. The document stated that Michałowo needed to identify and monitor the situation of dependent people in the municipality and collaborate regularly with social partners on issues of disabilities and the social inclusion of older people. This was meant to help achieve objective II, i.e. supporting families and the weakest groups (older people, people with disabilities, the chronically ill, and people with mental disorders). Gródek municipality's list of social problems included the shortage of social welfare facilities such as a day care welfare home, a community self-help home, a hospice, a welfare hotel for older people or protected housing within the municipality's resources, the growing number of people of post-retirement age, the lack of sufficient funding to carry out social welfare tasks involving older people, and the small number of NGOs and institutions dealing with problems of the elderly. It was also found that one of the fundamental objectives contained in the Gródek document was counteracting the social exclusion of the elderly, people with disabilities and the lonely. The Zabłudów Municipality Strategy for Resolving Social Problems for the years 2014–2022 stated that major social problems included the effect of population ageing, the migration of young people to large conurbations, architectural barriers, and the unavailability of social welfare facilities such as a day care welfare home, a community self-help home, a hospice, a welfare hotel for older people or protected housing within the municipality's resources. A

large part of the problems listed was the same as those diagnosed in Gródek municipality. Also similar was the fundamental objective aimed at improving the situation regarding the identified social problems. That objective was to counteract the social exclusion of older and lonely people and people with disabilities. Meanwhile, the Narewka Municipality Strategy for Resolving Social Problems for the years 2016–2022 indicated that social problems were mainly connected with difficulties in the functioning of families, alienation and the predominant poor state of health of older people as well as the negative demographic trend. This municipality clearly and precisely defined its "strategic objective I. supporting families, the children's care system and support for older people, those with disabilities", which would be achieved through measures such as the development of the system of assistance/services for older and ill people and those with disabilities in the environment where they live. As mentioned earlier, the Narew Municipality Strategy for Resolving Social Problems for the years 2014–2022 was the exception here: it offered a rather general description of the problems as well as the objectives, devoting no attention to older and dependent people and those with disabilities.

A slightly different outline of the problems and objectives is found in the strategic documents of the municipalities covered by the operations of the control institution, i.e. NZOZ Nadzieja. Unfavourable demographic trends and as yet unsatisfied needs of dependent and older people were not often listed as the municipalities' problems or weaknesses. Grodzisko Dolne municipality mentioned the poor offering of seniors support centres, Przeworsk municipality – the lack of proper infrastructure to ensure day care for older people and those with disabilities. Tryńcza municipality similarly mentioned infrastructural deficiencies: a lack of day care welfare centres and a full-time care facility, limited access to rehabilitation services, a lack of places in nearby care and treatment facilities (ZOLs), a lack of specialist health care, and staff shortages – the document underlined that the municipality had too few welfare employees at the social welfare centre. The other municipalities' development strategy outlines of social and/or demographic problems did not indicate issues connected with population ageing or with social and medical services intended for seniors. The municipalities where such problems were diagnosed formulated objectives involving improvement of the situation of older people. These objectives were the most numerous in Grodzisko Dolne municipality which, among other things, mentioned developing care services – including the full spectrum of rehabilitation services – for older people, opening new and developing existing day and full-time elderly care facilities, courses for older people teaching them how to use a computer and take advantage of e-administration, forming new and developing existing seniors clubs, setting up medical stations to improve the availability of health care. At the level of measures within one of the objectives, Przeworsk municipality suggested the necessity to improve the quality of social services for older

people and those with disabilities. In Tryńcza municipality – similarly to Grodzisko Dolne municipality – issues connected with improving the situation of seniors were already indicated at the strategic objective level, which in this municipality was set down as "ensuring help for older people and those with disabilities" and had a number of specific actions tied to it. A more detailed image of social problems is brought by an analysis of the strategies for solving social problems. All of the units except Tryńcza municipality mentioned the problem of population ageing and negative demographic trends as well as the accompanying infrastructural deficiencies and shortages in social and medical services. Obviously, these diagnosed problems came with objectives and actions designed as the next step. These were suggested in all the municipalities from Podkarpackie province under analysis (including Tryńcza municipality). Measures aimed at improving the situation of older people have been designed, encompassing medical and care actions in a broad sense as well as those that help stimulate the older population and their participation in the life of the local community.

The analysis of the strategic documents of the municipalities under consideration shows that the broadly understood aspects of the functioning of older and dependent people and those with disabilities are not treated as a priority – neither at the diagnostic nor at the strategic level. At the same time, they are not completely ignored, but – as the analysis of statistical data reveals – demographic problems and an insufficiently developed infrastructural and social service base should be given more attention in future. At the same time, the fact that a problem is not mentioned in the municipalities' development strategies does not necessarily mean that no projects are being implemented to alleviate its consequences. Thus, in the case of measures targeted at older people, if national-level programmes with funding appear, as was the case e.g. in Tryńcza and Zabłudów municipalities, they are carried out.

2.4. Health and Welfare Context

Readily available databases illustrating the condition of the health care sector do not enable an analysis at the local level to be performed. It is common knowledge that there are staff shortages everywhere in the medical and care sectors; this is noticeable in the results of the annual Occupations Barometer survey. Shortage occupations are those in which the number of available jobs is greater than the number of people interested in them and fulfilling employers' requirements (it is hardest for employers to find candidates for these jobs). Podlaskie province has a deficit of doctors, professional caregivers for the elderly and people with disabilities, and nurses and midwives, which is also the case in Hajnówka and Białystok counties. These deficits – according to the survey's authors – are the effect of a shortage of qualified employees as well as

economic migration to other countries and to large conurbations. Another reason mentioned is the lack of generational renewal in these occupations. The deficit of nurses and caregivers is also caused by people's lack of willingness to take these jobs, which in turn is related to tough work conditions, low pay and the low prestige of caregiving occupations. Although nurses enjoy respect and social trust in Poland, nursing is still an occupation requiring a long training process, dedication connected with the unusual work schedule and, according to the group itself, still inadequate pay. The only exception where the number of jobs on offer is similar to the number of candidates who apply and meet employer requirements is that of physiotherapists and psychologists in Podlaskie province, and psychologists in Białystok county. These data look worse at the level of municipalities similar to the ones implementing the innovation, i.e. with a peripheral location and affected by depopulation.

Podkarpackie province shows a deficit of doctors, physiotherapists, and nurses and midwives. Things are slightly different in the counties considered in the study: both of them show a state of equilibrium on the market for doctors, caregivers for the elderly and people with disabilities as well as psychologists and psychotherapists.

Deficits are reported in both counties regarding the need for physiotherapists and nurses. This is most often because people working in these occupations migrate to more attractive places – including other countries, where they can develop their careers and receive better pay. All of the occupations listed here are characterised by a steady high level of demand from employers and clients. The study indicates that this demand is sure to increase due to population ageing and the concomitant increased demand for medical services.

Table 15. Relationship between available employees and employers' needs (2022).

	Podlaskie province	Białystok county	Hajnówka county	Podkarpackie province	Leżajsk county	Przeworsk county
Physiotherapists	equilibrium	deficit	deficit	deficit	deficit	deficit
Doctors	deficit	deficit	deficit	deficit	equilibrium	equilibrium
Caregivers for older people or people with disabilities	deficit	deficit	deficit	equilibrium	equilibrium	equilibrium
Nurses and midwives	deficit	deficit	deficit	deficit	deficit	deficit
Psychologists and psychotherapists	equilibrium	equilibrium	deficit	equilibrium	equilibrium	equilibrium

Source: Own work based on Occupations Barometer data.

As the study progressed it became clear that, to some extent, the innovation was taking over services that should be provided by other entities. Due to the (locally frequent) shortage of providers of health and social services, patients' needs were not being met by the public care system. One example might be that it was not possible to take advantage of long-term nursing care in the municipalities from Podlaskie province considered in the study. As a rule, such care should be available to bedridden and chronically ill patients staying at home. It may be provided to patients who do not require treatment at an inpatient (residential) facility but, due to existing health problems, do need systematic and intensive nursing care at home.[10] None of the municipalities where the innovation was implemented offered this service because they did not have the medical personnel to undertake the task. Nurses, of whom there are too few in any municipality, could find better paid jobs at other facilities. In the existing system, there was no suggestion what steps should be taken to remedy such a situation. The local governments in the municipalities have no possibility of exerting pressure on the National Health Fund (NFZ) to provide the missing staff, as the NFZ cannot order anyone to take a job at a specific facility. On the other hand, the NFZ does not monitor the extent to which various needs are met in individual territorial units, nor is there any coherent system of incentives to take jobs in places where patients' needs are noticeably unfulfilled.

Let us analyse what the NFZ provides to potential patients as part of their state health insurance. This is a package of medical services that should be available to anyone in need of at-home care. However, the availability of these services largely depends on local or regional conditions, and also on the efficiency and effectiveness of local authorities or people at the facilities that provide the various types of service.

10 Long-term at-home nursing care may be provided to patients who: obtained 40 points or less on the Barthel scale; are not in an acute phase of a mental disease; are not taking advantage of at-home care for mechanically ventilated patients, in-home hospice care or an inpatient (residential) care facility (care-and-treatment or nursing-and-care facility).

Table 16. Medical service package to which patients are entitled under the public system – NFZ.

NFZ medical service package	
Medical services	• primary health care from a doctor and a nurse at a facility of the patient's choice • care provided by specialist doctors based on an official referral (not required to see a psychiatrist, oncologist, venerologist, dentist, gynaecologist and obstetrician) • after-hours medical services • emergency ambulance service • long-term nursing care • NFZ-provided at-home rehabilitation • non-commercial rental of rehabilitation equipment • commercial medical services • commercial rental of rehabilitation equipment • a pharmacy or dispensary • transport by ambulance (upon a primary health care doctor's referral)
Care/social services	• social welfare services (requiring certain criteria, e.g. financial criteria, to be fulfilled) • care services provided by social welfare centres (OPS) (i.e. availability of caregiving staff, respite care) • commercial care services

Source: Own work.

In rural areas, some services are not available everywhere – they include, for example, long-term nursing care, at-home rehabilitation, and specialists located close to a patient's place of residence. The possibility of choosing a doctor is often limited as well – a municipality usually has one GP, who often cannot freely visit patients at home because he or she is on duty at the local clinic. Another example of limited access to care is the fact that at-home rehabilitation offered by the NFZ (and financed by the fund) is available almost exclusively to people with a certificate of severe disability. Moreover, villages seldom have rental places offering patient care equipment, and rather than pharmacies, they more often have dispensaries, which offer only basic medications and are unable to store some medications at all. This has significant consequences for patients who are prescribed strong opioids, for example, when bringing them to the local dispensary takes at least a dozen or so hours.

Some ill people living in rural areas are unable to function by themselves, without professional help. If the services listed in the table are not actually available where they live, such people (after a stroke, with motor organ dysfunctions, e.g. following amputations in the course of diabetes or atherosclerosis, etc.) experience the consequences of the "systemic void" and "service void". Potentially possible solutions include fully or partially paid care as part of commercial health and care services (on condition that these are available and the patient is able to pay for them). For the poorest patients, the solutions include services subsidised by social welfare centres, which means meeting

certain criteria, e.g. an income criterion, and depends on such centres' capacity (e.g. financial ability and staff availability) and efficiency.

A matrix was produced for each of the municipalities where the project *To Give What is Really Needed* was implemented, showing which elements of the potential NFZ services package and social services are accessible to residents. It needs saying at this point that none of the "innovation municipalities" has a functioning system of long-term nursing care. The availability of the other services varies. The matrix offers a synthetic description of the social and health-related context for the innovation's implementation.

Table 17. Services available in the "innovation municipalities".

Model	Services	Gródek	Michałowo	Narew	Narewka	Zabłudów
Medical services	primary health care from a doctor and a nurse at a facility of the patient's choice	+	+	+/-	+	+
	care provided by specialist doctors based on an official referral (not required to see a psychiatrist, oncologist, venerologist, dentist, gynaecologist and obstetrician)	-	+	-	-	-
	after-hours medical services	+	+	+	+	+
	emergency ambulance service	+	+	+	+	+
	long-term nursing care	-	-	-	-	-
	NFZ-provided at-home rehabilitation	+	+	+	+	+
	non-commercial rental of rehabilitation equipment	-	+	-	-	+
	commercial medical services	+	+	-	+	-
	commercial rental of rehabilitation equipment	-	-	-	-	-
	a pharmacy or dispensary	+	+	+	+	+
	transport by ambulance (upon a primary health care doctor's referral)	+	+	+	+	+
Social services	social welfare services (requiring certain criteria to be fulfilled)	+	+	+	+	+
	care services provided by social welfare centres (OPS) (i.e. availability of caregiving staff)	+	+	-	-	-
	commercial care services	+	+	+	-	+
	respite care	-	-	-	-	-

Source: Own work.

Table 18. Services available in the control municipalities.

Model	Services	Grodzisko Dolne	Nowa Sarzyna	Przeworsk	Tryńcza	Zarzecze
Medical services	primary health care from a doctor and a nurse at a facility of the patient's choice	+	+	+	+	+
	care provided by specialist doctors based on an official referral (not required to see a psychiatrist, oncologist, venereologist, dentist, gynaecologist and obstetrician)	-	+	+	-	+
	after-hours medical services	+	+	+	+	+
	emergency ambulance service	+	+	+	+	+
	long-term nursing care	+	+	+	+	+
	NFZ-provided at-home rehabilitation	+	+	+	+	+
	non-commercial rental of rehabilitation equipment	-	+	+	+	+
	commercial medical services	-	+	+	-	+
	commercial rental of rehabilitation equipment	-	+	+	-	+
	a pharmacy or dispensary	+	+	+	+	+
	transport by ambulance (upon a primary health care doctor's referral)	+	+	+	+	+
Social services	social welfare services (requiring certain criteria to be fulfilled)	+	+	+	+	+
	care services provided by social welfare centres (OPS) (i.e. availability of caregiving staff)	+	+	-	+	+
	commercial care services	?	?	?	?	?
	respite care	**+**	+/- była w 2021 r.	**+**	**+**	**+**

Source: Own work.

Legend: ? – the people providing the information suspected that such services were available in the grey economy and did not want to elaborate

Let us now consider what potential possibilities of hospice care exist for patients from the municipalities where the innovation was implemented. Access to an NFZ-funded hospice care package is limited by a list of eight diseases[11] for which care known as the

11 For adults, the list of diseases that entitle a patient to receive NFZ-funded hospice care includes disease caused by the human immunodeficiency virus (HIV), cancer, consequences of inflammatory diseases of the central nervous system, systemic primary atrophy involving the central nervous system, cardiomyopathy, respiratory insufficiency not classified elsewhere, and decubitus ulceration.

"in-home hospice" is possible. The condition for a patient to receive this care is good family care efficiency. It needs mentioning that someone granted in-home hospice care loses the option to take advantage of some of the services available in the previously described variant, i.e. long-term nursing care (if it was available) and at-home rehabilitation offered under the NFZ programme (if the patient received this form of support).

The availability of services provided by hospices under contract with the NFZ is limited in Poland's rural areas. This is due to the structure of systemic solutions and, among other things, the underestimated valuation of such services for rural areas, which does not take into account the costs of getting to a patient (meaning the cost of fuel or vehicle depreciation; many hospices do not have a company car, either) or payment for the time it takes for an employee to get to a patient. Maintaining an in-home hospice operating in rural areas on the basis of NFZ rules is thus difficult – for practical, financial reasons and due to the necessity of covering real costs (e.g. travel) that the payer (NFZ) does not envisage. Moreover, NFZ rules specify a fixed minimum number of visits: at least two doctor's visits per month and two nurse's visits per week, whereas practice shows that in many cases, especially when a patient's condition is stable, doctor's visits do not need to be that frequent but, due to NFZ requirements, they must take place (which generates appropriately high costs because of the doctor's remuneration).

In the current health care system, the above option – as already mentioned – is only available to someone diagnosed with one of eight diseases. In addition, this availability is limited by the shortage and location of in-home hospices, and also the queues of patients waiting to be admitted (contracts negotiated with the NFZ define the number and availability of places). In a situation of a lack of in-home hospice care, the patient may take advantage of care provided by a primary care physician or family doctor, care in a hospital ward (if and when the patient is placed there) or commercial services (if available and affordable for the patient). In extreme and all too frequent cases, patients and their families struggle with a lack of the appropriate care that modern medicine is able to provide.

Table 19. Medical and social service package for in-home hospice patients – NFZ.

<table>
<tr><th colspan="2">NFZ hospice care package</th></tr>
<tr><td>Medical services</td><td>NFZ in-home hospice care includes:
• doctor's visit at least twice a month
• nurse's visit at least twice a week
• physiotherapist, psychologist as needed
• rental of medical, rehabilitation and nursing equipment free of charge

Additionally:
• primary health care from a doctor and a nurse at a facility of the patient's choice
• care provided by specialist doctors based on an official referral (not required to see a psychiatrist, oncologist, venerologist, dentist, gynaecologist and obstetrician)
• after-hours medical services
• emergency ambulance service
• non-commercial rental of rehabilitation equipment
• commercial medical services
• commercial rental of rehabilitation equipment
• a pharmacy or dispensary
• transport by ambulance (upon a primary health care doctor's referral)
Note: the patient loses the option to take advantage of long-term nursing care and rehabilitation from an NFZ clinic.</td></tr>
<tr><td>Social services</td><td>• social welfare services (requiring certain criteria to be fulfilled)
• care services provided by social welfare centres (OPS) (i.e. availability of caregiving staff, respite care)
• commercial care services</td></tr>
</table>

Source: Own work.

This list of potential services has to come with a commentary regarding their actual availability in individual municipalities. For a long time, the Podlaskie province municipalities where the innovation was implemented had been "blank spots" on the map of in-home hospice care availability. The FHPE won the two most recent competitions for an NFZ contract for in-home hospice care, but the contract was for fewer patients than actually needed help. The care under the contract must be provided in the exact way specified by the NFZ, there is no room for flexibility and adaptation of the services to a patient's current condition. Meanwhile, this is the solution proposed in the next type of care, i.e. care provided as part of the innovation (the innovation package).

This care option involves a package of services available to patients taking advantage of support in the FHPE innovative care model. In this case, the condition to be included in the programme is having an efficient support group, which encompasses the family,

the hospice team together with network members as well as neighbours and volunteers. In this option, medical and social assistance activities are not separate, and the liaison between them is the dependent care coordinator (KOOZ).

Table 20. Services available in the new model of care for dependent and chronically and terminally ill people and support for their primary caregivers (innovation package).

Innovation package	
Medical services	• doctor according to need • nurse according to need • medical caregiver from the FHPE according to need • psychologist, dietician, physiotherapist according to need • home visits from volunteer specialists according to need (e.g. psychiatrist, urologist) • rental of medical, rehabilitation and nursing equipment free of charge • possibility of combining FHPE rehabilitation with NFZ-funded rehabilitation (within the same health care facility) • **possibility of combining with long-term nursing care (if available)** • primary health care from a doctor and a nurse at a facility of the patient's choice • care provided by specialist doctors based on an official referral • after-hours medical services • emergency ambulance service • non-commercial rental of rehabilitation equipment • commercial medical services • commercial rental of rehabilitation equipment • a pharmacy or dispensary • transport by ambulance (upon a primary health care doctor's referral)
The KOOZ as the liaison combining medical, social and care services	• regular visits from the KOOZ • coordination of care provided by members of the support network • support in supplying medications • support in obtaining benefits for the patient or caregivers • support in unusual life situations • support in day-to-day matters • respite care to relieve caregivers

Care and social services	• support in supplying medications • respite care to relieve caregivers • a psychologist's support for caregivers • support for persons, families in mourning • social welfare benefits (requiring certain criteria to be met) • care services provided by social welfare centres (OPS) (i.e. availability of caregiving staff) • commercial care services • support network (coordinated by the KOOZ) comprising local stakeholders providing assistance to people in the FHPE programme

Source: Own work.

2.5. Summary

A comparison of the availability of services in the basic model of care in both locations considered in the study indicates that people living in Podlaskie province are in a worse situation than residents of Podkarpackie province in terms of the efficiency of the care system operating in the framework of what the government provides or should provide. It is also worth mentioning the data quoted in the section on the contexts of the innovation's implementation, namely that it is also much harder to travel using public transport in Podlaskie province and to access services provided locally. The FHPE's functioning and the innovative model of care supplements the offering connected with medical and welfare needs, entering the area of operation of two systemic orders: health care and social welfare. It is important to point out that both these systems are in crisis in Poland: they are underfunded and suffer from staff shortages. These problems are intensified in rural areas, which results in the varied availability of health care and social welfare services, and in the case of many services in rural areas (as shown above) – to the lack thereof.

3. Setting Up an Interdisciplinary Team of Employees

In this chapter we present the results of comparative studies conducted at two institutions: the Prophet Elijah Hospice Foundation (FHPE) that implemented the innovation – a new model of care in rural areas, and NZOZ Nadzieja, which operates on the basis of standard National Health Fund (NFZ) guidelines. The study was mainly based on the results of cyclic questionnaire surveys. Four surveys were conducted at the FHPE: in 2021 – on 19 people, 2022 – 11 people, spring 2023 – 18 people, and autumn 2023 – 20 people. At NZOZ Nadzieja, since the surveys started later, two surveys were carried out: in 2022 – on nine people, and 2023 – 15 people. The method used at the FHPE was an auditorium questionnaire, at NZOZ Nadzieja – a self-return questionnaire.

3.1. Staff of the FHPE and NZOZ Nadzieja

Over the period of the study the number of FHPE employees changed. Staff were employed on diverse terms: employment contracts or civil-law agreements. In 2020 there were five people with employment contracts and 27 with civil-law agreements, in 2021 – six and 14 people, respectively, and in 2022 – 24 and 28.[12]

FHPE staff were surveyed during the team's regular monthly meetings. This enabled the study to cover the widest possible group of employees. Due to the FHPE's uniqueness (registered as a foundation, financed under a contract with the NFZ and from funds gathered by the foundation as a public benefit organisation), the foundation hires employees forming the basic staff required by the contract with the NFZ (i.e. a palliative medicine doctor, nurses with a completed course in palliative care or a specialisation in palliative care, a psychologist, a physiotherapist). In addition (apart from what the NFZ

12 The noticeably greater number of FHPE staff in 2022 is connected with the opening of the inpatient (residential) hospice. Some employees care for patients from both the in-home hospice and the newly formed facility.

requires), the FHPE hires hospice caregivers and a dietician. These are the employees who took part in the auditorium surveys.

In the case of NZOZ Nadzieja, the questionnaires were passed on to staff members by the hospice's founder, as the facility has no tradition of meetings at which staff could be handed questionnaires to fill out in auditorium mode. Each time, the researchers asked that the questionnaires be passed on to all the employees who visit in-home hospice patients living in rural areas. Responses were only obtained from those employees who were willing to take part in the study and return completed questionnaires, which is why the study ultimately only covered the nurses employed there and the facility's manager. Due to the small size of both groups surveyed, the data are presented in figures and not percentages.

Table 21. Employees taking part in the study.

	FHPE				NZOZ Nadzieja	
	2021	2022	2023 (I)	2023 (II)	2022	2023
Number of employees: • with employment contracts • with civil-law agreements	6 14	24 28	n/a	n/a	n/a	n/a
N of those surveyed	19	11	18	20	9	15
Doctor	4	1	3	3	0	0
Nurse	5	3	5	6	8	14
Hospice caregiver	4	3	6	7	0	0
Psychologist	1	1	1	1	0	0
Dietician	1	0	0	0	0	0
Physiotherapist	4	3	3	3	0	0
Manager	0	0	0	0	1	1

Source: Own work based on own questionnaire survey.

The majority of the staff surveyed in both facilities were women. Among FHPE employees, the group aged 51–60 was especially numerous. The share of staff aged 31–40 and 41–50 was also quite high. At NZOZ Nadzieja, the most numerous age group among the staff were employees aged 41–50 and 51–60. The other age groups were represented by single employees.

Table 22. Employees at the organisations surveyed.

	FHPE				NZOZ Nadzieja	
	2021	2022	2023 (I)	2023 (II)	2022	2023
Age of employees surveyed						
up to 30 years	5	2	2	1	1	2
31–40	4	2	3	4	1	2
41–50	2	2	3	4	4	3
51–60	6	4	9	10	1	4
60+	2	1	1	1	1	3
Time of working at the given organisation						
Up to one year	6	2	7	5	0	2
More than a year but less than five years	8	5	6	10	0	1
More than five years	5	4	5	5	8	12
Places of employment						
One (only at the given organisation)	2	1	6	3	5	9
More than one	17	10	12	17	4	6
Distance from place of residence to place of employment						
up to 5 km	2	0	1	1	4	3
6–10 km	0	0	0	1	3	4
11–20 km	3	1	0	3	1	1
20+ km	14	10	17	15	2	6

Source: Own work based on own questionnaire survey.

The great majority of the FHPE staff have been working there less than five years, but most of the staff have been employed there longer than a year. At NZOZ Nadzieja, on the other hand, people employed for more than five years predominate (and in most cases this is more than 10 years), and the facility is characterised by a relatively stable team of employees.

For the large majority (about 70–80%) of the FHPE staff, this is not their only place of employment, whereas in the control facility the proportions are more balanced: for more than half the staff surveyed, NZOZ Nadzieja is the sole workplace. The surveyed personnel stated that they learned of vacancies at these facilities mostly from friends, i.e. on the grapevine.

The staff also differ in the distances they have to cover on the way to work. At the FHPE, about three-quarters of the employees have to commute over 20 km to work, and the majority live more than 30 km from the FHPE headquarters. At NZOZ Nadzieja, on the other hand, the staff surveyed live quite close to the facility – up to 10

kilometres in half the cases. However, there is also a numerous group who live further than 20 km from the facility.

3.1.1. Work Conditions at the Facilities

The staff surveyed were asked to evaluate three aspects of working at a hospice: a sense of meaningfulness of the work performed, the work organisation, and remuneration. The staff of both facilities gave high marks to the first two aspects. Remuneration was given the lowest marks. In the first survey this was 8.1 at the FHPE and 7.8 at NZOZ Nadzieja, on a scale of one to 10. However, it needs mentioning that FHPE employees manifested growing satisfaction with the remuneration they were offered, while the other aspects of working there remained at a relatively stable high level. At NZOZ Nadzieja, during the project the staff's sense of meaningfulness of their work remained very high, and their satisfaction grew in the other two aspects. This is also true of satisfaction with remuneration, though it was lower than among FHPE employees in both the first and the second survey.

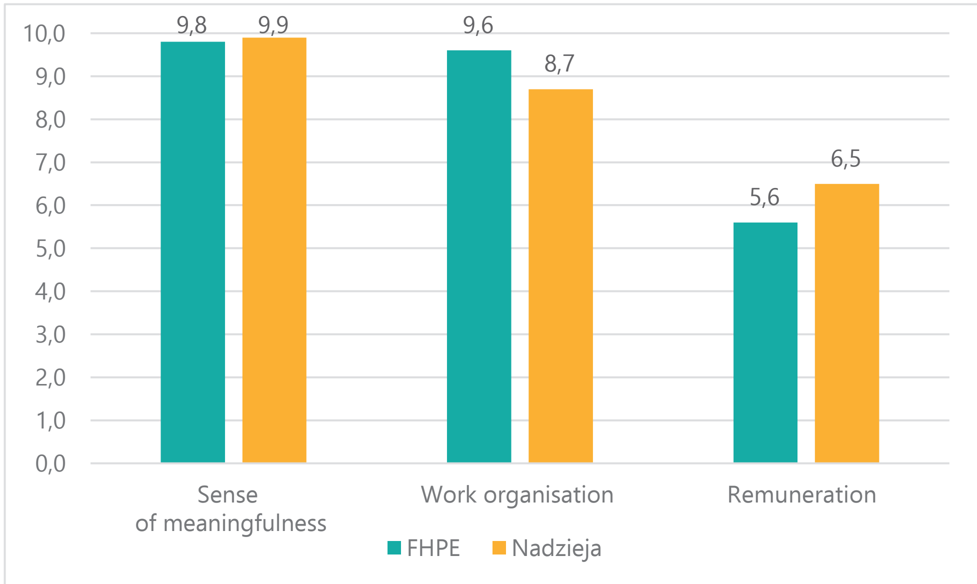
Table 23. Sense of meaningfulness, work organisation, and remuneration as judged by employees of the two organisations. Average marks on a scale of one to 10.

	FHPE				NZOZ Nadzieja	
	2021	2022	2023 (I)	2023 (II)	2022	2023
Sense of meaningfulness	9,9	9,8	9,6	9,8	9,9	9,9
Work organisation	9,4	9,5	9,4	9,6	9,4	9,7
Remuneration	8,1	8,4	9,2	9,3	7,8	8,8

Source: Own work based on own questionnaire survey.

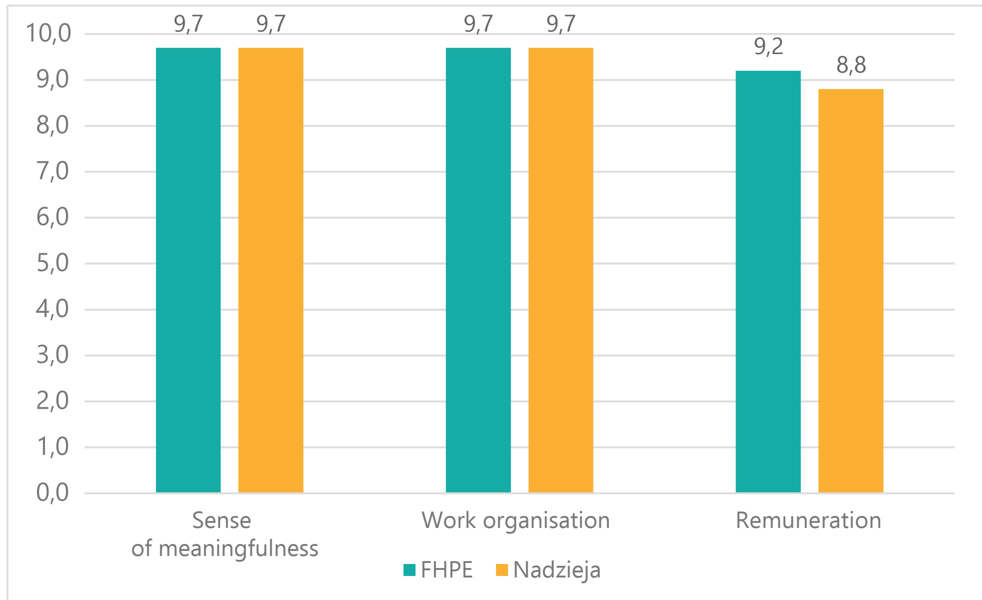
Nurses are the most numerous group at both organisations. Let us compare their opinion on work conditions in the first (2021/2022) and the last (2023) survey at the two organisations. Note that in the first survey the nurses at the FHPE and NZOZ Nadzieja gave similarly high marks to the sense of meaningfulness of their work. The other two aspects were judged differently: work organisation got higher marks at the FHPE, and remuneration got higher marks at NZOZ Nadzieja. At the same time, as the surveys at both facilities show, out of all the employees, nurses are the job group that is relatively the least satisfied with the individual aspects of working there.

Figure 13. Sense of meaningfulness, work organisation, and remuneration as judged by employees of the two organisations – nurses (2021/2022).



Source: Own work based on own questionnaire survey.

Figure 14. Sense of meaningfulness, work organisation, and remuneration as judged by employees of the two organisations – nurses (2023).



Source: Own work based on own questionnaire survey.

In unstructured statements, FHPE employees indicated that the main asset of working at this kind of facility was helping others in their homes. They also mentioned independence, flexible work hours as well as self-fulfilment and career development. The main assets of working at a hospice mentioned by NZOZ Nadzieja staff included helping ill people and a sense of being needed. These employees also mentioned that working there gave them personal development/self-development, irregular work hours,[13] and also interaction with other people and patients' gratitude. The fundamental difficulty pointed out by the staff surveyed at both facilities was the large distances between patients and tough conditions of travelling to patients' homes. The difficult emotions caused by patients' passing and having to work with "difficult patients" were mentioned equally often.

3.1.2. Job Descriptions at the Two Organisations

One of the biggest changes that the innovation brings to the existing care system is the creation of a separate position called the Dependent Care Coordinator (KOOZ). This was a response to a problem noticed by the hospice management: that employees were burdened with actions not connected with their professional tasks, at the expense of time they could spend helping more patients. Hence, questions were added to the study to find out whether bringing a KOOZ into the team would relieve other employees of such actions, and to check the extent to which dealing with tasks other than professional ones was present at the control hospice. The similarities and differences in the tasks handled by the two facilities' employees are presented synthetically in tables 24 and 25 showing the results of the first and last questionnaire surveys conducted at the FHPE and NZOZ Nadzieja.

According to the responses of FHPE staff, in 2021 – which was before the innovation's implementation – they most often helped their charges with shopping and household matters. These jobs were most often done by hospice caregivers, and much less often by other FHPE staff. The employees surveyed often also helped with rentals of rehabilitation equipment. In this regard, nurses declared the greatest activity, and occasional help with this was the most frequent answer. In the first survey year (Table 24) the biggest group of people declared they occasionally helped patients with other medical services than those connected with hospice care. Many also indicated that they occasionally helped with rehabilitation equipment rentals as well as helping a patient's family on matters concerning the patient, even including shopping. The subjects were also asked to list things with which they never helped patients and/or their families. It turns out

13 However, there were also employees who considered this an inconvenience.

that the greatest number of respondents never helped their patients with official matters and transport. In 2021, not helping in household matters was often indicated as well.

Table 24. List of extra jobs performed – FHPE 2021 and 2023.

Type of task in which help was provided	2021			2023		
	often	occa-sion-ally	never	often	occa-sion-ally	never
handling official matters	2	6	12	0	7	10
shopping	5	9	3	3	12	4
transport	0	7	11	0	9	8
household matters (e.g. stoking the heating furnace, carrying water, cooking a meal)	5	5	9	7	6	5
other medical services than those connected with hospice care	2	12	5	2	9	7
rehabilitation equipment rental	4	10	5	3	10	3
helping the patient's family with matters concerning the patient	2	11	5	2	10	5

Source: Own work based on own questionnaire survey.

In 2023, the second year of testing the innovation, the number of extra tasks that the FHPE staff often performed decreased. The most frequent answer – similarly to 2021 – was help with household tasks and shopping. Answers about supporting patients with medical services other than those connected with hospice care and helping patients' families were less frequent than in 2021. The reason may be that the innovation model's KOOZ and the support network started to relieve FHPE staff of certain tasks. It needs remembering, though, that due to the unique and tough labour market, the FHPE reports quite frequent staff turnover, so the responses from different years partly come from different people working in the same jobs. Let us also note that in 2023 the responses about tasks that staff never did were similar to those given in 2021.

The same questions were given to the staff at the hospice operating under contract with the NFZ, in an area better equipped in infrastructure and having a richer and more readily available offering of services within the existing care system.

Table 25. List of extra jobs performed – NZOZ Nadzieja 2021 and 2023.

Type of task in which help was provided	2022			2023		
	often	occasionally	never	often	occasionally	never
handling official matters	2	6	12	0	7	10
shopping	5	9	3	3	12	4
transport	0	7	11	0	9	8
household matters (e.g. stoking the heating furnace, carrying water, cooking a meal)	5	5	9	7	6	5
other medical services than those connected with hospice care	2	12	5	2	9	7
rehabilitation equipment rental	4	10	5	3	10	3
helping the patient’s family with matters concerning the patient	2	11	5	2	10	5

Source: Own work based on own questionnaire survey.

The survey was repeated after a year in order to check whether the situation had changed despite the lack of a change involving bringing a KOOZ into the team.

The staff of the unit providing services under contract with the NFZ also notice the needs of the patients in their care and go beyond what is defined in the contract in their work. This might be an indication to expand the help provided or to take note of patients’ other needs and transfer them into the care of a different institution. In the case of the innovation, this kind of need is fulfilled by the KOOZ or a person/organisation from the social support network chosen by the KOOZ. As a result, the last survey shows staff being less burdened with extra tasks, which is especially noticeable in the case of doctors. This is important in view of the existing shortage of doctors on the medical labour market, and in addition doctors’ time is expensive: their remuneration is the highest. This element of the innovation seems to bring advantages in terms of utilising human as well as financial resources.

The NZOZ staff were not asked about the innovation, but the survey did cover questions related to problems with hospice care in Poland and possible solutions that might minimise existing difficulties. Among the biggest problems in providing in-home hospice care, the respondents mentioned the condition of roads and the long travel time and distance to get to patients. These issues lead to physical tired-

ness. There are further problems involved: the lack of company cars and difficult access (also geographically) to the necessary facilities. Respondents also indicated work organisation and the high workload of hospice staff as being important.

Table 26. Biggest problems with the way in-home hospice care works in Poland, according to NZOZ Nadzieja hospice staff.

	2022	2023
Condition of roads, transport problems, getting to patients	3	5
Work organisation and workload of hospice staff	2	
Lack of company cars	2	
Difficult access to essential facilities	2	
Lack of awareness of available assistance options	1	2
Worse access to hospice caregivers	1	
Loneliness of people living in rural areas	1	
Low outlays on hospice operations	0	1

Source: Own work based on own questionnaire survey.

As a supplement to the responses on problems with the way hospice care works in Poland, we have possible solutions suggested by the respondents. First of all, the hospice's employees mentioned the need to improve transport and technological conditions, including making company medical cars available to staff. Secondly, they pointed to the need to increase the care capacity by adding hospice caregivers to the hospice teams. Thirdly, they suggested that the recommendations enabling a patient to be given hospice care should be expanded.

Table 27. Proposed solutions to problems with the way in-home hospice care works in Poland, according to NZOZ Nadzieja hospice staff.

	2022	2023
Improvement of transport and technological conditions (including company medical cars)	3	1
Increasing the number of nursing visits	2	0
Expanding the care capacity (extra hospice caregivers)	3	1
Closer cooperation of community nurses and GPs with patients and their families	2	0
Expanding the list of recommendations to receive hospice care	3	0

	2022	2023
Support from the local (municipality) social welfare centre (GOPS)	0	1
Increasing the funding for the NFZ contract	0	1

Source: Own work based on own questionnaire survey.

3.1.3. How the Work Affects the Physical and Mental Condition of Staff

The things that employees interacting with patients experience in their work may expose them to a strong risk of suffering symptoms of burnout. Daily contacts with suffering people, seeing death, and watching the despair of a dying patient and their family may lead to various changes in the behaviour of professional caregivers. It may therefore be assumed that working in in-home hospice care predestines employees to workplace burnout syndrome. During the formation of the interdisciplinary medical team to implement the innovation, a person tasked with taking care of the employees' mental well-being was invited to the group. To check whether this person's presence brought the expected outcome, it was necessary to conduct a comparative study among the employees of both the organisations under consideration.

Two tests were used to investigate burnout among FHPE and NZOZ Nadzieja staff; the tests had been used earlier, by the psychologist-expert at the initial stage of her work with the FHPE team. That stage was the basis for diagnosing the mental condition of the facility's employees before the start of the innovation's implementation. The first test[14] comprised 20 elements, some of which concerned physical symptoms (e.g. feeling somatic pain, blood pressure problems, experiencing reduced immunity) and others the person's mental and emotional state (e.g. sadness, irritability, losing interest in their work). Employees were asked to indicate the frequency of experiencing given feelings/states. Frequent indications of physical and mental states could point to difficulties and problems caused by work. The results of the test show that in both surveys (2021 and 2023), there were isolated "always/very often" responses, applied to losing interest in the job, reluctance to perform duties, problems with concentration, a mean and cynical attitude towards others, chronic fatigue, and sleep disorders. Responses of "often" were slightly more numerous – mostly applied to irritability and impatience. The predominant responses were "seldom" and "never" – the greatest number of respondents chose these for mood swings and negative emotions as well as problems concentrating.

14 Received from the psychologist working with the FHPE team. Maintaining the survey's repeatability was the priority.

Table 28. Test 1 for burnout among FHPE staff in 2021 and 2023. Number of marked responses for each mental state.

In recent weeks I've been...	2021		2023	
	always and often	never and seldom	always and often	never and seldom
1. feeling irritable and impatient	5	10	3	13
2. feeling powerless and helpless in the face of professional duties	2	11	1	13
3. feeling sadness/loss of enthusiasm	3	11	0	16
4. feeling a loss of interest in my work	3	10	0	19
5. feeling reluctant to perform my duties	3	11	1	17
6. having mood swings and negative emotions	2	11	0	16
7. having lowered self-esteem and sense of effectiveness	3	10	0	17
8. feeling guilty in connection with the results of my work	2	10	0	17
9. having problems concentrating	4	10	1	15
10. having difficulties making decisions	2	9	0	15
11. feeling that a small effort is beyond my strength	2	11	0	18
12. feeling a weakening of relationships with coworkers and clients, and trying to avoid others	1	9	0	17
13. feeling mean and cynical towards others	1	11	1	17
14. blaming myself for failures	1	10	0	17
15. feeling chronic fatigue	4	11	2	13
16. having sleep disorders	4	9	1	15
17. experiencing reduced immunity	1	10	1	16
18. feeling somatic pain	1	10	1	15
19. having blood pressure problems	0	11	2	16
20. having disorders connected with the digestive tract	1	11	2	16

Source: Own work based on own questionnaire survey.

The responses were assigned point values: "always" – 4 points, "often" – 3 points, "seldom" – 1 point, "never" – 0 points. After the points for each employee were added up, it turned out that most of the respondents were not experiencing burnout, as shown

by the scores of 0–19 and 20–39. The responses of just two people indicated that they may have been affected by burnout, i.e. experienced some of the symptoms. They were in a special situation, at an unadvanced stage of burnout, which would intensify unless countermeasures were undertaken.

Table 29. Scores illustrating the risk of burnout – Test 1, 2021 and 2023[15].

Number of points	Number of people whose responses correspond to a given score 2021	Number of people whose responses correspond to a given score 2023
60–80 points	0	0
40–59 points	2	0
20–39 points	7	4
0–19 points	6	16

Source: Own work based on own questionnaire survey.

The other test used involved choosing "yes" or "no" in response to 10 statements – again, these concerned the respondents' mental as well as physical condition. In 2021 the most "yes" answers went to two statements: thinking about work also in a person's spare time, and numerous duties not allowing the respondent time for recreation. In 2023 only the former of these two statements were chosen a lot. Let us also note that in 2021 just one person indicated that they would gladly change jobs, while in 2023 no one chose this option. Both in 2021 and in 2023, the respondents more often chose "no" answers, which may suggest a relatively low risk of burnout.

15 Interpretation of the scores for the respondents:
60–80 points – you are experiencing the great majority of burnout symptoms at great intensity. This means that you should seek the help of a psychologist, therapist or doctor, as the intervention of specially trained people is essential. Just taking time off or keeping busy with things unrelated to work is not enough. The return to good health and equilibrium will be a long process, but this state of things must not be ignored.
40–59 points – if you are experiencing these symptoms, it is very likely that the problem of burnout has affected you. It is not at an advanced stage, but this state will get worse unless you undertake some remedial measures. At this stage, a short holiday may not bring the desired results; you might need to make changes in your work organisation.
20–39 points – burnout does not seem to affect you, but be vigilant nevertheless. You may feel tired sometimes, but you are able to cope with this quite effectively by taking time off or concentrating on activities outside your job.
0–19 points – you are not experiencing burnout symptoms. You are one of those employees who cope effectively with stress and constraints in the workplace or you have a lot of support within the organisation. If you have worked out some strategies for coping with difficult situations, continue working with them.

Table 30. Test 2 for burnout among FHPE employees in 2021 and 2023. Number of mentions of the individual states.

Possible mental states	2021		2023	
	YES	NO	YES	NO
1. I think about work even in my free time	8	8	12	7
2. I feel overwhelmed by my responsibilities	6	10	3	16
3. When I get up in the morning on workdays I feel tired or exhausted	6	10	4	15
4. I'm increasingly frustrated, impatient and irritable at work	2	14	1	18
5. I've lost the desire for further education/training	6	10	1	18
6. I've been getting minor infections, headaches etc. more often	3	13	3	16
7. I'd gladly change jobs	1	15	0	19
8. I'm increasingly helpless in the face of problems at work	2	14	0	19
9. People who come to me at work often irritate me	2	14	0	19
10. I'm too busy to indulge in recreational activities	8	8	3	16

Source: Own work based on own questionnaire survey.

Once again, the responses were added up. The "yes" answer was rare, with over half the respondents choosing it no more than once. In 2021 five people chose a minimum of three "yes" answers, which was about a third of the total possible answers and, it needs underlining, this does not indicate burnout but only suggests certain possible burnout symptoms. In 2023 the number of people in this category was lower – only two cases were noted.

Table 31. Scores illustrating the risk of burnout – Test 2, FHPE 2021 and 2023.

Number of "yes" answers	Number of people who chose "yes" answers 2021	Number of people who chose "yes" answers 2023
0–1	9	13
2–3	2	4
More than 3	5	2

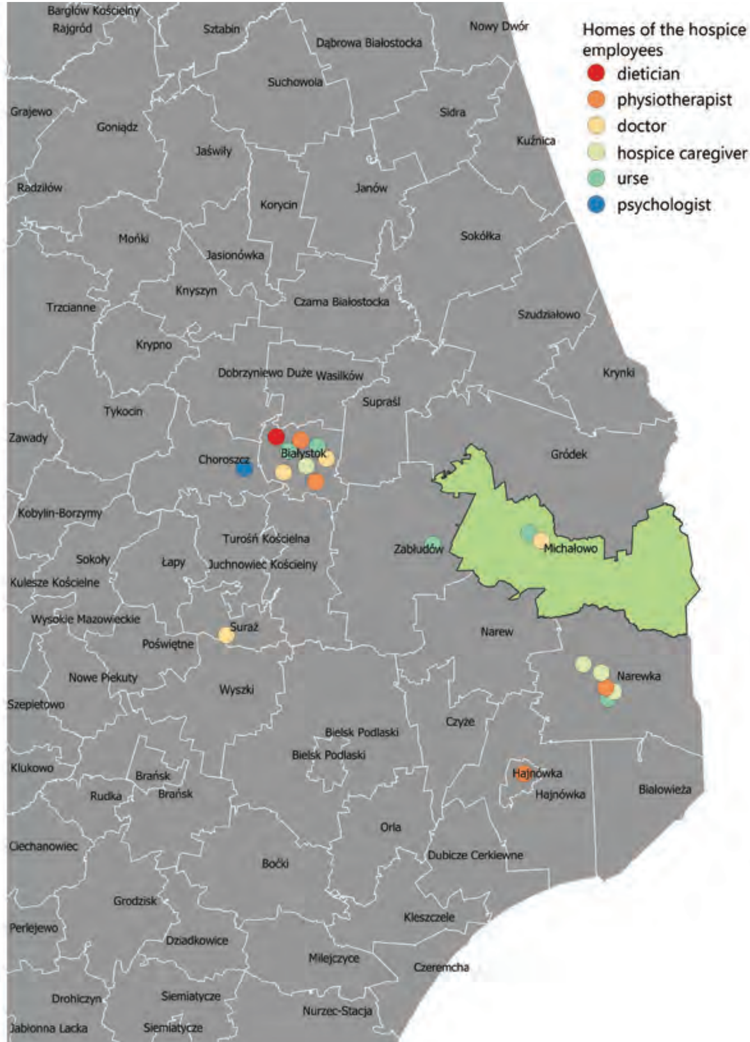
Source: Own work based on own questionnaire survey.

One significant element of the innovation was a measure aimed at providing psychological care and working to ensure the FHPE staff's mental well-being. The person chosen for this task had experience in hospice work but was from outside the team.

Monthly meetings were planned, in two groups and four hours each, but by September 2022 only five out of the planned 10 had taken place, and attendance was very poor. The reason may have been that the meetings were held on a day off, and also people's unwillingness to admit to weakness, especially in the workplace in the presence of coworkers. It may also have been that the person leading the meetings, a psychologist-expert, was not compatible with the staff's expectations. Due to the poor attendance, the proposal was made more flexible: meetings were to take place in one group, and other options included individual meetings as well as consultations over the phone or online. However, none of this brought the expected results.

An interview conducted with the psychologist-expert hired for the project showed that she saw her role in the innovation in terms of activities aimed at providing care and support to staff employed at the FHPE, in order to prevent burnout symptoms and reduce the negative effects of working under stress, having to confront death, taking action under pressure and usually in situations involving great responsibility. The psychologist was asked what actions she had planned and carried out in order to work with the FHPE team. Her first action was the (anonymous) diagnosis of the level of risk of burnout in the team; a study conducted to this aim showed there was a possibility of burnout syndrome appearing in some of the team members (based on the tests presented above). Regular meetings – once a month on a Saturday – were proposed to the team, in the form of workshops familiarising them with topics related to identifying and dealing with emotions, coping with stress, psychoeducation on the behaviours of ill people and how their health might affect their attitude to the people helping them, issues of effective communication with patients and their families, reducing stress, etc. These meetings did not garner much interest, so the team members were offered individual consultations – personal, over the phone or online, but the activities in this part of the innovation have been petering out. The psychologist pointed out that for most of the team members, working at the FHPE was an additional job – their second or even further job, so this kind of proposal was considered an extra burden rather than a measure supporting them in their work. Only two people wanted to take advantage of the individual consultations; they were very self-conscious and unsure before the planned meeting, but ultimately neither of these meetings took place. One person quit their job at the FHPE beforehand, while the other did not schedule a meeting in the end. According to the psychologist-expert, the negligible interest shown in this proposal offered as part of the innovation was strongly influenced by the time of the meetings, i.e. a day off. This was the first and main reason why this element of the innovation failed. The second reason was the significant distance between the FHPE headquarters and the homes of many of the employees. The map below shows the locations of the FHPE staff members' homes (status as of 2021).

Figure 15. Homes of the FHPE employees (2021).



Source: Own work based on own questionnaire survey.

Cultural considerations were another factor, meaning the unwillingness still found in rural areas, even in an environment connected with care or medicine, to take advantage of help from a psychologist (or psychotherapist or psychiatrist), which is treated as proof of weakness, mental disease or “madness”. This is the effect of stereotypes, the inability to name emotions and talk about them, and aversion to seeking ways of coping with them that involves external support. The view that you have to deal with your problems on your own and that asking for help is a sign of weakness still persists among people living in the region (but also in many other

areas in Poland). Similar themes of being ashamed to use help appeared in the narratives of FHPE staff when their patients' families did not want the employees' cars to be seen outside their homes. In their opinion, this would be proof that they were unable to cope with caring for their family members. These attitudes are slowly becoming the subject of public debate, because Poland is currently dealing with a huge mental health crisis and shortages in the support and aid system, which is why there is increasing talk of the necessity for education on mental health.

The expert was also asked what she thought were the greatest dangers for people working at hospices. In first place she listed burnout, leading to lessened sensitivity, protecting oneself by a lack of empathy, depersonalising one's patients, brusqueness, irritability and other behaviours discouraging people in need from asking for help and support. Support for staff in such situations can come from good work organisation, making sure that staff are not overburdened with responsibilities and work shifts, but this is inseparable from decent pay enabling staff to take care of mental hygiene and rest. This is very hard in the Polish care system, which lacks both specialist employees and adequate remuneration in care jobs, which leads people to work for many employers, partly to make more money but also out of concern for patients who would otherwise be left without help.

The final topic covered in the interview was the functioning of the health care system. The questions were designed to enable the expert to indicate what elements could be changed in the existing system without losing the potential offered by people working at hospices. According to her, the main thing that needs resolving is the pay received by hospice staff. She also saw a necessity to redesign the work organisation at hospices. She recalled her own work experience at this type of facility, where a grassroots impulse resulted in the development of new work organisation standards: regular meetings (once a week, once every two weeks) of the team were scheduled, and conversations were held with the team (as often as possible) about current matters, taking into account patients' needs, and staff were reminded that patients were individuals with individual needs. The expert also said it might be necessary to include volunteers better/more effectively in the hospice's operations (again, in this she referred to her own experience). In her view, volunteers should be treated as allies who, after appropriate training, could support the hospice staff in their tasks. The next element she proposed involved educating the staff working at hospices, improving their skills but also focusing on making employees more sensitive to patients and their needs. It is also necessary, according to the expert, to provide hospice staff with psychological and emotional support, which could lower the risk of burnout.

The test to check the risk of burnout was also carried out among the staff of the NZOZ Nadzieja hospice. In test number one, responses indicating that the respondents had physical or mental issues were not numerous. The predominant responses were "seldom" and "never". The greatest number of respondents indicated that they did not feel they would lose interest in their job, feel reluctant to perform their duties or were experiencing problems with their digestive system (due to stress/nerves).

Table 32. Test 1 for burnout among NZOZ Nadzieja staff. Number of marked responses for each mental state.

In recent weeks I've been...	2022		2023	
	always and often	never and seldom	always and often	never and seldom
1. feeling irritable and impatient	0	10	1	10
2. feeling powerless and helpless in the face of professional duties	1	11	2	13
3. feeling sadness/loss of enthusiasm	1	11	0	12
4. feeling a loss of interest in my work	0	10	0	13
5. feeling reluctant to perform my duties	0	11	1	13
6. having mood swings and negative emotions	0	11	1	13
7. having lowered self-esteem and sense of effectiveness	1	10	1	10
8. feeling guilty in connection with the results of my work	1	10	1	12
9. having problems concentrating	1	10	1	12
10. having difficulties making decisions	0	9	0	13
11. feeling that a small effort is beyond my strength	0	11	1	13
12. feeling a weakening of relationships with coworkers and clients, and trying to avoid others	1	9	0	13
13. feeling mean and cynical towards others	0	11	1	15
14. blaming myself for failures	1	10	0	14
15. feeling chronic fatigue	1	11	0	12
16. having sleep disorders	1	9	1	12
17. experiencing reduced immunity	1	10	0	13

In recent weeks I've been...	2022		2023	
	always and often	never and seldom	always and often	never and seldom
18. feeling somatic pain	1	10	1	12
19. having blood pressure problems	1	11	3	9
20. having disorders connected with the digestive tract	0	11	2	10

Source: Own work based on own questionnaire survey.

After adding up the points, again it turned out that most of the employees did not have burnout symptoms, as shown by the very low sums of points achieved in the test.

Table 33. Scores illustrating the risk of burnout at NZOZ Nadzieja – Test 1, 2022 and 2023.

Number of points	Number of people whose responses correspond to a given score 2022	Number of people whose responses correspond to a given score 2023
60–80 points	0	0
40–59 points	0	1
20–39 points	1	1
0–19 points	10	13

Source: Own work based on own questionnaire survey.

Test number two brought the following responses: the most "yes" answers – chosen by 10 and 12 people, respectively – went to the statement that the respondents thought about work even in their spare time. Four people each chose "yes" for the statements that they sometimes got infections and headaches and that they were too busy for recreation. "No" answers were much more numerous, which in this test indicates a low level of risk of burnout for the staff being tested.

Table 34. Test 2 for burnout among NZOZ Nadzieja employees in 2021 and 2023. Number of mentions of the individual states.

	2022		2023	
	YES	NO	YES	NO
1. I think about work even in my free time	10	1	12	3
2. I feel overwhelmed by my responsibilities	1	10	1	14
3. When I get up in the morning on workdays I feel tired or exhausted	1	10	2	13
4. I'm increasingly frustrated, impatient and irritable at work	1	10	0	15
5. I've lost the desire for further education/training	0	11	1	14
6. I've been getting minor infections, headaches etc. more often	4	7	3	12
7. I'd gladly change jobs	0	11	0	15
8. I'm increasingly helpless in the face of problems at work	0	11	0	14
9. People who come to me at work often irritate me	0	11	0	14
10. I'm too busy to indulge in recreational activities	4	7	2	12

Source: Own work based on own questionnaire survey.

Once again, the responses were added up. The "yes" answer was rare. In 2022 four people chose it no more than once for the statements listed above. Six people chose a minimum of two (to three) "yes" answers. Only one person chose four "yes" answers, but even this does not indicate burnout but only suggests certain possible burnout symptoms. In 2023 four-fifths of the respondents chose "yes" no more than once.

Table 35. Scores illustrating the risk of burnout – Test 2, NZOZ Nadzieja 2022 and 2023.

Number of “yes” answers	Number of people who chose “yes” answers 2022	Number of people who chose “yes” answers 2023
0–1	4	12
2–3	6	2
More than 3	1	1

Source: Own work based on own questionnaire survey.

3.2. Costs of In-Home Hospice Care (FHPE – NFZ): Estimate

3.2.1. Minimum costs of care determined on the basis of NFZ guidelines

Our study also aimed to consider financial issues related to in-home hospice care. It was a difficult and complex endeavour, not just because employee remuneration is confidential. In order to check and compare the costs of patient care per month at the FHPE and at a “typical” in-home hospice working under contract with the NFZ, it was necessary to determine the remuneration of individual members of the hospice teams. Such remuneration is confidential at both facilities and may be based on the given facility’s financial capacity and decisions made by its manager. Therefore it was decided to use publicly available information contained in the legislation on setting the lowest base pay of certain staff employed at health care facilities. We are aware that these calculations do not reflect real data, but they will show the order of magnitude and indicate possible differences between care provided by the FHPE and in-home hospices operating in rural areas and providing services according to NFZ rules.

We will concentrate only on the personnel costs involved, calculated on the basis of how individual services are priced. The starting point for this analysis was the minimum rates set down in the NFZ pay scale. Table 36 presents the minimum pay for medical staff, shown as monthly and hourly rates. The former values are based on the data contained in the 8 June 2017 Act on the method of determining the lowest remuneration of employees in medical professions employed at health care entities. According to this law, the lowest base pay is set as the job coefficient[16] times the gross amount of PLN 3,900. The hourly rate was calculated based on the assumption that on average, every employee works 160 hours per month.

16 The coefficient values were as follows: doctors with second-degree specialisation – 1.27; doctors with first-degree specialisation – 1.17; pharmacists, physiotherapists, laboratory diagnosticians, nurses and midwives with specialisation – 1.05; medical caregivers – 0.86; orderlies and hospital attendants – 0.64.

Table 36. Minimum pay for medical employees.

Professional group	Gross remuneration – monthly	Gross remuneration – hourly
doctors with second-degree specialisation	PLN 6,769	PLN 42.30
doctors with first-degree specialisation	PLN 6,210	PLN 38.80
pharmacists, physiotherapists, laboratory diagnosticians, nurses and midwives with specialisation	PLN 5,478	PLN 34.20
medical caregivers	PLN 3,772	PLN 23.60
orderlies and hospital attendants	PLN 3,680	PLN 23.00

Source: https://kadromierz.pl/blog/tabela-wynagrodzen-pracownikow-medycznych-2022/#Ile-wyniosly-podwyzki-w-ochronie-zdrowia and based on the 8 June 2017 Act on the method of determining the lowest remuneration of employees in medical professions employed at health care entities and the 26 May 2022 Act on amendments to the Act on the method of determining the lowest remuneration of employees in medical professions employed at health care entities and certain other Acts.

According to the systemic solutions designed by the NFZ, in-home hospice care is available to patients with specific diseases.[17] At in-home hospices providing services according to NFZ rules, it is assumed that a patient is entitled to a minimum of two doctor's visits per month and a minimum of two nurse's visits per week. As regards other services, the NFZ provides for the possibility of visits by a psychologist and a physiotherapist – these are available according to a patient's needs, but in practice are seldom provided. Assuming that each visit lasts an hour, the estimated cost of employee pay (which does not include travel, dressings, medications) in this basic care package would be PLN 358.20. The personnel costs at an in-home hospice also depend on the option of services provided. At the FHPE the list of diseases entitling a patient to care is much longer. Here, the following are eligible for care:

1) people diagnosed with a disease from the list of eight diseases specified by the NFZ and entitling a person to in-home hospice care,
2) chronically, terminally ill people nearing the end of their lives but suffering from other diseases (i.e. diseases not on the NFZ list), whose condition does not allow them to function on their own and who need help/treatment.

The services provided by the staff team are tailor-made, i.e. adapted to the patients' needs. As a rule, a doctor sees every patient once a month, to evaluate their condition and review existing recommendations and means of providing help.

17 See footnote 4.

However, if a patient's condition is stable, the doctor does not visit more often, as would have been required for patients under NFZ-funded care. In the case of patients who are stable, nurses are able to deal with many medical needs, while hospice caregivers handle social/welfare needs – with KOOZ support. The document *Needs Assessment Questionnaire and Support Plan for Patients of the Prophet Elijah Hospice Foundation in Michałowo* was the basis for the list of personal assistance packages that patients received from the FHPE within the project *To Give What Is Really Needed*. This document was always filled in by the KOOZ. In the course of a year (August 2021 – July 2022) the greatest number of patients (six in each case) received the following packages of services: a doctor and a hospice caregiver visiting once a week, a doctor and a nurse visiting twice a week, a doctor and a physiotherapist visiting once and/or twice a week. Five people received help in the form of visits from a doctor and a nurse once a week. There were cases when a patient was only visited by a doctor from the FHPE team – four people received such help. The same number of patients had monthly visits from a doctor and weekly visits from a nurse and a physiotherapist. Other options were provided to individual patients. The information on what service packages were available to FHPE patients and which were used most often is presented in the table below.

Table 37. Packages of services provided by the FHPE with the number of patients (the analysis covers the years 2021–2022, status as of 31 August 2022).

Care services provided	Monthly cost of care in PLN	Number of patients
Doctor: once a month + Hospice caregiver: once a month + Physiotherapist: twice a week	339,80	1
Doctor: once a month + Hospice caregiver: once a week	136,60	6
Doctor: once a month + Hospice caregiver: once a week + Physiotherapist: once a week	273,60	2
Doctor: once a month + Hospice caregiver: once a week + Nurse: twice a month	205,10	1
Doctor: once a month + Hospice caregiver: twice a week	230,90	2
Doctor: once a month + Hospice caregiver: twice a week + Physiotherapist: once a week	367,90	1
Doctor: once a month + Hospice caregiver: twice a week + Physiotherapist: once a week + Nurse: once a week	504,80	1
Doctor: once a month + Hospice caregiver: twice a week + Physiotherapist: twice a week + Nurse: once a week	410,10	1

Care services provided	Monthly cost of care in PLN	Number of patients
Doctor: once a month + Hospice caregiver: three times a week	325,20	1
Doctor: once a month + Hospice caregiver: three times a week + Nurse: once a week	462,20	1
Doctor: once a month + Hospice caregiver: three times a week + Physiotherapist: four times a week + Psychologist: once a week	873,00	1
Doctor: once a month + Hospice caregiver: three times a week + Physiotherapist: twice a week	599,10	1
Doctor: once a month + Hospice caregiver: twice a month + Nurse: once a week	253,70	1
Doctor: once a month + Nurse: once a week	179,30	1
Doctor: once a month + Nurse: once a week + Physiotherapist: once a week	316,20	4
Doctor: once a month + Nurse: once a week + Physiotherapist: twice a week	453,20	1
Doctor: once a month + Nurse: once a week	179,30	5
Doctor: once a month + Nurse: twice a week	316,20	6
Doctor: once a month + Nurse: once a month + Physiotherapist: once a week	316,20	1
Doctor: once a month + Nurse: twice a month + Physiotherapist: once a week	247,70	1
Doctor: once a month + Physiotherapist: once a week	179,30	6
Doctor: once a month + Physiotherapist: twice a week	316,20	6
Doctor: once a month	42,30	4

Source: Own work based on data gathered by the KOOZ in the form called the Patient Needs Card, on https://kadromierz.pl/blog/tabela-wynagrodzen-pracownikow-medycznych-2022/#Ile-wyniosly-podwyzki-w-ochronie-zdrowia, and on the 8 June 2017 Act on the method of determining the lowest remuneration of employees in medical professions employed at health care entities and the 26 May 2022 Act on amendments to the Act on the method of determining the lowest remuneration of employees in medical professions employed at health care entities and certain other Acts.

As the gathered data (status as of 31 August 2022) show, during the first months of innovation testing (July 2021 – August 2022), 12 people under the FHPE's care in the project *To Give What Is Really Needed* were people from the first group listed above, i.e. people with cancer. The other 18 suffered from diseases that would not have made them eligible for care at an in-home hospice operating on the basis of NFZ rules. This group included a person after a stroke, a person with deep dementia and aphasia, and a

person who had had limbs amputated. It should also be noted that many of the patients had been under the FHPE's care for a longer time. The FHPE dates of admittance were compared to the dates of discharge. It turns out that 15 people were discharged during the innovation testing period (status as of 31 August 2022). Among them, the time of being under the FHPE's care was the shortest for a person who had been a patient for a month, while the longest was for a person who had remained the FHPE's patient for 12 months. The average time of being under the FHPE's care in the group of discharged patients was around four months. It should be noted that due to the diseases involved, deaths were not indicated as a frequent reason for discharge (only for two patients). It was more often the case that patients were discharged from the FHPE's care in the project because their condition had improved. It was only in two cases that due to the progress of their diseases and their worsened condition, it was decided to move them into the care programme provided by the NFZ.

Table 37 presents the (estimated) monthly costs of the FHPE's patient care in the project *To Give What Is Really Needed*. All of the services packages on offer have been taken into account. The calculation follows the procedure outlined here on the example of the first line of Table 37, which comprises a doctor's visit once a month + a hospice caregiver's visit once a month + a physiotherapist's visit twice a week. The hourly rate (see Table 36) for a doctor's work (in this case, a doctor with a second-degree specialisation) is PLN 42.30; the hourly rate for a medical caregiver's work is PLN 23.60; the hourly rate for a physiotherapist's work is PLN 34.20. In this case the physiotherapist makes two visits per week, or eight visits per month, the total cost thus being PLN 273.60 (PLN 34.20 × 8). The overall cost of care is the sum of those amounts: 42,3 + 23,6 + 273,6, which equals PLN 339,5. This procedure was repeated for all the care options. The amounts ranged from PLN 42.30, when only a monthly doctor's visit was involved, to PLN 873.00 when the care package comprised a monthly doctor's visit, three hospice caregiver's visits per week and a physiotherapist's service four times a week. **In the case of the FHPE, the personnel cost of tailor-made care is PLN 327.30 per month.**

At in-home hospices providing services under contract with the NFZ, patients are entitled to a minimum of two doctor's visits per month and a minimum of two nurse's visits per week. The cost of personnel remuneration in this basic care option is PLN 358.20. The document *Appendix to the NFZ President's Directive No. 11/2004* indicates that in most cases, an in-home hospice doctor makes an average of one visit per patient per week, a nurse – three visits per week, while the other team members' visits depend on the patient's needs. This care option is more costly than the basic option, costing PLN 579.60.

In the case of the FHPE, the average personnel cost of tailor-made care is PLN 327.30 per month, and at other in-home hospices – PLN 468.90 (the average of the NFZ basic option costing PLN 358.20 and the most frequent option as reported by the NFZ costing PLN 579.60). The difference between the care costs at the two facility types is **31%**, meaning that patient care at the FHPE is one-third cheaper than that provided by in-home hospices operating according to NFZ rules.

At the same time, it should be noted that the above options of care provided by in-home hospices operating according to NFZ rules do not include the costs of physiotherapists. The costs of care at these facilities may thus be even higher. Taking the minimum NFZ rates, some expanded options were also calculated: (a) the FHPE care option offering the **most services** (a doctor once a month + a hospice caregiver three times a week + a physiotherapist four times a week + a psychologist once a week)[18] and (b) a "realistic" NFZ option comprising two doctor's visits per month, two nurse's visits per week, one psychologist's visit per month and two physiotherapist's visits per week. For comparison, the sums obtained are juxtaposed with the amount for the basic option of NFZ care.

Table 38. Highest estimated cost of hospice care.

	FHPE: expanded option*	NFZ in-home hospice	
		basic option**	realistic option***
Highest estimated monthly cost of care	PLN 873.00	PLN 358.30	PLN 674.20

Source: Own work.

**Doctor: once a month + Hospice caregiver: three times a week + Physiotherapist: four times a week + Psychologist: once a week*
***Doctor: twice a month + Nurse: twice a week*
****Doctor: twice a month + Nurse: twice a week + Psychologist: once a month + Physiotherapist: twice a week*

18 Status as of 31 August 2022.

3.2.2. Costs of Care, Taking into Account FHPE Wage Policy and Current Market Rates

A simulation was also conducted for the average cost of FHPE care, based on the pay rates adopted on the basis of the FHPE's wage policy, which takes into account market rates. In such a case, the average monthly cost of patient care (average cost based on all the available options listed in Table 37) is PLN 1,138. This means that the cost of flexible care adapted to the needs of dependent people that is provided by the FHPE is **almost double the average monthly cost of in-home hospice care at the minimum rates specified by the NFZ (in the realistic option listed in Table 38 – PLN 674.20)**. It should be underlined here that the FHPE provides tailor-made, flexible services that are appropriate for the patient and maximally adapted to their needs. The services made available to FHPE patients are often numerous and diverse; access to them would otherwise have been difficult for many of the patients or – if they tried to get help from the health care system – preceded by a long waiting period.

We also need to remember about local labour market conditions – in the region in question, this is an employee's market, a tough market where many medical professions are shortage occupations. Employers seeking personnel usually have to adjust to prospective employees' pay demands – this is the only way of assembling a team that will provide services at a given facility. The minimum pay rates specified in the legislation mentioned earlier do not satisfy employees' wage aspirations due to local labour market conditions, and actually offered pay is higher and diverse across Poland. That is why, seeking further possibilities to compare the costs of care provided by the FHPE and other facilities/hospices, we conducted an interview with an expert (informant) who was the manager of an in-home hospice operating exclusively according to NFZ rules, located in a big city with a population exceeding 500,000. The interview yielded information on the remuneration paid to employees in various positions at the institution represented by this expert, who also said that people working at the in-home hospice could work there on the basis of a regular employment contract, a freelance agreement or a B2B contract.

The greatest number of people employed at the institution represented by the expert worked there on the basis of B2B contracts. The monthly remuneration for work in this form of employment was about PLN 9,000 (gross pay including employer-paid contributions and benefits) for nurses and about PLN 14,200 (gross pay including employer-paid contributions and benefits) for doctors. To compare these rates with the pay offered by the FHPE, it was necessary to calculate the

hourly rate for work/visits – it may be assumed that at the institution represented by the expert, an hour of a doctor's work cost PLN 237 (it was assumed that a doctor had 30 patients under their care and visited each patient twice a month), while an hour of a nurse's work was worth PLN 75 (it was assumed that a nurse had 15 patients under her care and visited each patient twice a week). Assuming (according to NFZ requirements) that a doctor's visit takes place no less than twice a month and a nurse's visit no less than twice a week, the monthly cost of caring for a patient of this hospice was **PLN 1,074**. Note that this cost does not include the remuneration of a psychologist or a physiotherapist, whose services are provided as needed. In order to compare the hospices, we also calculated the average cost of care provided to a patient for the same set of services (only a doctor's and a nurse's care) and taking into account the FHPE's pay policy. The result – the average monthly cost of caring for a patient at the FHPE – was **PLN 850.20**. The difference in patient care costs between the two hospices is 21%, i.e. the cost of care at the FHPE is about one-fifth lower.

3.2.3. FHPE Care and Social Welfare Homes

For people requiring round-the-clock care due to age, disease or disabilities, the institution where they can get help is the social welfare home (DPS). People in need of support are usually placed there when it is impossible to provide care in their homes – especially if the possibility of getting help (e.g. from an in-home hospice) in a given area are limited. Theoretically, DPSs are the institutions that should take in those rural residents who are not eligible for hospice care from the NFZ and who are unable to function on their own at home due to their condition. The designers of the innovation suggest that such people should also be covered by hospice care, which fits in with the policy of deinstitutionalisation of care that Poland is currently implementing, including promoting growing old in one's place of residence. It also has some financial justification.

Fees are charged for DPS stays, which can be financed from a patient's old-age or disability pension, but only up to 70% of that benefit. The pensions of rural residents, especially those once insured in the Agricultural Social Insurance Fund (KRUS), are often very small. The rest of the fee for staying at a DPS is covered by the patient's family members required by law to provide maintenance. If a patient does not receive a pension or there is no family to cover part of the costs of staying at the DPS, the payment obligation is transferred to the municipality from which that person was referred to the DPS. Obviously, not every municipality in Poland has its own DPS, so the availability of these homes is not equal in urban and rural

areas and in different provinces. In the municipalities within which the FHPE operates, there are five such social welfare homes. Treating them as an alternative to FHPE care, we decided to compare the costs of care at the two facility types. The table below shows the average monthly cost of care at a DPS, which ranges from PLN 5,000 to PLN 5,300, and the average cost of care at the FHPE. **The difference between these amounts is enormous – the cost of DPS care is four times higher than the cost of care in the FHPE programme.**

Table 39. Average monthly cost of care taking into account actual pay rates at the FHPE and the cost of care at a DPS.

	FHPE – the project To Give What Is Really Needed	DPS
Average monthly cost of care	PLN 1,138.00	PLN 5,000.00 – 5,300.00

Source: Own work.

To summarise: the costs of services vary depending on the rates adopted and the catalogue of services used to calculate the costs of care at the FHPE and at reference facilities.

Table 40. Summary of costs of care at the FHPE and at reference facilities.

	FHPE	Reference facility
Minimum option of services and minimum NFZ rates*	PLN 321.80	PLN 468.90
Option of the expanded catalogue of services and minimum NFZ rates**	PLN 873.00	PLN 674.20
Option of monthly cost of care taking into account actual rates at the FHPE and institution X***	PLN 850.20	PLN 1,074.00
Option of monthly cost of care taking into account actual rates at the FHPE and the costs of care at a DPS****	PLN 1,138.00	PLN 5,000.00 – 5,300.00

Source: Own work.

**The cost of care at the FHPE was counted as the average monthly cost of all the medical service options provided, based on NFZ rates. The cost of care at the reference facility is the cost of basic care provided by an in-home hospice operating according to NFZ rules, i.e. a minimum of two doctor's visits per month and a minimum of two nurse's visits per week.*
***Here, the cost of care at the FHPE comprised the following catalogue of services: doctor once a month + hospice caregiver three times a week + physiotherapist four times a week + psychologist once a week. For the reference facility, it was as follows: doctor twice a month + nurse twice a week + psychologist once a month + physiotherapist twice a week. The minimum rates specified by the NFZ were applied.*
****In this case we counted the costs (using actual pay from two facilities: the FHPE and the reference facility) for the following catalogue of services: two doctor's visits per month and two nurse's visits per week.*
*****For the cost of FHPE care, we calculated the average cost from all the FHPE care options. The cost of DPS care is based on our inquiry.*

It turns out that the cost of care at the FHPE in the various options analysed here is between one-third and one-fifth lower than the cost at the given reference facility. Only in one case (the second one) did the cost of FHPE care exceed the costs estimated for the reference facility. To provide as complete a picture as possible, the estimated costs of care at a social welfare home (DPS) were also noted.

4. Building a Support Network of Local Institutions

The next element of the innovation involved building a support network for the rural older and dependent people and their caregivers. The support network as we understand it is a network of local institutions formed within the present project. Essentially, it comprises five networks operating in the municipalities under consideration. This arrangement is determined by the administrative division of the extensive area covered by the FHPE's operations and the tasks assigned to local-government bodies at the lowest level. The *powiat*/county (NUTS 4) turned out to be too large geographically; even though attempts were made to build a network at the county level in two cases, they actually function at the lower, local level of individual municipalities. In this chapter we present the network of contacts between municipality institutions identified before the innovation's implementation began, and then describe how the network was built and the effects of these activities.

4.1. Relationships Between the Institutions Before Innovation Implementation

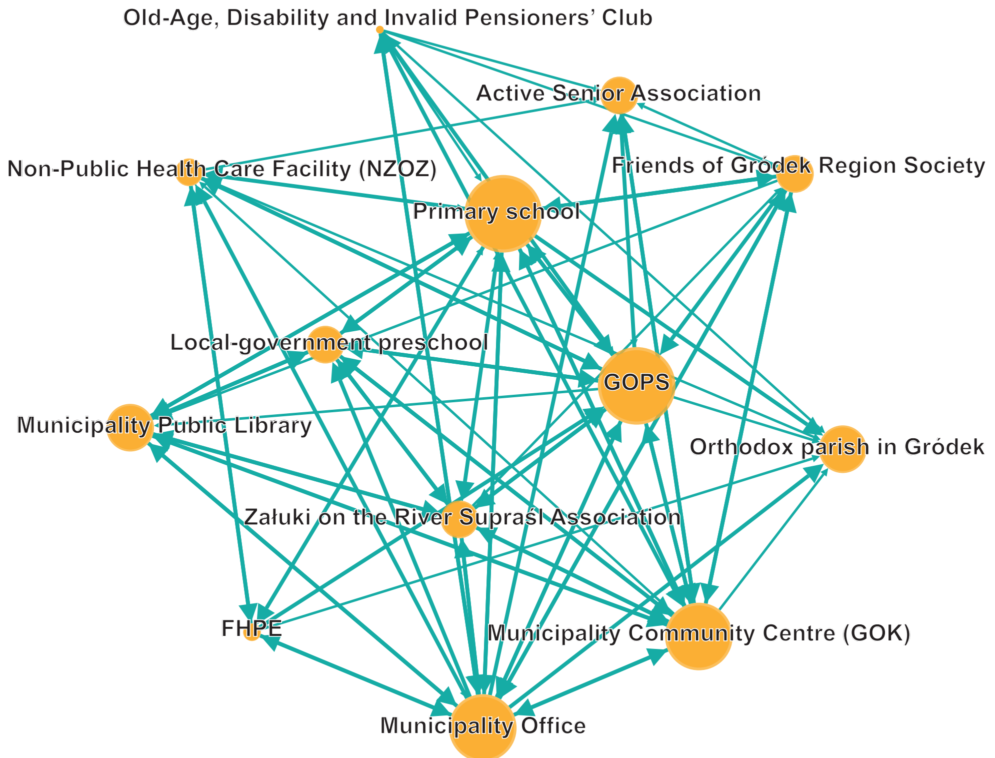
Local social capital is reflected in the level of collaboration between institutions and organisations functioning in the municipalities where the innovation was implemented. This collaboration is shown synthetically in diagrams that offer a graphic presentation of the relationships between institutions. The sociograms were based on questionnaire surveys carried out during the first networking meetings.[19]

19 Each diagram was based on the following question: "Has the institution which you represent collaborated (regularly or occasionally) with the following institutions in order to help someone who is dependent or chronically ill?". The lines in the diagram connecting the various actors show that at least one institution declared such collaboration. The arrowheads show which institution mentioned the collaboration – there is an arrowhead going one way in some cases, and arrowheads going both ways in others.

a) Gródek municipality

The meeting in Gródek[20] was attended by representatives of 13 institutions out of 22 that had been invited.[21] According to the sociogram, the most important actors present at the meeting were the Municipality Social Welfare Centre (GOPS) and the primary school. It is with them that most other institutions collaborate and communicate with. The FHPE indicated that it collaborated (regularly or occasionally) with five institutions within the municipality, and was indicated by four of them. The meeting in Gródek municipality was mainly attended by organisations and institutions tied to the local-government administration, but also NGOs that had not collaborated with the FHPE before but do work for the benefit of older people.

Figure 16. Collaboration network in Gródek municipality.



Source: Own work based on own questionnaire survey.

20 This is a municipality where the FHPE project leader was able to set up very good coordination of collaboration between institutions for the benefit of dependent and chronically ill people. Unfortunately, after institutional changes in the health care system this form of collaboration was no longer viable. The earlier good experience of collaboration was noticeable both in ease of communication and in the fact that the meeting participants knew one another. People attending the meetings included residents already active and heavily burdened with their activity, who nevertheless declared readiness for collaboration, but without any ideas as to what they could offer.

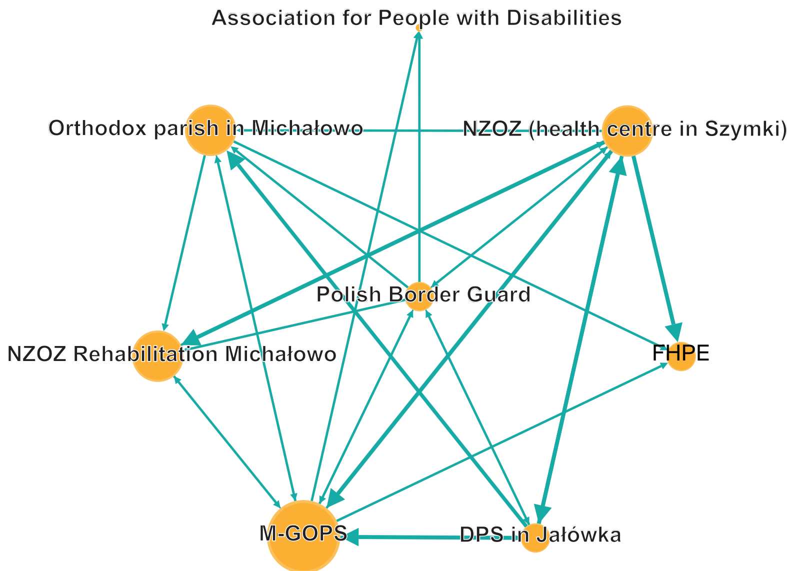
21 This was the only meeting in which the FHPE president took part.

b) Michałowo municipality

The networking meeting in Michałowo municipality was attended by representatives of eight institutions out of 20 that had been invited. The clear sociometric star here was the Town-Municipality Social Welfare Centre (M-GOPS),[22] as it maintained relations with all the other organisations. The network shown in the sociogram indicates less regular and more often one-directional forms of communication or collaboration. This municipality has NGOs of the old type (Volunteer Fire Service – OSP, Farmers' Wives Association – KGW) that were not present at the meeting; besides them, the activity of the local community is not formalised, and NGOs are few in the municipality. The relatively weak collaboration and poor familiarity between the people representing the various institutions was reflected in the work of the group, which was less spontaneous and dynamic than, for example, in Zabłudów. One major theme recurring during the meeting was the tough work conditions for the organisations active in the municipality, the shortage of resources, and activism burnout.

Michałowo municipality is home to the FHPE's headquarters, and three entities listed the foundation as the organisation with which they communicated and collaborated; they were the health centre in Szymki, the Orthodox parish, and M-GOPS. However, only the health centre described the collaboration as regular.

Figure 17. Collaboration network in Michałowo municipality.



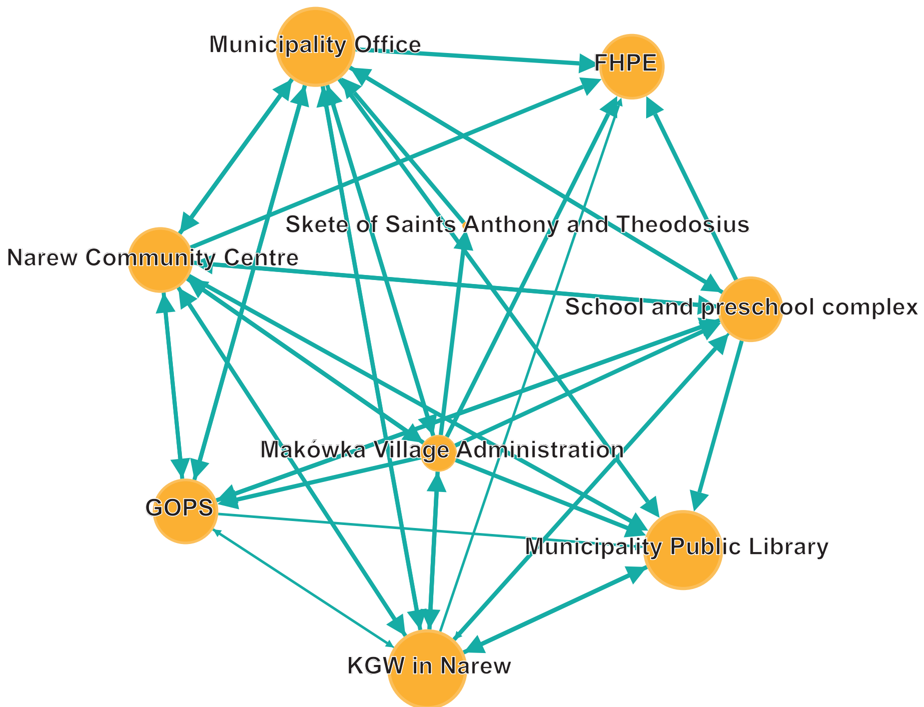
Source: Own work based on own questionnaire survey.

22 A sociometric star means a situation in which one person within a group is considered central, while the other group members communicate the most with that person. In this case, the notion has been adapted to the network of collaboration between institutions.

c) Narew municipality

The networking meeting was attended by representatives of nine out of 20 institutions that were invited, including the municipality mayor (*wójt*). Local-government structures predominated, and included schools, the library, the community centre, and the preschool. It is also noticeable that some institutions collaborate regularly on a daily basis. During conversations at the networking meetings people complained of the residents' poor involvement in local activity and of overburdening with activism among people committing to various actions, who were also represented at the meeting. It also appears that active people are "utilised" by local institutions and tied to them professionally or in some formal way. The FHPE is building an in-patient (residential) hospice in this municipality, and its recognition and network is denser and more intensive than in the other municipalities, as seen in Fig. 18.

Figure 18. Collaboration network in Narew municipality.



Source: Own work based on own questionnaire survey.

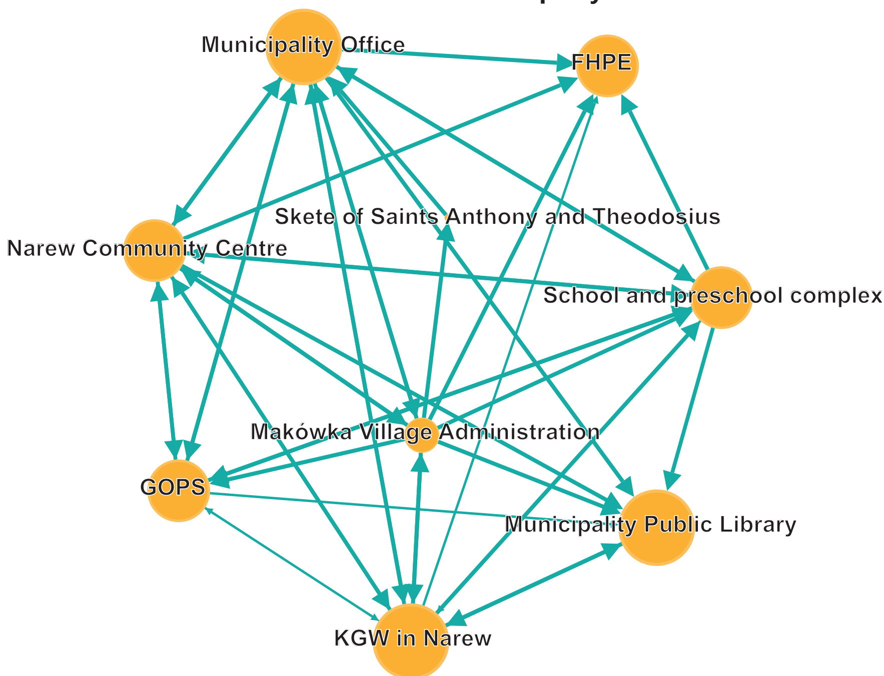
d) Narewka municipality

At the meeting in Narewka, 11 of the 20 institutions that had been invited were represented, but more people attended, as many institutions were represented by more

than one person. This is a municipality where the team implementing this part of the innovation had earlier completed a similar project, which was noticeable in the way the meeting participants communicated, their "speaking the same language" and knowing one another. The municipality mayor took part actively in the meeting. All those attending were very active and involved in the activities of more than one organisation. However, complaints about the poor involvement of residents in the local community's affairs was a recurring theme.[23]

The diagram shows that local-government units are the most important actors: the Municipality Office, Municipality Council, and GOPS. The local Farmers' Wives Association (KGW) was also an important institution. The FHPE was mentioned as a collaboration partner by four institutions represented at the meeting. The collaboration network linking these institutions is quite dense, but the participants pointed out that many people present at the meeting belonged to several of the institutions.

Figure 19. Collaboration network in Narewka municipality.



Source: Own work based on own questionnaire survey.

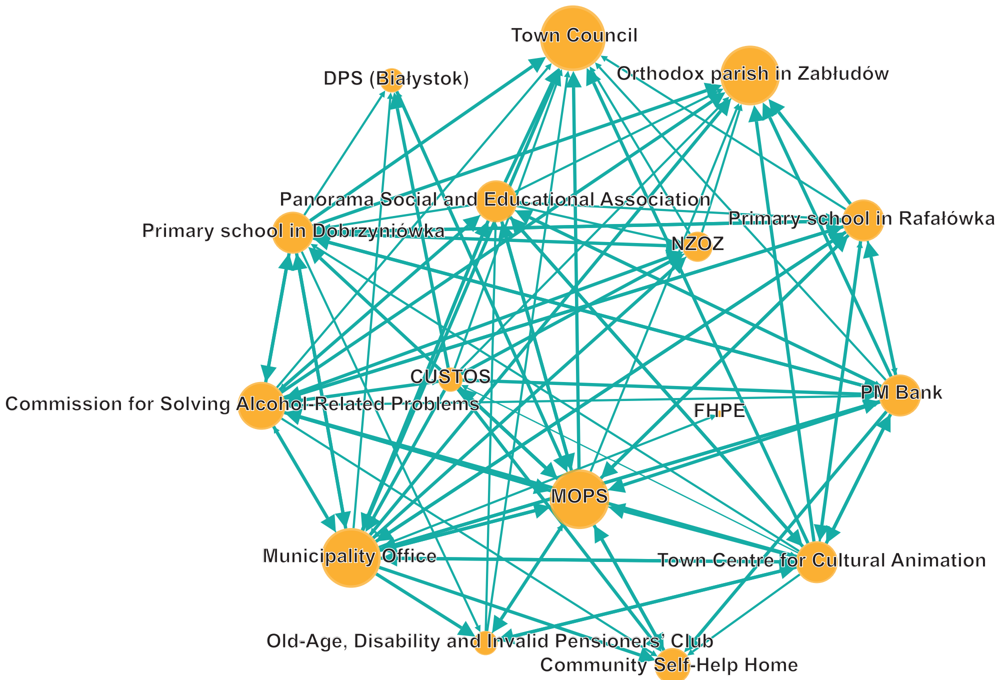
23 This was a major problem in the discussion on potential actions for the benefit of chronically ill and dependent people: those present expressed concern whether the current, great burden on active units would enable them to get involved in further activity. A negative attitude towards neighbourly assistance (both from those in need of help and from potential helpers) and concern regarding the responsibility of people deciding to become volunteers was also mentioned. These signals indicate a low sense of security and a lack of trust in the local community. Obvious tensions and conflicts were revealed during the group's work and discussion; they stemmed from earlier collaboration experiences and may be the reason for the fears expressed by the participants.

e) Zabłudów municipality

The meeting was attended by representatives of 16 institutions (out of 23 invited), including the mayor of the town and municipality. There was noticeable collaboration between the active institutions, and the municipality clearly already had a network within which local social capital could be found for work for the benefit of dependent and chronically ill people. Moreover, thanks to the strong position of the leader – the Town Social Welfare Centre (MOPS) manager – the residents and local authorities are aware of the problems of dependent and ill people, and these problems are being solved. Thanks to the existing network and the trust built on previous experience, good communication, openness in communication, readiness to ask questions and active problem-solving were all noticeable in the workshop part of the meeting.

The diagram illustrating the contacts and collaboration in Zabłudów municipality shows that institutions and organisations with local-government ties are major actors in the existing network. The organisations represented at the meeting collaborate with one another in various configurations, not only through the local authorities. Local entrepreneurs are also included in such collaboration. Not many NGOs were represented at the meeting, although there are a dozen or so of them in the municipality. The arrowheads mostly going both ways indicate good, two-way communication among the various entities. Most of the institutions declare regular collaboration with other entities. The network's most important actors with which the most entities collaborate are the Town Council, Municipality Office, and MOPS. Only one entity – the Municipality Office – pointed to collaboration with the FHPE; this collaboration was occasional.

Figure 20. Collaboration network in Zabłudów municipality.



Source: Own work based on own questionnaire survey.

4.2. Municipality Network Members' Involvement During Innovation Implementation

The meetings described above were the first step towards building a network of support for older, dependent and chronically ill people and their caregivers. In the first stage, experts suggested by ROPS-B undertook this task. They later supported the KOOZ, who was tasked with organising regular meetings within the network and monitoring patients' needs, and then getting in touch with organisations active in the network that could fulfil any emerging needs. The result was the formation of two parallel networks: on the one hand, a network of institutions actively involved in the regular meetings, and on the other – a network/list of institutions working within the municipalities and counties that could provide patients with support. The purpose of this list, drawn up within the former network type and updated by the KOOZ, was to facilitate communication and access to help.

During the networking meetings, in discussions moderated by the ROPS-B experts in association with the KOOZ, the people representing the various institutions indicated

what kind of entities they were collaborating with or would like to collaborate with in future. Their experience and declarations were the basis for drawing up lists of entities (public institutions and NGOs) containing contact information. This list constituted a document providing the KOOZ and the entities in a given network with an information package on the possibilities of meeting various needs as well as a shortcut to data needed to get in touch entities that could help satisfy those needs.

According to the guidelines adopted in the project *To Give What Is Really Needed*, the lists of services and activities were meant to be updated during **direct networking meetings** organised by the KOOZ. This in turn was meant to facilitate a systematic and continual collaboration between the hospice (KOOZ) and other entities from the network. The lists were meant to be regularly shared with or accessible to all the network members. There were also meant to be other benefits for the members from belonging to the network, something for which the KOOZ was responsible. Scheduled meetings of the network's institutions at least once every three months were envisaged as a way of upholding relationships, exchanging information, e.g. about new projects and activities, planning joint actions for the benefit of dependent people and their caregivers, engaging in mutual education and updating the lists of services and activities, inviting other communities and institutions to expand the network of municipality and county contacts.

What did the creation of the network look like in practice, and to what extent can its presence become a lasting element of activities pursued by an entity like an in-home hospice implementing the new model of patient care?

Invitations to the county and municipality meetings were issued by the management of ROPS-B, specifically Director Elżbieta Rajewska-Nikonowicz. Before the first meetings, invitations were delivered personally, by mail or by email by the ROPS-B experts hired for the project as well as MOPS, M-GOPS and GOPS directors in the municipalities covered by the innovation. When inviting people to successive networking meetings, these people were supported by the KOOZ acting on behalf of the ROPS-B director, and invitations by phone were also added. The lists of guests invited to successive meetings were constantly expanded.

As a result of these efforts, in the course of two and a half years of the project there were four meetings in Michałowo municipality, five each in Zabłudów, Gródek and Narewka, and six in Narew. As for the county-level meetings, it was harder to gather representatives of institutions from this level together, and in order to achieve better results they were invited to the meetings held in the municipalities, so that two networking levels were combined within a single meeting. The work of the KOOZ was presented at these meetings, with a special focus on taking advantage of network members, and the

needs of patients and other residents were discussed. With time, additional elements were added, e.g. lectures (on caring for dependent people – for family members, on mental health, healthy eating, etc.). The meetings most often took place during work hours, on workdays. This might be the reason for better attendance by the staff of institutions affiliated with the local government, who were sent to the meetings as part of their job, and poorer attendance among representatives of other institutions.

As the support network was being built, doubts arose as to whether its members should declare their willingness to join it in writing – as formal membership. A document was designed and discussed at some of the meetings, but no clear conclusions were reached as to what would be better for the network's durability and density. The problem was that although everyone agreed that a formal declaration would increase the commitment and sense of duty of the units/institutions, there were also arguments against eliciting this kind of declaration. On the one hand, there was the fear that institutions/entities asked to file a written declaration would be afraid of the obligations this would entail and would prefer to remain outside the network just in case. On the other hand, in the case of some of the institutions involved in the network (e.g. the police or the border guard), joining the network would have to take place at a much higher level than the municipality or even the county, and would require the consent of superiors.

One of the effects of the innovation was a list of entities forming the support network, which was drawn up by the ROPS-B experts and hospice staff as well as the institutions taking part in the networking meetings. These lists included organisations operating within the municipalities (and two counties) to which terminally and chronically ill people and their caregivers could turn for help in various situations when they needed support. The lists were updated and shared during successive meetings, and also presented to hospice patients. An analysis of the listed entities' involvement in the networking meetings and of how their potential was used by the KOOZ during the project raises questions as to the actual, and not just declared working of this network. Building social capital is a long and slow process, especially in rural areas where indicators of social confidence in public institutions (cf. Mularska-Kucharek 2011), individual cultural capital, etc. are low. The burden on activists and employees of aid institutions in rural areas is substantial.

a) Gródek municipality

The Gródek support network initiated as part of the innovation comprised 26 entities. Among them, the manager of the Municipality Social Welfare Centre (GOPS) took part in all of the networking meetings. The other actors attended with varying regularity, and were usually represented by one person.

Table 41. Institutions taking part in the networking meetings.

Networking meeting 1		Networking meeting 2		Networking meeting 3		Networking meeting 4		Networking meeting 5	
Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people
FHPE	2	FHPE	2	FHPE	2	FHPE	2	FHPE	2
OPS	1	OPS	1	OPS	1	OPS	1	OPS	1
Polish Border Guard in Bobrowniki	1	Załuki on the River Supraśl Association	1	Municipality mayor (wójt)	1	Village leader (sołtys)	2	Village leader	2
Active Senior Association	1	Municipality Community Centre (GOK)	1			Forest District Office	1	Załuki on the River Supraśl Association	1
Primary school	1					Primary school	1	Active Senior Association	1
						Active Senior Association	2	Municipality mayor	1
								Public Library in Gródek	1

Source: Own work based on data gathered by the KOOZ.

Consultations with the GOPS manager were held during the project, while the Active Senior Association provided respite care and support for an FHPE patient, cleaning his home. Moreover, the local Polish Border Guard got involved in getting a gift to a patient, by offering transport.

Table 42. Local institutions belonging to the support network – Gródek municipality.

Institutions that declared participation in the network	Were they used during innovation testing?
FHPE	
Municipality Social Welfare Centre (GOPS)	YES
Centre for Helping Families with Alcohol-Related Problems	NO
Consulting Point affiliated with the Municipality Commission for Solving Alcohol-Related Problems in Gródek	NO

Institutions that declared participation in the network	Were they used during innovation testing?
Interdisciplinary Team in Gródek	NO
Gródek Municipality Office	NO
Municipality mayor and Municipality Council in Gródek	NO
Health Centre in Gródek	NO
Municipality Community Centre in Gródek	NO
Public Library in Gródek	NO
Primary School in Gródek	NO
Local-Government Preschool in Gródek	NO
Active Senior Association	YES
Disability and Old-Age Pensioners' Club in Gródek	NO
Friends of Gródek Region Society	NO
Załuki on the River Supraśl Association	NO
Farmers' Wives Association (KGW) in Gródek	NO
Municipal Budgetary Establishment in Gródek	NO
Orthodox Parish in Gródek	NO
Orthodox Parish in Mostowlany	NO
Orthodox Parish in Królowy Most	NO
Volunteer Fire Service in Gródek	NO
Polish Border Guard in Bobrowniki	YES
Waliły Forest District Office	NO
Better Tomorrow Association to Help Families in Danger of Social Exclusion	NO
Village leaders of the villages in Gródek municipality	NO

Source: Own work based on data gathered by the KOOZ.

People in need in the municipality also received gifts from private donors and entrepreneurs: food, clothing, appliances (a microwave), bed linen, blankets. Food parcels were donated by the Droga Family Assistance Association, the Little Homeland Association, and the Biedronka Foundation.

b) Michałowo municipality

The local support network in Michałowo municipality comprised 26 institutions. However, only a few of them came to the regular networking meetings. Only the M-GOPS and the Michałowianka Welfare Cooperative (SS Michałowianka) took part in all the meetings. Both were usually represented by one or two people.

Table 43. Institutions taking part in the networking meetings.

Networking meeting 1		Networking meeting 2		Networking meeting 3		Networking meeting 4	
Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people
FHPE	2	FHPE	2	FHPE	2	FHPE	2
M-GOPS	1	SS Michałowianka	2	M-GOPS	2	M-GOPS	2
SS Michałowianka	1	DPS Jałówka	1	SS Michałowianka	1	SS Michałowianka	1
NZOZ Rehabilitation Michałowo	1			Village leader (sołtys)	3		
DPS Jałówka	1			KGW	2		
Roman Catholic parish	1			Local Polish Border Guard	1		
Orthodox parish	1						

Source: Own work based on data gathered by the KOOZ.

Four entities were active during the innovation implementation: the Town-Municipality Social Welfare Centre (M-GOPS), Municipality Office, Michałowianka Welfare Cooperative, and the Social Welfare Home (DPS) in Jałówka. The KOOZ collaborated with the M-GOPS in providing elderly FHPE patients with emergency (alarm) bands as part of the Senior Citizens' Support Corps programme (for people aged 65+; the programme is being implemented by MGOPS). The KOOZ was responsible for helping people fill in applications, delivering the bands and instructing the patients on how to use them. M-GOPS, through the KOOZ, also delivered Christmas parcels to the FHPE's patients. The Municipality Office, Michałowianka Welfare Cooperative and DPS Jałówka carried out cleaning work in patients' homes and in their surroundings (which included mowing grass, chopping down bushes near an access road, evening out a road, and supplying gravel).

Table 44. Local institutions belonging to the support network – Michałowo municipality.

Institutions that declared participation in the network	Were they used during innovation testing?
FHPE	
Town-Municipality Social Welfare Centre (M-GOPS)	YES
Coordinator of the Municipality Commission for Solving Alcohol-Related Problems in the Michałowo Municipality Office	NO
Michałowo Municipality Office	YES
Consulting Point for addicts and their families	NO
AM-medica sp. z o.o Medical Centre	NO
NZOZ Family Clinic in Szymki	NO
NZOZ Family Clinic in Michałowo	NO
NZOZ Rehabilitation Michałowo	NO
Mayor and Municipality Council	NO
Municipality Community Centre in Michałowo	NO
Village Community Centres in Sokole, Hieronimowo, Nowa Wola, Juszkowy Gród, Bondary, Szymki	NO
Public library and branch libraries	NO
Primary School in Michałowo	NO
Municipality Preschool in Michałowo	NO
Schools Complex in Michałowo	NO
Iskra Michałowo Association for People with Disabilities	NO
Michałowianka Welfare Cooperative	YES
Polish Border Guard post in Michałowo	NO
Orthodox parish in Michałowo	NO
Roman Catholic parish in Michałowo	NO
Social Welfare Home (DPS) in Jałówka	YES
Police station in Michałowo	NO
Spokojna Przystań Social Welfare Home in Garbary	NO
Farmers' and Farmers' Wives Association in Bondary	NO
Village leaders of the villages in Michałowo municipality	NO

Source: Own work based on data gathered by the KOOZ.

Besides network member institutions, patients also received support from other entities. Private donors provided (through the KOOZ) clothing, blankets and an electric

wheelchair, while food parcels were donated by the Little Homeland Foundation, the Order of Malta Service, the Droga Family Assistance Association, and the Biedronka Foundation. The FHPE's patients in Michałowo municipality who were in need also received support from their neighbours, who – like the network institutions mentioned earlier – did cleaning work and tidied up the surroundings of patients' homes. It is also worth noting the commitment of the KOOZ and the FHPE hospice caregivers, who cleaned a patient's home and provided respite care.

c) Narew municipality

In Narew municipality the network of local institutions had fewer members than those described earlier. At the same time, more networking meetings were held here than in the other municipalities. These were most often attended by employees of the Municipality Social Welfare Centre (GOPS), Municipality Office, Narew Community Centre (NOK), and village leaders. Most of the institutions listed here were represented by one person each – the most attended from GOPS.

Table 45. Institutions taking part in the networking meetings.

Networking meeting 1		Networking meeting 2		Networking meeting 3		Networking meeting 4		Networking meeting 5		Networking meeting 6	
Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people
FHPE	2	FHPE	2	FHPE	2	FHPE	2	FHPE	2	FHPE	2
GOPS	4	GOPS	4	GOPS	2	GOPS	3	GOPS	3	GOPS	4
Narew Municipality Office	1	Village leaders	5	Narew Municipality Office	2	Village leaders	9	Narew Municipality Office	3	NOK	1
Roman Catholic Parish	1					NOK	1	Village leaders	2	Village leaders	4
Municipality Public Library	1					Narew Municipality Office	1	County Family Assistance Centre (PCPR)	1		
Makówka village leader	1							KGW Narew	1		

School and Pre-school Com-plex in Narew	1							NOK	1		

Source: Own work based on data gathered by the KOOZ.

The network in Narew municipality comprises 14 institutions, of which one declared willingness to support the FHPE's patients as part of activities within the innovation – this was an initiative of volunteers from the School and Preschool Complex, who offered the possibility of providing respite care.

Table 46. Local institutions belonging to the support network – Narew municipality.

Institutions that declared participation in the network	Were they used during innovation testing?
FHPE	
Municipality Social Welfare Centre (GOPS) in Narew	NO
Consulting Point for addicts	NO
Narew Municipality Council	NO
Municipality Public Library in Narew Filia biblioteczna w Łosince Filia biblioteczna w Trześciance	NO
Narew Community Centre (NOK)	NO
Farmers' Wives Association (KGW) in Narew	NO
School and Preschool Complex in Narew	YES/ NO
Orthodox parish in Łosinka	NO
Roman Catholic parish in Narew	NO
Orthodox parish in Narew	NO
Health Centre in Narew	NO
Narew Volunteer Fire Service (OSP)	NO
Village leaders (sołtys) from Narew municipality	NO

Source: Own work based on data gathered by the KOOZ.

In Narew the KOOZ presented a patient with a blanket from a donor. As part of their duties, the KOOZ also delivered a walking frame, a bed and an anti-bedsore mattress from the rental facility. Moreover, as in the other municipalities, food parcels for the

FHPE's patients in the municipality were provided by the Order of Malta Service, the Droga Family Assistance Association, and the Biedronka Foundation.

d) Narewka municipality

The support network in this municipality comprised 22 institutions. Representatives of the social welfare centre (GOPS) and the Narewka Municipality Office (UG Narewka) attended all of the networking meetings. The other entities shown below only attended once. The most numerous group at any one meeting was that of the village leaders.

Table 47. Institutions taking part in the networking meetings.

Networking meeting 1		Networking meeting 2		Networking me-eting 3		Networking meeting 4		Networking meeting 5	
Institution	No. of pe-ople	Institu-tion	No. of pe-ople	Institu-tion	No. of pe-ople	Institu-tion	No. of pe-ople	Institu-tion	No. of pe-ople
FHPE	2	FHPE	2	FHPE	2	FHPE	2	FHPE	2
GOPS	1	GOPS	3	GOPS	1	GOPS	1	GOPS	3
UG Narew-ka	1	UG Na-rewka	1	UG Na-rewka	1	UG Na-rewka	2	UG Na-rewka	2
Primary School	1			Health Centre	1	Village leaders	5	Village leader	1
						KGW	1	County Family As-sistance Centre (PCPR)	1

Source: Own work based on data gathered by the KOOZ.

Among the institutions forming the network, five entities were involved in helping patients. GOPS provided consultation to the KOOZ, and they worked together for the benefit of one married couple: using its resources, the GOPS sent a caregiver there, while the KOOZ and a welfare centre employee had a conversation with these patients' family to motivate its members to be more supportive and provide care. The involvement of the Municipality Office and the Narewka municipality mayor (*wójt*) consisted in levelling out the barely driveable road to the home of one of the FHPE's patients. This was a request from the patient, which the KOOZ passed on to the municipality authorities. The Day Care Welfare Centre in Lewkowo Stare in association with the KOOZ organised a meeting with a psychiatrist. Children from the Narewka primary school's volunteering club and

members of the Seniors Club expressed willingness to provide respite care – they reported this to the KOOZ, but the service itself has not been provided yet. Moreover, pupils from the school donated a Christmas table decoration as a gift for one of the patients.

Table 48. Local institutions belonging to the support network – Narewka municipality.

Institutions that declared participation in the network	Were they used during innovation testing?
FHPE	
Municipality Social Welfare Centre (GOPS) in Narewka	YES
UG Narewka and Narewka municipality mayor (wójt)	YES
Consulting Point for Solving Alcohol-Related Problems at the GOPS in Narewka	NO
Narewka Municipality Council	NO
Village Centre in Lewkowo Stare	NO
Day Care Welfare Centre in Lewkowo Stare	YES
Narewka Primary School (school volunteering club)	YES
Storczyk Association	NO
Narewka of Culture and Generations Association	NO
Kalina Farmers' Wives Association (KGW) in Planta	NO
Malwa KGW in Olchówka	NO
Łuczyna KGW in Narewka	NO
Okulanka KGW in Skupowo	NO
Jezioranki KGW in Siemianówka	NO
Orthodox parish in Narewka	NO
Orthodox parish in Siemianówka	NO
Roman Catholic parish in Narewka	NO
Health Centre in Narewka	NO
Municipality Community Centre in Narewka	NO
Local-Government Public Library in Narewka	NO
Village leaders from Narewka municipality	NO
Spokojna Przystań Social Welfare Home (DPS) in Garbary	NO
Seniors Club	YES/NO

Source: Own work based on data gathered by the KOOZ.

The KOOZ also presented an FHPE patient with a blanket from a donor. Also, food parcels were provided by the Order of Malta Service, the Droga Family Assistance Association, and the Biedronka Foundation.

e) Zabłudów municipality

In Zabłudów municipality, 27 local institutions were registered in the support network. Those whose representatives appeared regularly at the networking meetings included the Town Social Welfare Centre (MOPS), the private company Custos offering commercial care services, Podlasko-Mazurski Cooperative Bank in Zabłudów (PM Bank) and the Town Centre for Cultural Animation (MOAK). It is worth noting the exceptional commitment of the care sector entrepreneur, who attended all the meetings and was very active in terms of helping older people in the area covered by the innovation. In the course of the innovation's implementation his company became an important partner for the MOPS.

Table 49. Institutions taking part in the networking meetings.

Networking meeting 1		Networking meeting 2		Networking meeting 3		Networking meeting 4		Networking meeting 5	
Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people	Institution	No. of people
FHPE	2	FHPE	2	FHPE	2	FHPE	2	FHPE	2
MOPS	1	MOPS	2	MOPS	2	Village leader	2	MOPS	1
Custos	1	PM Bank	1	MOAK	1	MOAK	4	MOAK	2
PM Bank	1			town and municipality councillor	1	PM Bank	1	Custos	1
Białostoczek Primary School	1			PM Bank	1				
				Custos	1				

Source: Own work based on data gathered by the KOOZ.

The resources of the Town Social Welfare Centre (MOPS) were utilised during innovation testing – its representatives provided the KOOZ with support in arranging a rehabilitation stay for a patient from this municipality.

Table 50. Local institutions belonging to the support network – Zabłudów municipality.

Institutions that declared participation in the network	Were they used during innovation testing?
FHPE	
MOPS in Zabłudów	YES

Institutions that declared participation in the network	Were they used during innovation testing?
Centre for Helping Families with Alcohol-Related Problems (operates from the Family Clinic)	NO
Panorama Social and Educational Association in Zabłudów	NO
Consulting Point of the Municipality Commission for Solving Alcohol--Related Problems in Zabłudów	NO
Non-Public Primary Health Care Facility (POZ) in Zabłudów	NO
NZOZ Family Clinic in Zabłudów	NO
NZOZ Zdrowie Therapeutic Rehabilitation in Zabłudów	NO
Zabłudów Town Council	NO
Community Self-Help Welfare Home in Krynickie	NO
PM Bank	NO
Custos Zabłudów	NO
Town Centre for Cultural Animation in Zabłudów	NO
Rafałówka Primary School	NO
Dobrzyniówka Primary School	NO
Białostoczek Primary School	NO
School and Preschool Complex in Zabłudów	NO
Police station in Zabłudów	NO
Roman Catholic parish in Zabłudów	NO
Orthodox parish in Zabłudów	NO
Miód Malina Farmers' Wives Association (KGW)	NO
Village leaders (sołtys) from Zabłudów municipality	NO
BArWa Very Active Village Association	NO
Association for the Development of Folwarki Village	NO
Active Zabłudów Association	NO
Very Active Kuriany Village Association	NO
Fans of Krynickie Village Association	NO

Source: Own work based on data gathered by the KOOZ.

Through the KOOZ, patients from Zabłudów municipality received food parcels from the Droga Family Assistance Association, the Biedronka Foundation, and the Order of Malta Service. Apart from that, utilisation of the network was negligible, which may be the effect of the extensive programme offered by this municipality's MOPS.

In all the municipalities, even though a comparison between the number of institutions forming a given support network and the number of cases when they were actually used seems not to reflect well on the importance of these networks, some effects that are hard to capture in figures should be mentioned. Thanks to the participant obser-

vation carried out systematically and by the same people, we can see a great change in the quality of contacts between the institution representatives attending the meetings. These interactions became less formal, the group developed a common language that facilitated agreement and communication during the actions that were undertaken, nor is there any doubt that – at least at the declaration level – they established that the necessity to provide care to people in need was a value shared by all, and that they agreed at least partially on how such help should be provided. There is reason for concern in the fact that many of the people involved in the network's activity were of an age when they were planning to retire or were already doing so. This raises the question whether the work put into building the networks will be continued at the institutions when the people directly involved in the building process are gone.

4.3. The Support Network in the Opinion of Staff and Experts

Discussing how the networks functioned in the municipalities, we should also look at how forming a network affected the work of the FHPE team; this presentation will be based on the results of a questionnaire survey conducted in 2021 and 2023.

When we asked about the respondents' expectations towards the support network in 2021, the large majority said they expected the network to have an effect on their work. They declared that this element of the innovation would lessen their burden of responsibilities as well as enabling them to provide better care to FHPE patients. Only four of the people surveyed at the time did not answer the question.

Table 51. How the network will affect work at the FHPE – expectations (2021, N=19).

FHPE staff	People who believe the network will affect their work	How?			
		Collaboration with other staff will be better / exchange of experiences	The burden of responsibilities will be lessened	Better help will be provided to patients	People will become stronger mentally
Overall	15	2	8	6	1
Doctors	4			4	
Nurses	4		2	1	1
Hospice caregivers	4		4		
Other staff (physiotherapists, dietician, psychologist)	3	2	2	1	

Source: Own work based on own questionnaire survey.

The respondents indicated that their main expectation for the network of local institutions was taking care of patients' needs better and more completely. Commitment seemed to be important to them, as possibly leading to better contacts with the network's members. Regardless of their job position, the respondents were counting on patients becoming the focus of attention for the support network being formed. Doctors were thus counting on support and a fuller response to patients' needs, nurses – on better fulfilment of the needs of patients who were not eligible for hospice care according to NFZ criteria, better contacts (between patients and their families on the one hand and institutions on the other) and an improved quality of services, and hospice caregivers – simply on receiving support.

Subsequent rounds of the survey included a question about whether the support network actually affected the FHPE team's work and how. The share of employees noticing changes in their professional responsibilities was significant in the three rounds, at over a half of all respondents.

Table 52. Staff opinions on how the network affected their work during the innovation implementation (2022–2023).

	survey II: autumn 2022	survey III: spring 2023	survey IV: autumn 2023
Number of people who said the network had affected their work	7 (of 11 surveyed)	11 (of 18 surveyed)	13 (of 20 surveyed)

Source: Own work based on own questionnaire survey.

The respondents underlined that thanks to the formation of a support network comprising local institutions, patients received more services supporting them in the final period of their lives, in illness. Help was provided in such a way as to also benefit the families and caregivers. It seems that the very awareness of the existence of a support network and the possibility of finding help there had a positive effect on the quality of work at the FHPE, because it was an important element to the respondents to be relieved of the necessity to perform tasks not related to their job. The staff also pointed out that the formation of a support network offered the possibility of helping patients outside the procedures defined by the NFZ. Building local institution networks, the FHPE employees stated, had a positive impact on teamwork skills, improved information flow and ensured better contacts with patients and their families. Also in future, the hospice staff expected the network members to continue their support in caring for patients. Their responses show that they would like the institutions in the network to communicate with the FHPE regarding patients' needs. In their opinion, actions undertaken by the actors require good organisation of work for the benefit of patients, and support for them and their families in dealing with official matters. One respondent said that the existence of the network was a measure preventing burnout. Moreover, respondents pointed out that apart from having such a network, it was also necessary to expand the hospice team and include hospice caregivers in it on a permanent basis.

Social policy and health care experts were also asked for their opinion on support networks comprising local institutions. Many of them said that a well-organised, complementary support network could help dependent people to continue living at home for the longest time possible. The creation of such a network would make it easier to provide benefits and services to older and ill people in their environment. Moreover, sharing and promoting experience and best practice within the network could provide the institutions involved with inspiration for activity and collaboration. According to some respondents, the support network should be appointed as "one package" with the care coordinator, since building the network and combining the services available in a given area should be one of the most important responsibilities of that person. The experts suggested that the various entities forming a network should have a liaison in

the form of a social services centre, which should sign agreements with the interested entities – but with the stipulation that such an agreement would not specify the actual duties and tasks of the network partners.

4.4. Summary

The process of building a support network within the project revealed some regularities connected with collective activity in small communities. First of all, it was naturally assumed to be obvious that the construction and animation of the networks planned within the innovation would reflect the existing administrative division. This applied both to large units – the *powiat*/county – and to smaller ones – the *gmina*/municipality. This decision may have stemmed from the ROPS-B experts' earlier favourable experience in leading networking meetings to build networks in that particular form. This shows the great role that local governments and the institutions they finance play in upholding the vitality of rural areas. These institutions' greater involvement in the regular networking meetings held as part of the innovation is also clearly visible, especially when people running higher-level institutions announced they would be attending. Their presence drew other local actors to the meetings as well. The low level of activity of the network of people representing other organisations operating in a given area might be explained, as mentioned earlier, by their small number, heavy load of tasks, and commitment to activism in connection with the many crisis situations occurring during the innovation's implementation. The highest attendance at the meetings was observed for organisations in which the ROPS-B experts were actively involved; the KOOZ's effectiveness in organising meetings was poorer in terms of the number of people and institutions present. This raises concern over the effectiveness of the KOOZ's activity in future, when the ROPS-B experts' support for the project is halted and the invitations are issued by a representative of the hospice as a unit. On the other hand, the KOOZ showed skills in filling the networking meetings with content interesting to the network members, taking advantage of the FHPE's staff's network of contacts to invite specialists from fields related to physical and mental health to the meetings.

5. Creating the Position of Dependent Care Coordinator (KOOZ)

The next element of the innovation was to create a new position in the hospice team: Dependent Care Coordinator (KOOZ). This move was prompted by the observations of FHPE staff suggesting that even the inadequate help available in their area of operation was sometimes used in a less than optimal way. This meant that insufficient resources were being distributed in a way that caused losses. For example, a nurse's or hospice caregiver's visit to a patient might come on the same day as a visit from the social welfare centre caregiver. In the case of patients living in the peripheries, this meant that two cars covered what was quite a distance only for the staff to discover that the patient's needs had already been taken care of. It would be the task of the KOOZ to regularly and accurately identify the needs of patients and plan actions in such a way as to fulfil them through rational use of the potentials and possibilities offered by the institutions forming the support networks described earlier.

5.1. Assumptions About the Role of the KOOZ Prior to Innovation Implementation

To recruit the right person for the KOOZ position, the following expectations were set down for the candidates:

- knowledge of welfare work and a firm willingness to develop their competence further,
- substantial independence and initiative in any actions undertaken,
- well-developed communication skills,
- a category B driving licence and a car of their own.

A university level-education in sociology, pedagogy or nursing was considered an added bonus.

The job offer was published in media such as the foundation's website and Facebook page, in County Labour Offices (Białystok, Hajnówka, Bielsk Podlaski), and at the Career Offices of the University of Białystok and the Medical University of Białystok. Information about the search for a candidate was also announced at all the networking meetings in the municipalities: Narew, Narewka, Zabłudów, Gródek, Michałowo.

Eight people applied for the job, of whom two withdrew from the contest before their interviews. There were ultimately three female and three male candidates for the KOOZ position. Interviews were held with them as they applied, conducted by a committee comprising the experts from the Regional Centre for Social Policy in Białystok (ROPS-B; partner 1 in the project *To Give What Is Really Needed*) and the project coordinator from the Prophet Elijah Hospice Foundation (FHPE). This committee recommended one person, who was then interviewed by the project manager (leader – the FHPE president), who approved the candidate for the post of KOOZ. The KOOZ started work in August 2021, i.e. within the time set down in the project schedule. The person chosen for the job was a woman from one of the municipalities who had worked in various jobs in the past, fulfilled the formal conditions and, according to the committee, was the best fit for the task ahead in terms of soft skills.

The responsibilities of the KOOZ were set down as follows:

a) identifying the needs of dependent people and their caregivers, evaluating the possibilities and planning the means to fulfil them, and in particular:
   - applying on behalf of these patients to aid and medical institutions in order to secure better care
   - providing information and help in obtaining any due benefits/services
   - helping with writing memos, applications, appeals etc.
   - helping obtain necessary rehabilitation and medical equipment
   - proposing neighbourly aid and support
   - proposing round-the-clock welfare care homes in consultation with the FHPE's doctor and nurse;

b) working together with aid institutions active in the support network, and in particular:
   - upholding the collaboration by organising meetings with the network members
   - taking action aimed at expanding the support network;

c) working together with the FHPE medical team;

d) monitoring and documenting the progress of the innovation's implementation;

e) systematically providing the employer with feedback on progress made in all activities.

The new KOOZ compared her future duties to the tasks of a social worker. She expected intensive work in the field and that she would be expected to be on hand when needed (flexible) and have organisational skills. She thought the least taxing duty would be contact with FHPE patients, expecting the necessity of contacting and collaborating with institutions to be more difficult. She also indicated that the initial period of her work would be crucial, as she would have to identify patients' needs and the institutions in the municipalities and their resources. In her case, the starting point might be supporting patients in obtaining resources (cash benefits and in-kind aid) from the County Family Assistance Centre (PCPR), the Social Insurance Institution (ZUS) and other organisations.

In the first year of testing the innovation, after the KOOZ started work, the FHPE staff were also asked to share their expectations towards the coordinator. Almost half of them did not have any ideas, responding "I don't know" or not giving an answer. Among the 10 people who said yes, most thought that the KOOZ (like the support network) would lessen their burden of responsibilities (especially in non-medical tasks).

Table 53. How the KOOZ will affect work at the FHPE – expectations (2021, N=19).

FHPE staff	People who believe that the KOOZ will affect their work	How?		
		Increasing the number of patients	The burden of (particularly non-medical) responsibilities will be lessened	Collaboration
Overall	10	1	8	1
Doctors	4	0	4	0
Nurses	3	0	2	1
Hospice caregivers	1	0	1	0
Other staff (physiotherapists, dietician, psychologist)	2	1	1	0

Source: Own work based on own questionnaire survey.

FHPE staff expected commitment to and reliable performance of duties in helping patients. They also indicated that the KOOZ should coordinate the team's work, which would ensure proper information flow and help in non-medical matters.

Table 54. Employees' expectations towards the KOOZ (2021, N=19).

Position	Expectations towards the KOOZ
Doctors	Commitment, coordinating the team's work, reliable performance of duties, empathy, creativity
Nurses	Commitment, proper assessment of patients' needs, identifying the needs and doing their best to help people in rural areas
Hospice caregivers	Support, working in the group
Other staff (physiotherapists, dietician, psychologist)	Better information flow, help in non-medical matters, contact with patients

Source: Own work.

5.2. The KOOZ in the Innovation

5.2.1. Fulfilment of the KOOZ's Duties

The key aspect of the KOOZ's work during the implementation of the innovation in the project *To Give What Is Really Needed* was organising support for the FHPE's patients. The new position of coordinator was strictly tied to the formation and activity of a collaboration network of local institutions providing services to older, terminally ill and dependent people, as the KOOZ primarily drew upon the resources of this network in her work.

On the basis of documentation gathered (in a form called the Patient Needs Card), it was possible to analyse the needs put forward by patients and to indicate the entity responsible for dealing with them as well as the KOOZ's role. This documentation was updated during each monthly visit the KOOZ made to patients. However, patients did not suggest their needs at every visit – on average, they expected some kind of action from the KOOZ once every two to three months. The actions undertaken by the KOOZ may be divided into three groups: welfare and social needs of the FHPE patients, their needs connected with their health – medical and rehabilitation needs, and those actions of the KOOZ that did not fit into the previous two groups. Among the tasks connected with welfare and social needs performed by the KOOZ, most involved passing on food parcels and gifts – part of this was items given to the FHPE by donors, which the KOOZ then distributed among the patients according to their needs, while another (smaller) part was items that the patients themselves asked for as being necessary. In this group of needs it is also worth noting those related to keeping a patient's home and/or surroundings clean and tidy. In the great majority of cases, the role of the coordinator in meeting welfare and social needs involved mediating between the patient and the

entity with the resources or competence to meet a particular need. It seems that in many cases the KOOZ took over the role usually played by local social welfare centre (OPS) staff. Due to their huge burden of work, these employees gratefully welcomed someone who, often being in the field, could support them in activity for the benefit of dependent people. In the table below, the seemingly small number of people that the KOOZ dealt with in her work may suggest that this element of the innovation was not sufficiently active. However, we must not forget about the KOOZ's monthly visits to patients. These were important from the point of view of the patients' social relationships, gathering information then passed on to the other members of the care and medical team, and updating knowledge on the patients' needs. Moreover, it should be pointed out that the actions involved were extremely diverse, which suggests deficits in meeting different kinds of needs.

Table 55. Welfare and social needs of the FHPE's patients, gathered by the KOOZ (July 2021 – December 2023).

Welfare, social needs	Who fulfilled them	No. of people	Municipalities	Role of the KOOZ
Christmas/Occasional parcels	Droga Family Assistance Association, Little Homeland, Order of Malta Service, Biedronka Foundation, local OPS in Michałowo, PGE Foundation	n/a*	Michałowo, Narew, Gródek, Narewka	she delivered the parcels (where necessary, she also collected them from the donors)
Food parcels from the Roman Catholic parish	the Roman Catholic parish	1	Michałowo	she delivered the parcels
Donations (clothing, bed linen, blankets, a microwave, an electric wheelchair, a commode, a telephone, a rehabilitation bed)	private entrepreneur, volunteer, Droga Family Assistance Association, donors	n/a*	Gródek, Michałowo	she delivered the gifts to the patients
Levelling out a road that was undriveable and medical staff had to walk about 1 km to the patient	Municipality Office	1	Narewka	she reported the need to the Municipality Office
Clearing some bushes along the access road to a patient's home	Municipality Office	1	Michałowo	she reported the need to the Municipality Office
Mowing of grass	DPS Jałówka	1	Michałowo	she coordinated the operation
Cleaning a home and mowing of grass, supplying gravel and tidying up the area around the home, spreading out the gravel and packing the driveway (neighbours)	Michałowianka Welfare Co-operative and DPS Jałówka, neighbours	1	Michałowo	she put those in need in touch with volunteers
Cleaning a home	KOOZ, FHPE hospice caregiver, Active Senior Association	2	Michałowo, Gródek	she and the FHPE hospice caregiver cleaned the home, and for the other person she was responsible for getting in touch with the association
Help with filling in an application for a certificate to apply to ZUS for a supplementary benefit	KOOZ	2	Michałowo	she helped fill in the documents and file them with ZUS

Welfare, social needs	Who fulfilled them	No. of pe-ople	Municipa-lities	Role of the KOOZ
Help with filling in an application to the local OPS for a care allowance for a patient	KOOZ	1	Narew	she delivered the documents and helped fill them in
Help with filling in applications for emergency (alarm) bands from the Senior Citizens' Support Corps pro-gramme (local OPS)	local OPS in Michałowo, KOOZ	2	Michałowo	she delivered the documents, helped fill them in, delivered the bands and instruc-ted the patients how to use them
Help with filling in applications for a coal allowance	KOOZ	n/a	all the munici-palities	she prepared the applications, patients signed them and filed them themselves or the KOOZ did
Help with drawing up a divorce petition for a patient	KOOZ	1	Narew	she delivered the documents and helped fill them in
Help with obtaining power of attorney to take part in the elections	KOOZ	1	Narew	she delivered the documents and helped fill them in

Source: Own work based on data gathered by the KOOZ in the Patient Needs Card.

** It is hard to establish the exact overall number of patients who received parcels because some of them had been in the FHPE's care longer than a year and had received this form of support more than once.*

In the case of rehabilitation and medical needs, meeting the needs that patients reported required a lot of commitment from the KOOZ. Here, the coordinator served as a mediator between the patient and institutions: she was responsible for gathering together necessary documents, delivering them to the patient and his or her caregivers, helping them fill in any forms, and then filing them with the relevant institution. In this, the KOOZ took over tasks usually performed by the family or OPS or primary health care (POZ) staff, e.g. a community nurse. This might be an indication as to the group of patients for whom this innovation is most important. In a situation of properly working institutions and family present on site, older people can take advantage of their help. However, when – as is often the case in rural areas in Poland – we have people whose life situation does not allow them to get help from family, or who live in a locality from which it is hard to travel to obtain institutional aid, or such aid is not provided at a satisfactory level due to staff shortages or overwork, the appointment of a KOOZ could fill in such existing gaps. However, we need to underline that the presence of a KOOZ and their support provided to patients does not eliminate the need to improve the poorly functioning and inefficient national welfare and health care systems.

Table 56. Medical and rehabilitation needs of the FHPE's patients, gathered by the KOOZ (July 2021 – December 2023).

Medical, rehabilitation needs	Who fulfilled them	No. of people	Municipalities	Role of the KOOZ
Reconnaissance (at the PCPR) on how to obtain financial aid from the PCPR in the programme for eliminating architectural barriers (construction of a ramp, a bathroom remodelling) and delivery of the application	KOOZ (PCPR was passive)	3	Gródek, Narew	she delivered the documents and helped file the applications
Help with applying to a court to declare a patient legally incapacitated (the KOOZ proposed she would find a lawyer to handle the case and she would deliver the documents)	KOOZ	1	Gródek	she delivered the documents
Delivery and filling in of documents for the procedure to establish the degree of disability	KOOZ	5	Gródek, Michałowo, Narewka	she delivered the documents, then filed them
Respite care	volunteers from the primary school, members of the Senior+ Club, FHPE, KOOZ, Active Senior Association	7	Narewka, Gródek, Michałowo	she coordinated the respite care provided, and once provided it herself
Help with placing a patient in a DPS	KOOZ	1	Gródek	she contacted the DPS
Help with transporting a patient to the health centre for a morphology blood test	proposed by the Municipality Community Centre (GOK) in Narew	-	Narew	she got the patient in touch with the GOK in Narew
Consultation with an architect volunteer, who would conduct an inspection and measurements for the possible installation of a balcony lift for a patient's wheelchair	an architect volunteer	1	Gródek	she arranged the meeting and took part in it together with the patient
Delivery and filling in of an application for the installation of a track stair climber	KOOZ	1	Gródek	she delivered the documents and helped fill them in
Obtaining a list of rehabilitation centres and information on how to proceed in order to receive NFZ-funded rehabilitation	KOOZ	10	all the municipalities	she drew up the list herself

Medical, rehabilitation needs	Who fulfilled them	No. of people	Municipalities	Role of the KOOZ
Rental of rehabilitation equipment (wheelchair, electric wheelchair, walking frame, bed, anti-bedsore mattress, mini bike)	KOOZ	7	Narewka, Michałowo, Narew, Gródek	she shared information about the FHPE's rental facility – the equipment was collected by a caregiver from the patient's family or the KOOZ delivered it to the patient
Getting a patient's family member in touch with the local OPS in Zabłudów about a rehabilitation stay	local (town) OPS Zabłudów, KOOZ	1	Zabłudów	she served as a mediator
Help with filling in an application for financial support to buy supplementary products (hygiene products)	KOOZ	1	Narewka	she delivered the documents, helped fill them in and file them
Help with filling in an application to the PCPR for the installation of a ramp at a porch entrance (in the programme to eliminate architectural barriers)	KOOZ	1	Michałowo	she delivered the documents and helped fill them in
Help with filling in documents to obtain a benefit for a caregiver	KOOZ	1	Michałowo	she delivered the documents and helped fill them in
Help with filling in an application to establish the degree of disability	KOOZ	1	Narewka	the KOOZ's initiative: the patient was not convinced, the KOOZ filed the application
Help with filling in an application for financial support from the State Fund for Rehabilitation of People with Disabilities (PFRON) for replacing a regular bathtub with a walk-in tub with door	KOOZ	1	Michałowo	she delivered the documents, which the patient's caregiver filed with PFRON
Help with getting reimbursement for the costs of a trip to Poznań for medical consultations and treatment	the costs were reimbursed from money provided by donors	1	Narewka	she filled in the documents and arranged the reimbursement

Source: Own work based on data gathered by the KOOZ in the Patient Needs Card.

Other actions undertaken by the coordinator did not stem directly from needs suggested by patients, but, rather, were connected with strengthening the operation of the network of local institutions and with educational activity, which the KOOZ is also obliged to conduct. From the viewpoint of the innovation's designers, this element of the KOOZ's work constituted activity for the benefit of the local communities, helped build the FHPE's position in the local environment, and was an opportunity to repay others for the support for hospice patients that the KOOZ could have requested from local institutions.

Table 57. Other activities of the KOOZ (July 2021 – December 2023).

Other needs	Who fulfilled them	No. of people	Municipalities	Role of the KOOZ
Educational meetin-gs with the primary school volunteers	KOOZ and an FHPE nurse	17 in Gró-dek, 22 in Narewka	Gródek, Na-rewka	she organised the meeting in consulta-tion with the school principal
Meeting with a psy-chiatrist at the Day Care Welfare Home in Lewkowo Stare	Psychiatrist from the Mental Health Cen-tre in Hajnówka, DPS Lewkowo Stare	-	Narewka	she helped organise the meeting
Meeting with a psychiatrist for members of the Seniors Club	Psychiatrist from the Mental Health Centre in Hajnówka, Seniors Club	-	Narewka	she helped organise the meeting

Source: Own work based on data gathered by the KOOZ in the Patient Needs Card.

Our observations as well as the expert knowledge of the social policy and health care specialists show that most of the tasks undertaken by the KOOZ in this innovation were ones that are not institutionally or organisationally assigned to existing units when there is no such care coordinator within the structures of a municipality or an institution. The completion of many of these tasks depends on someone's – mostly volunteers' – good will. Those that have been assigned to a specific unit will not be carried out automatically – they require a patient and his or her caregivers/family to take the initiative.

Table 58. Entities that should/could carry out the tasks performed by the KOOZ – welfare and social needs.

Welfare, social needs	Who could carry this out when there is no KOOZ?
Christmas/Occasional parcels	Volunteers
Food parcels from the Roman Catholic parish	Volunteers
Delivery of donated gifts (clothing, bed linen, blankets, a microwave, an electric wheelchair, a commode, a telephone)	Volunteers
Levelling out a road that was undriveable and medical staff had to walk about 1 km to the patient	Volunteers, the road's owner
Clearing some bushes along the access road to a patient's home	Volunteers, the road's owner
Mowing of grass	Volunteers
Cleaning a home and mowing of grass, supplying gravel and tidying up the area around the home, spreading out the gravel and packing the driveway (neighbours)	Volunteers, support from the family, neighbours
Cleaning a home	Volunteers, support from the family and neighbours; if the relevant benefit has been granted – OPS
Help with filling in an application for a certificate to apply to ZUS for a supplementary benefit	ZUS
Help with filling in an application to the local OPS for a care allowance for a patient	OPS
Help with filling in applications for emergency (alarm) bands from the Senior Citizens' Support Corps programme (local OPS)	OPS
Help with filling in applications for a coal allowance	OPS
Help with drawing up a divorce petition for a patient	Legal services – commercial or provided by the municipality, volunteers, support from the family
Help with obtaining power of attorney to take part in elections	OPS, volunteers, support from the family

Source: Own work based on the interview with the experts.

However, it is worth mentioning that some of the tasks in which the KOOZ took part could be carried out through the mediation of existing institutions. In most cases, these tasks could be assigned to social welfare centres (OPS) as the units responsible for elderly care, this solution being a practical dimension of the implementation of social and elderly-related policies – especially at the local level.

Table 59. Entities that should/could carry out the tasks performed by the KOOZ – medical, rehabilitation needs.

Medical, rehabilitation needs	Who could carry this out when there is no KOOZ?
Reconnaissance (at the PCPR) on how to obtain financial aid from the PCPR in the programme for eliminating architectural barriers (construction of a ramp) and delivery of the application	The patient and/or their caregivers, family
Help with applying to a court to declare a patient legally incapacitated (the KOOZ proposed she would find a lawyer to handle the case and she would deliver the documents)	Family/caregivers, support from OPS
Delivery and filling in of documents for the procedure to establish the degree of disability	The patient and/or their caregivers, family
Respite care	Volunteers, commercial services
Help with placing a patient in a DPS	Family/caregivers (supported by commercial services), OPS
Help with transporting a patient to the health centre for a morphology blood test	The family doctor can issue an order for medical transport, commercial services
Consultation with an architect volunteer, who would conduct an inspection and measurements for the possible installation of a balcony lift for a patient's wheelchair	Volunteers
Delivery and filling in of an application for the installation of a track stair climber	Volunteers, family/caregivers
Obtaining a list of rehabilitation centres and information on how to proceed in order to receive NFZ-funded rehabilitation	Volunteers, family/caregivers
Rental of rehabilitation equipment (wheelchair, electric wheelchair, walking frame, bed, anti-bedsore mattress, mini bike)	Volunteers, family/caregivers
Getting a patient's family member in touch with the local OPS in Zabłudów about a rehabilitation stay	Volunteers, family/caregivers, OPS
Help with filling in an application for financial support to buy supplementary products (hygiene products)	Volunteers, family/caregivers, OPS
Help with filling in an application to the PCPR for the installation of a ramp at a porch entrance (in the programme to eliminate architectural barriers)	Volunteers, family/caregivers, OPS
Help with filling in documents to obtain a benefit for a caregiver	Volunteers, family/caregivers, OPS
Help with filling in an application to establish the degree of disability	Volunteers, family/caregivers, OPS

Medical, rehabilitation needs	Who could carry this out when there is no KOOZ?
Help with filling in an application for financial support from the State Fund for Rehabilitation of People with Disabilities (PFRON) for replacing a bathtub with a walk-in tub with door	Volunteers, family/caregivers, OPS
Help with getting reimbursement for the costs of a trip to Poznań for medical consultations and treatment	Volunteers, family/caregivers

Source: Own work based on the interview with the experts.

Other tasks performed by the KOOZ, e.g. those serving to popularise knowledge on caring for older people, increase the sensitivity of members of local communities to the needs of the elderly (such as meetings with school volunteers, organising a meeting with a psychiatrist for senior citizens) could – according to the observations from the study – be undertaken, first and foremost, by volunteers, local activists, and NGOs working for the benefit of older people.

5.2.2. How the KOOZ Affected the Scope of Work of FHPE Staff

The survey conducted among FHPE staff yielded information on how these employees perceived the addition of the KOOZ to the team's structure. Their expectations towards this job position were also considered. The responses they gave in three survey rounds (2022, spring 2023, autumn 2023) show that the great majority of employees saw that the KOOZ had had an impact on their work. The voices of those who did not see a difference between when the KOOZ was in place and when the job did not exist were isolated, marginal (not exceeding 10% of all those surveyed). Those respondents who noticed that the KOOZ's work had affected their own work had a positive view of this. None of the employees surveyed had any reservations about the KOOZ's work, nor did anyone indicate any negative impact of the coordinator on their own work. The FHPE staff noticed that the KOOZ's job had had an effect on the patients and their needs as well as on their own scope of work. They saw the coordinator as a work liaison between patients and their families, local institutions, and the foundation. According to them, the coordinator was an entity that increased the capacity for helping those in need, among other things thanks to the organisation of non-medical care, support in contacts with administration and other official bodies, support in obtaining various kinds of benefits (in-kind and financial) and in renting rehabilitation equipment. The staff most often underlined that the tasks performed by the KOOZ had lessened their own burden in handling patient-related matters that were not directly tied to their professional responsibilities. Moreover, they pointed out that the KOOZ improved the

exchange of information between patients and FHPE staff, thanks to which the relationships with patients were closer and more intensive, and information flow was faster.

We should also note the consequences of the new KOOZ position for the employees themselves. Here, the responses showed that the coordinator gave the staff a sense of support and lessened their work burden. This resulted in noticeably greater effectiveness of operation of the entire FHPE team. Some of the respondents said that thanks to the KOOZ position being created, patients were receiving comprehensive care in terms of their medical as well as social needs.

The FHPE staff also expressed their expectations towards further collaboration with the KOOZ. Most of them mentioned support in organising non-medical care, helping patients deal with matters that the patients and their caregivers were unable to handle. Another aspect that seems to be important to the respondents is the possibility of obtaining information about the needs of families and giving the families information on available allowances and other welfare and social benefits as well as other forms of aid organised in their place of residence based on local resources. Another key issue is getting up-to-date information about patients' needs and how they change, meaning that – as the respondents underlined – the flow of information is extremely important. The staff also expect the KOOZ to be on hand when needed (flexible) and that this would be a person holding together the activity of the team as a whole.

The staff's expectations and needs fit in well with what the KOOZ does. For example, the respondents expected the KOOZ to support them in handling official matters, contacts with institutions, in organising welfare and rehabilitation support, and these are exactly the tasks that the coordinator performed, as the data above show. Let us underline that some of the tasks taken over by the KOOZ were listed among the FHPE team's initial expectations. This is true, above all, for support in meeting patients' non-medical needs, the exchange of information and coordinating various forms of aid.

In the final survey (autumn 2023) the respondents were asked to offer opinions on the need to create dependent care coordinator positions at other in-home hospices. As many as 16 of the 20 people surveyed agreed. They indicated that a KOOZ could facilitate work and relationships with patients, ensure better collaboration with them, and support teams in providing comprehensive services to those in need – including non-medical services. The others had no opinion on the matter; these were probably people who had only recently started working at the FHPE. Employees often perform extra tasks connected with caring for patients. Below is a list of the tasks mentioned in two surveys: in 2021 at the start of the innovation, and near the end of this period, in autumn 2023 (the number of mentions is not given, just the character of the task and the opinion of the respondents). It turns out that after the KOOZ position was created,

some tasks – e.g. handling official matters and shopping – were performed less often by doctors as well as physiotherapists and hospice caregivers.

Table 60. Matters with which FHPE staff often help patients – comparison 2021–2023.

Often helping with:	2021				2023			
	Physiotherapists	Doctors	Nurses	Hospice caregivers	Physiotherapists	Doctors	Nurses	Hospice caregivers
handling official matters								
shopping								
transport								
household matters								
other matters unrelated to hospice care								
rental of rehabilitation equipment								
helping patients' families deal with patient affairs								

Source: Own work.

5.3. Instead of a Summary: Possibilities of Replicating the KOOZ Job Position

As mentioned earlier, we also asked social policy and health care specialists about the dependent care coordinator job. The main issue underlined by the experts was the institutional and organisational placement of this new position. Most of these respondents indicated that the main space for the work of someone with the KOOZ's competence lay within the social welfare system – at social welfare centres or social services centres. Some also said that such a coordinator could be employed at other units (private ones, NGOs, etc.) that provide services to people in need, dependent people, the ill and the elderly.

In most cases the experts agreed that the group of people under the coordinator's care should not be too big. They usually mentioned a maximum of 30–40 patients, strongly underlining that any more would prevent the coordinator from doing their job efficiently and effectively. The number of patients should be planned so as to ensure relatively stable contact with them, which means more or less one visit per month. Some respondents said that the tasks performed by the coordinator could be assigned

to a welfare worker or an elderly/disabled person's assistant. The ideal situation would be one in which the coordinator would combine the function of an assistant with the function of a welfare worker, because this would enable them to support patients in the needs they had at home as well as those that required "going outside", i.e. contacts with other institutions, taking advantage of services provided outside the patient's place of residence.

Some of the experts thought it would be possible to incorporate the range of tasks performed by the dependent care coordinator into the tasks of welfare services coordinators, who are institutionally assigned to welfare services centres (on the basis of the 19 July 2019 Act on welfare services centres). This solution was backed by the respondents' suggestion that the coordinator should be embedded in the structures of existing institutions: local-government, health care and social policy ones. In these experts' opinion, this would improve the coordinator's effectiveness – particularly in contacts with various entities operating according to strictly defined regulations. A danger that the experts mentioned was that placing the dependent care coordinator within the structure of a private institution or a third-sector entity could make it harder to establish contacts with public-sector units, thus having a detrimental effect on the coordinator's activity, as it would be hard to get state and local-government institutions to commit to working with entities from the private sphere, businesses or NGOs. In such a situation, any collaboration between the coordinator and various entities might depend mainly on the good will, commitment, and legal and organisational capacity of those entities.

Nevertheless, the respondents underlined that the fundamental task of the dependent care coordinator should be to manage/coordinate the services available at the local level (municipality, county). These services should encompass as great a range as possible, i.e. social, welfare, medical and rehabilitation services. The strongest emphasis was placed on services provided by social-policy entities and medical/health care entities. A dependent care coordinator should support people in need, dependent people – the respondents mainly focused on older, ill and dying people. These are in fact the groups specifically targeted by the innovation implemented in this project. Hence, the coordinator, according to the respondents, should coordinate/organise services provided to such people by diverse entities – not only those for which offering support to ill people, the elderly and those at the end of life is a statutory task.

6. What Next for the Innovation?

6.1. Conclusions from the Study

The innovation proposes a new model of rural hospice care for chronically ill and dependent people and of helping their caregivers. The innovation consists in incorporating three new elements into this care, involving:

a. as part of in-home hospice care, forming an interdisciplinary team comprising doctors, nurses, physiotherapists, hospice caregivers, a dietician and a psychologist;

b. building a collaboration network of local, formal and informal institutions/organisations that could provide services to older, terminally ill and dependent people;

c. creating the job position of Dependent Care Coordinator (KOOZ).

When the health and welfare care system is inadequate, in a situation stemming from factors such as changes taking place in rural areas, this new model of rural hospice care ensures care for chronically ill and dependent people as well as their caregivers. **It combines actions/measures governed by two legislative orders: social policy and health care.** Attempting to merge them at the micro level was a success in the case of this innovation, but it was difficult. Social policy has its institutional representation at the municipality level and solutions available in the social welfare system are managed from the local level. The situation is different in the health care system, because the local (local-government) level has no actual influence on changes to the model of health care, as this is defined from the central, national level. The health care system operates under pressure caused by financial and staff shortages, which is reflected in the way medical personnel function, and in practice means consent to people working at multiple institutions (public and/or private). Depending on a patient's financial capacity, it is possible to obtain help within the public system (it takes longer but is free) or the private system (it is quicker but you have to pay). In the case of end-of-life care in rural areas, it can be difficult or impossible to obtain help from either of the two systems. Existing shortages are exploited by those who stand to gain from them, having embedded their life strategies in the existing inefficient system, which is why

they defend existing solutions and resist change. Moreover, health care is dispersed, and due to the shortage of medical staff it is governed by market rules. The consequences of dispersed agency in health care were noticeable during work on translating the innovation into national policy. The work progressed much better in the social policy sphere than on issues connected with health care, even though the former also has to deal with significant staff and financial shortages.

The care provided in the innovative model of hospice care enables a **flexible approach to patients' various life situations**. This is good for the beneficiaries, but from the point of view of the current service contracting system it is difficult to introduce as a standard practice. Furthermore, it creates risky situations in which actions undertaken as part of the innovation would be treated as replacing the duties of other health care and welfare units. Building a lasting change that interferes with two systems, health care and social policy, is not possible from the grassroots level, as it requires solving or having ideas for solving the permanent crisis in health care and social policy (which has already undertaken the first measures for the benefit of dependent, older people). Without them, it will not be possible at all. **Introducing lasting, innovative projects is difficult without guarantees of stable, reliable sources of funding.**

At the level of micro, bottom-up activity, the innovation is needed and works well wherever there are substantial shortages of services within the existing national systems of social welfare and health care. The project's innovative measures may be used to resolve emerging problems in the short term, but incorporating them into a system that is the cause of the aforementioned shortages would require a reform of the whole policy/system. This means actions at the macro level that would be long-term and take into account those elements of the innovation that turned out to be efficacious and effective in a crisis situation.

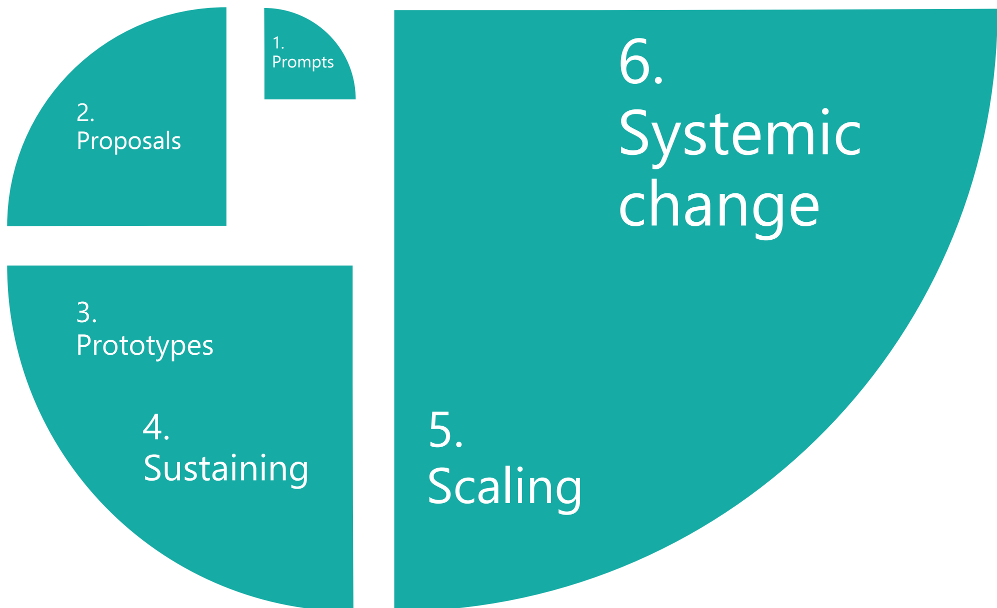
Wherever the social welfare system worked efficiently/well, the **KOOZ was less involved in aid activity** (the case of Zabłudów municipality). **Nor did the need for such a job position appear among the expectations of the control institution's employees.** Even though the needs of older people are not set down as priorities in the strategic documents and opinions of the local authorities in Zabłudów municipality, the situation of dependent people is better there compared to the other municipalities in the study. Alongside objective factors (such as location and easier travel to Białystok), this depends on the way the local OPS functions and on the attitudes of its employees. This makes the support system for dependent people more efficient than in the other municipalities. As the study shows, a competent manager, someone who actively seeks funding and organises aid, is of key importance. These traits may be listed as desirable when recruiting staff for particular jobs. However, it would be best if the quality of an

institution's work did not depend solely on the qualities and competence of individuals, but instead was built into the system.

The implementation of the innovation also revealed the model's weaker/problematic points. One thing that did not work was **expanding the medical team to include a psychologist** whose task was to ensure the mental well-being of the FHPE's staff. Few employees were interested in psychological support. This might be the effect of attitudes in Poland (especially widespread in rural areas) that stigmatise mentally ill people and those having psychological problems, which is then reflected in the frequency of seeking the help of a psychologist or psychiatrist. Offering such a possibility may also have been perceived as a way of judging the staff's work, and revealing psychological problems might then have been treated as the basis for a negative work evaluation. Problems were also observed during the creation and operation of the support networks. Of the many institutions listed as being in such a network, only few took part in the meetings/workshops; the absence of others, e.g. representatives of local medical institutions, is also noteworthy.

Project-based financing breaks institutional continuity (for example, at the level of the name of the activities being undertaken). In practice, only superficial changes are made to activities in order to obtain funding in new competitions. Instead of building lasting and predictable solutions, such undertakings create a pool of short-term, dispersed and overlapping measures.

Figure 21. Innovation as a process: the spiral of innovation.



Source: Komorowska, Wygnański (2019); adapted from Murray, Caulier-Grice, Mulgary (2010).

Referring to the above model, presented by Murray, Caulier-Grice and Mulgary (2010), elements 1–3 of the innovation could come from the micro level, in a bottom-up approach. On the other hand, according to the respondents, ensuring the durability of the measures (item 4, sustaining) would require stable sources of funding, and a competition system is not considered one of them. As the study shows, items 4 and 6 require system and policy change at the national level. Item 5 (scaling), as the FHPE's previous experience has shown, can be carried out gradually, through the promotion of innovative solutions, without national-level support. However, proceeding this way, the scaling institutions obtain funding for innovative activities in a competition system.

6.2. Introducing the Tested Solutions into Policy-Making: End-of-Project Thoughts from the Participants, Experts and Researchers

One of the planned elements and effects of the project implementing the innovation involved taking steps to enable the solution tested in the project to be incorporated into national policies. In the project *To Give What Is Really Needed* this was the task of the Regional Centre for Social Policy in Białystok (ROPS-B). During the project the centre's specialists started building, and later supported the Dependent Care Coordinator (KOOZ) in building, support networks in the counties and municipalities. In the late stage of the innovation's implementation their tasks included – based on consultations

in other counties of Podlaskie province that were not included in the innovation – drawing up recommendations as to the final, optimal system of support for terminally ill, chronically ill and dependent people and their caregivers in rural areas. During field meetings in each of the counties, the specialists presented the model adopted in the innovation and its first effects, and gathered the opinions of representatives of local institutions regarding the possibility of scaling of this model. These consultations mainly focused on organising and changing the care part of the innovation, not the medical part, which means that drawing conclusions on this basis is limited. After collecting all the opinions, the ROPS-B specialists in consultation with representatives of the FHPE as the innovation's leader drew up a list of recommendations that were next shown to specialists representing province authorities, at a meeting of entities responsible for designing care and health policies in individual provinces.

Two conventions of the directors of Regional Centres for Social Policy, organised by ROPS-B, were used to further the work on recommendations at the national level; representatives of the Health Departments of Marshal's Offices from all the provinces were also invited. During the first convention, organised in September 2022,[24] the work proceeded in the form of consultations and focused on presenting the innovation and discussing the possibilities for adapting it to currently binding and planned social policies. This was also an opportunity to learn about solutions being introduced in other provinces, and to hear about the experience of people working in those parts of Poland where rural areas look different and have to deal with other problems.

The second, three-day convention[25] took place in October 2023 and included visits to the municipalities where the innovation was being implemented, where the participants

24 The convention was held on 29–30 September 2022 in Białystok and attended by representatives of the following institutions: ROPS in Białystok; OWOP; IRWiR PAN; Health Department of the Podlaskie Province Marshal's Office; ROPS in Toruń; ROPS in Lublin; ROPS in Zielona Góra; Regional Centre for Social Policy (RCPS) in Łódź; ROPS in Kraków; Health, Families, Equal Treatment and Social Policy Department of the Małopolskie Province Marshal's Office in Kraków; Mazovian Centre for Social Policy; ROPS in Opole; Health and Social Policy Department of the Opolskie Province Marshal's Office; ROPS in Rzeszów; ROPS in Gdańsk; Health Department of the Pomorskie Province Marshal's Office; ROPS in Kielce; Health Department of the Świętokrzyskie Province Marshal's Office; ROPS in Olsztyn; Health Department of the Warmińsko-Mazurskie Province Marshal's Office in Olsztyn; ROPS in Poznań; Health Department of the Wielkopolskie Province Marshal's Office; ROPS in Szczecin; Health Department of the Zachodniopomorskie Province Marshal's Office in Szczecin; FHPE; local OPS in Gródek; local OPS in Zabłudów; Custos Zabłudów; local OPS in Narewka.

25 The convention was held on 18–20 October 2023 in Białystok, Makówka, Narew and Narewka. It was attended by representatives of 30 institutions: Chancellery of the President of Poland; Ombudsman's Office; Office of the Association of Provinces of the Republic of Poland; Mazovian Centre for Social Policy; Warmińsko-Mazurskie Province Marshal's Office in Olsztyn; ROPS in Toruń; ROPS Poznań; Health Department of the Pomorskie Province Marshal's Office; ROPS Gdańsk – Pomorskie Province Marshal's Office; Health and Social Policy Department of the Podkarpackie Province Marshal's Office; ROPS Rzeszów; Health and Social Policy Department of the Lubelskie Province Marshal's Office; ROPS in Kielce – Świętokrzyskie Province Marshal's Office; Health Department of the Małopolskie Province Marshal's Office; ROPS of Śląskie Province in Katowice; Health Department of the Podlaskie Province Marshal's Office; ROPS Białystok; Hajnówka County Office; PCPR Hajnówka; Gródek Municipality Office; Narew Municipality Office; Narewka Municipality Office; local OPS in Narew; local OPS in Narewka; local OPS in Zabłudów; local OPS in Gródek; local OPS in Michałowo; FHPE; OWOP; IRWiR PAN.

could see its elements in practice. It was also an opportunity for in-depth discussions on the recommendation proposals, which had been sent out in advance to the participants. Thanks to the commitment shown by all the attendees, this intensive work resulted in many additions and clarifications. The amended recommendations were sent out to ROPS directors and Health Department representatives with a request that they sign them as guidelines for policy activity at the national level. Those who accepted invitations to this convention included entities important for national policies, such as the Chancellery of the President of the Republic of Poland and the Ombudsman's Office. The recommendations in their final form were passed on to the following: Ministry of Health, Agency for Health Technology Assessment and Tariff System, National Health Fund (NFZ), Commissioner for Patients' Rights, Ministry of Family and Social Policy, Ministry of Development Funds and Regional Policy, European Social Fund Department, Ministry of Agriculture and Rural Development, Ministry of Education and Science, Ombudsman.

The specialists and other people connected with hospice care, health education and elderly care present at both conventions were asked to take part in some of the research being carried out in the project. Over a dozen interviews were conducted on the strengths but also potential difficulties that the proposed form of care could involve. Experts were invited to discussions on the innovation itself and on the possibility of incorporating it into the national care system for people in need of support in rural areas. The questions raised by the experts are partially confirmed by the results of the research carried out during the innovation implementation. Let us discuss them to summarise the results of the observation of the entire process of implementing the new model of care for terminally ill, chronically ill and dependent people and their caregivers in rural areas.

First and foremost, all the experts agreed that the innovation responded to a real and very important problem connected with the ageing of the rural population. They also admitted that the existing care system for senior citizens and chronically ill people, largely based on care provided by families and most often at the expense of women's unpaid work, was neither adequate nor fair. They were aware of social change that most often led to the increasingly frequent singularisation of old age and a necessity for the professionalisation of care. The opinions on the efficiency of the current system and its adaptation to new needs were more diverse. The uniqueness of Podlaskie province/region was highlighted, and also the fact that issues such as a scattered settlement layout, a shortage of aid institutions and a deficit of employees were not so acute in all regions of Poland. People also mentioned that in some provinces, including in rural areas, solutions that responded to this kind of trend were being implemented, e.g. day care homes for older people existed, respite care was available, neighbourly care was practised, and incentives for health care staff were even

being introduced[26] to encourage them to take a job in a given location. It appears that the message about the probable intensification of problems in connection with further depopulation and the decline of services in rural areas all over Poland has not reached people's awareness, despite the innovation authors' efforts: people did not quite see the innovation as a solution that could find application in their own areas. It is worth underlining that there are data suggesting what kind of developments we may expect in demographic and migration change in Poland. These data show that without very substantial changes in migration policy, for example, depopulation will also affect villages that currently do not have this problem. However, the issue seems to be more complex, touching upon policies at the national as well as local level and, as such, not necessarily highlighted by the authorities at those different levels. Building municipality investment plans and budgets on the basis of predicted shortcomings – in terms of services, accessibility and so on – might discourage prospective new residents from settling in a given locality, business from investing there, etc. A major role may also be played by the fact that rural municipalities, which have limited budgets, focus more on meeting current needs than on building a strategy for the future. In the long term, they could probably gain from taking trends into account and preventing future problems, but – for obvious reasons – they concentrate on the day-to-day. A similar view on the necessity to provide additional support to senior citizens in rural areas and supplement the existing support system with the solution from the innovation was expressed by people representing the local governments of the municipalities covered by the operations of the NZOZ Nadzieja hospice. They can see the ageing of rural populations but believe they are coping fine with the new problems by applying existing solutions. However, we need to remember that the five municipalities in Podkarpackie province have a different geographical layout, with denser rural settlements and better public transport than we see in the Podlaskie province municipalities considered in our project. There is also a richer offering of health and welfare care in those southern municipalities. This may be the result of more prompt and better responses to existing problems, but could also be connected with the fact that over the past eight years Podkarpackie province received exceptionally large funding for infrastructural projects, but also for projects and activities benefitting the region's residents. Even if this was an unusual situation, it is worth noting that the specialists working in rural communities in those regions consider already existing institutional solutions and available care programmes to be sufficient. The range of services for people at the end of life is wider there as well: in 2021 Podkarpackie province had 58 in-home hospices (2.75 per 100,000 residents), while the figure for Podlaskie province was 18 (1.54 per 100,000 residents).[27]

26 For example, a system of scholarships for medical students funded by the Lubuskie province authorities. The scholarships are available in exchange for a pledge to work within the province for a specified time in the future.

27 https://basiw.mz.gov.pl/mapy-informacje/mapa-2022-2026/analizy/opieka-paliatywno-hospicyjna/?fbclid=IwAR3VxM6eXHzMLOisfoCHi_G6RDc84l4fW0Or45brR60KtcmG1dJnsT663rY, access 14 August 2023

The question arises as to who and at what level should be responsible for raising awareness about the challenges that municipalities, counties, aid institutions and, finally, the whole of society will have to face up to in future. Should innovative measures really be implemented from the NGO level, and do they then stand a chance of succeeding (Kazepov, Colombo, Sarius 2020)? The research conducted for this project has shown that if an NGO is the driving force behind such measures, even if it enjoys the unequivocal support of local authorities and embarks on solving a problem on which everyone agrees, it will still find it difficult to get all the necessary allies to collaborate. In the case of the project *To Give What Is Really Needed*, the element that was the hardest to mobilise to collaboration turned out to be health care system units. Only three primary care clinics operating in the municipalities from the study attended the network's meetings at least once and took part in building the support network. Getting across the necessity-for-change message and the new proposals to representatives of the medical community – both institutions and individuals – was harder than in the case of the social policy community. Without the good will of doctors themselves, there is no institution that could make health care entities at the municipality level get involved in collaboration, networking, etc. The probability that an NGO could persuade these two communities to work together for a group of beneficiaries of the innovation in the way it proposes seems low. Allies are needed at the government ministry level, proposals need to be presented to circles responsible for designing long-term policies, public awareness needs to be built by underlining the importance and consequences of population ageing and highlighting the unique situation of older people in rural areas. One very good step in the case of this project seems to have been including the Ombudsman's Office and representatives of the Polish President's Chancellery into the debate on the possible incorporation of the innovation into the nation-wide support system. An issue important to the Ombudsman was the lack of equal access to health and welfare care for a large section of society, which is why this official could become a supporter of amending existing regulations. As for getting other representatives of the authorities interested in propagating the innovation, this was difficult due to the election campaign and parliamentary elections taking place in the final period of the innovation's implementation.

The experts also expressed concern that some of the KOOZ's tasks could overlap with the duties of welfare workers, family assistants or even the coordinators planned for soon-to-be-launched social services centres. People working in the field pointed out that without a strict quota of patients per KOOZ, this person would be yet another employee overburdened with work and bureaucracy, having poor chances of performing the tasks for which he or she was actually appointed. On the other hand, members of local authorities were concerned that the appointment of multiple KOOZs in one

municipality, with a specified number of patients each, would mean yet more jobs to be financed from municipality budgets. On the other hand, if the KOOZs' work were to be financed from a different source, we would be risking the temptation to cut the number of social welfare jobs in local-government units. A similar mechanism appeared in one of the counties covered by the innovation, where the number of physiotherapists able to provide in-home services was so small that the same people visited patients under the care of primary health care units and those under the care of the FHPE. Since the hourly pay was higher in the innovation, patients did not receive the aid to which they were entitled from the social insurance system, but used the services provided in the innovation, for which the physiotherapist received higher pay. Concern was expressed that this kind of avoidance of incurring the cost of services by entities obliged to provide those services would also appear at other institutions whose operations the innovation was meant to supplement, not replace.

Labour shortages in some regions of Poland might also mean that the introduction of an additional source of medical or welfare services would increase the wage expectations of people working in the relevant shortage occupations. This happened before the innovation in one of the municipalities from the project, where nurses working in long-term nursing care left for better-paid jobs at a DPS, which made the service unavailable in that municipality. A similar risk, as the experts pointed out, could emerge in the case of hospice caregivers, nurses, doctors, physiotherapists, or actually any of the occupations essential for a given entity's functioning, while the labour resources on the market will be insufficient. In the long term, changing one seemingly minor element of the support system might lead to a crisis, unless it is carefully planned and encompasses all the elements in need of change – in this case, it would require changes to the scale of training in shortage occupations, encouraging people to take jobs in regions where they are the most in demand, and adapting the health care training system, for example by changing the accessibility of education in particular specialisations.[28]

All of these difficulties, existing or indicated by experts as potentially possible, often led to the conclusion that the kind of services offered in the innovation would not be necessary if the institutions already in place in the current care and support system operated properly and efficiently. If the NFZ-funded health care system worked well, it would not be necessary to wait in queues lasting many weeks (or more) to see a

28 Existing shortages in the health care system and the risks of fixing them with "individual" solutions were brought to the fore during the pandemic. At the peak of infections, as a way of stopping the virus from spreading among medical facilities it was proposed that every medical employee should only work at one, core workplace. This measure was abandoned because working in multiple places is so widespread in medical occupations (the reason being not just a wish for more income, but also shortages on the labour market: without people working multiple jobs, many patients would not receive care) that the FHPE, for example, would have been left with one doctor and no nurses if this solution had been put into practice.

specialist and shorter ones to see a GP. There would not exist two different speeds of using the services of the same doctors, i.e. as part of state social insurance and through "shortcuts" bypassing several stages, e.g. getting into hospital by first paying for private visits with doctors who also work in the public health care system. If getting to a doctor were possible by efficient, comfortable and affordable public transport or through services provided under social insurance, it would not be necessary to supplement existing services with the range of hospice services offered in the innovation. Bedridden patients would get care from a doctor coming for home visits as well as readily available nursing services at home. The experts underlined that the problem might not be the system itself, which does envisage various needs and responds to them, but its multidimensional inefficiency. This inefficiency applies to the dramatic shortage of funding for existing needs, but also to the shortage of resources in the form of trained staff, who patch up the gaps in the system by working in many places at once, and to the lack of plans for the development of various medical specialisations, including those connected with the needs of older people. Finally, it applies to the lack of long-term, well-planned and consistently pursued policies, in both health care and social policy. According to the experts, but also employees of institutions operating at the local level, another serious problem is the short duration of various kinds of programmes for which funding is obtained through projects, grants and special funds. In the case of measures connected directly with people's health and with social welfare, it would seem best to secure stable, predictable funding independent of changes in the political government, which would enable support for the most vulnerable groups to be planned for the long term.

From the point of view of researchers of rural areas these dilemmas, however more tragic because tied directly to human safety, health and life, are rather like the ones that have appeared for many years in the context of processes taking place in the countryside. They are related to the question of what to do with areas where various functions are declining: residential, service-providing, coupled with increasing scarcity of jobs, specialists, etc. The literature (cf. Halamska 2018) has considered the question of whether to "support or afforest", which refers to the economic rationality of certain measures. The question becomes more difficult when it concerns decisions involving human health and life, but the dilemmas are similar: who should bear the responsibility and (above-average) costs of ensuring access to the relevant services in regions where services, including basic ones, are in decline? Where do you set the boundary of the "absolute minimum" in relation to health care and social welfare? To what extent is the proposed policy of deinstitutionalisation advantageous not only socially, but also economically in communities where stopping specialists from leaving has to come at a significantly higher cost? Who should be responsible for covering the difference involved in these growing costs: individual organisations, municipalities, the whole of

society? These dilemmas, though seldom expressed directly in debates on rural areas, are familiar from discussions on issues such as the phasing out of certain sectors of the economy. One example might be the emotions involved in the attempted reduction of coal mining and mines being shut down (whether in Poland or, for example, in the UK in the 1980s), or the lesson on the consequences of ill-judged decisions that Poland learned after closing down state-run farms in the early 1990s.

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APPENDIX

FHPE Staff Survey Tool[1]

The survey is being conducted by a team from the Polish Academy of Sciences' Institute of Rural and Agricultural Development (IRWiR PAN) as part of the project To Give What Is Really Needed *– an innovative model of professional at-home care for dependent, terminally ill and chronically ill people and support for their caregivers in rural areas. The aim of the study is to compare the activities and opinions of the staff working at the institution implementing this social innovation with the responses of staff working at a hospice operating according to NFZ rules.*

1. How long have you been working at this hospice?

....

2. In what job position are you employed at this hospice?

....

3. Is this your only place of employment? [*Please mark your choice by placing an "X" symbol in the appropriate box, Yes or No]*

Yes ☐

No ☐

If the answer is no, please list your other places of employment.

....

....

4. How did you find out about the possibility of working at the hospice?

....

....

5. On a scale of 1 to 10, please evaluate your <u>sense of the meaningfulness</u> of your work at this hospice.

1 2 3 4 5 6 7 8 9 10

1 – no sense of meaningfulness *10 – very strong sense of meaningfulness and satisfaction*

6. On a scale of 1 to 10, please evaluate your satisfaction with <u>the work organisation</u> at this hospice.

1 2 3 4 5 6 7 8 9 10

1 – completely dissatisfied *10 – completely satisfied*

1 Surveys using this tool (with modifications) were repeated regularly at both institutions.

7. On a scale of 1 to 10, please evaluate your satisfaction with the remuneration at this hospice.

1 2 3 4 5 6 7 8 9 10

1 – completely dissatisfied *10 – completely satisfied*

8. So far during your visits to the hospice's patients, have you helped with the tasks listed below? [*Please mark your choice by placing an "X" symbol in the appropriate box.]*

I helped:	Often	Occasionally	Never
with dealing with official matters			
with shopping			
with transport			
with household matters (e.g. stoking the heating furnace, carrying water, cooking a meal)			
with other medical services than those connected with hospice care			
with rehabilitation equipment rental			
the patient's family in matters concerning the patient			
other, what were they?			

9. Please list what you consider to be the good points (max. 3) of working at the hospice.

....

....

10. Please list what you consider the biggest difficulties (max. 3) in working at the hospice.

....

....

11. Does your work cause physical problems? What kind? How do you cope with them?

....

....

12. Does working at the hospice affect your mental state? If so, how do you cope with this?

....

....

13. Have you taken advantage of meetings with the psychologist provided as part of the innovation and the workshops she offered? If so – what did you think of them? If not – why did you not take part in them?

....

....

The Prophet Elijah Hospice Foundation is carrying out the project To Give What Is Really Needed, *its aim being to build a support network for dependent people and their caregivers in rural areas and to create the new job position of Dependent Care Coordinator (KOOZ).*

14. Do you think the support network being built influenced you work over the past year? In what way?

....

....

15. What do you expect from the support network?

....

....

16. Did the addition of the Dependent Care Coordinator affect your work? If so, how?

....

....

17. What do you expect from the Dependent Care Coordinator? With what matters do you go to them?

....

....

18. Please read the statements below and choose the answer that best matches your feelings. [*Please circle your choice in the appropriate box.]*

In recent weeks I've been...	Always/ very often	Often	Sometimes	Seldom	Very seldom/ never
1. feeling irritable and impatient	4	3	2	1	0
2. feeling powerless and helpless in the face of professional duties	4	3	2	1	0
3. feeling sadness/loss of enthusiasm	4	3	2	1	0
4. feeling a loss of interest in my work	4	3	2	1	0
5. feeling reluctant to perform my duties	4	3	2	1	0
6. having mood swings and negative emotions	4	3	2	1	0

In recent weeks I've been...	Always/ very often	Often	Sometimes	Seldom	Very seldom/ never
7. having lowered self-esteem and sense of effectiveness	4	3	2	1	0
8. feeling guilty in connection with the results of my work	4	3	2	1	0
9. having problems concentrating	4	3	2	1	0
10. having difficulties making decisions	4	3	2	1	0
11. feeling that a small effort is beyond my strength	4	3	2	1	0
12. feeling a weakening of relationships with co-workers and clients, and trying to avoid others	4	3	2	1	0
13. feeling mean and cynical towards others	4	3	2	1	0
14. blaming myself for failures	4	3	2	1	0
15. feeling chronic fatigue	4	3	2	1	0
16. having sleep disorders	4	3	2	1	0
17. experiencing reduced immunity	4	3	2	1	0
18. feeling somatic pain	4	3	2	1	0
19. having blood pressure problems	4	3	2	1	0
20. having disorders connected with the digestive tract	4	3	2	1	0

19. Please read the statements below and choose YES or NO. [*Please mark your choice by placing an "X" symbol in the appropriate box.*]

	YES	NO
1. I think about work even in my free time		
2. I feel overwhelmed by my responsibilities		
3. When I get up in the morning on workdays I feel tired or exhausted		
4. I'm increasingly frustrated, impatient and irritable at work		
5. I've lost the desire for further education/training		
6. I've been getting minor infections, headaches etc. more often		
7. I'd gladly change jobs		
8. I'm increasingly helpless in the face of problems at work		
9. People who come to me at work often irritate me		
10. I'm too busy to indulge in recreational activities		

Now count how many times you chose "yes". A few could mean you are at risk of burnout syndrome. The first signs of burnout tell us we need to make small changes, e.g.

take a short holiday.

Demographics:

Female ☐

Male ☐

Year of birth: ....

Place of residence (name of locality): ....

How many kilometres is it from your home to the hospice headquarters? ....

Questionnaire for the participants of the ... municipality networking meeting

1. What institution do you represent? Number on the attendance list …

2. Is aid for dependent or chronically ill people the statutory or optional, additional activity of the institution you represent? (please circle your choice)
   a) statutory   b) additional   c) has not provided aid before

3. How, through what kinds of activity, does the institution you represent support dependent and chronically ill people in the municipality? What kind of support can they receive from your institution? Please give some examples.

....

....

....

....

....

4. Has the institution you represent collaborated with the institutions listed below on helping dependent or chronically ill people?

Number of the organisation (from the meeting attendance list)	Collaboration				Form of contact		
	Regularly, we have patients in common, we are in constant contact	Occasionally, we sometimes act jointly for the benefit of a patient	Never, we have not collaborated		If X most often personally	If X most often by phone	If X most often by email
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							

Demographics

1. Sex: M F

2. Year of birth: ………………

3. What is your position in the institution you represent today? ……………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

4. How many years have you worked at the institution you represent today?
……………………………………………………………………………………………

5. What is your education? Level and type – specialised?
……………………………………………………………………………………………

NEEDS ASSESSMENT QUESTIONNAIRE AND SUPPORT PLAN FOR PATIENTS OF THE PROPHET ELIJAH HOSPICE FOUNDATION (FHPE) IN MICHAŁOWO

PART I
DIAGNOSIS, CURRENT STATUS AND DATA AS OF ....

Register No. ....

1. Data of the patient (dependent person)

first name ....

surname ....

date and place of birth ....

date of admission to the FHPE ....

2. Health situation of the patient *(from an interview by the hospice or a nurse)*

Chronic diseases ....

Injuries and their consequences ....

Other illnesses and their consequences ....

Orientation in time, space and personal situation (normal, partial, lack of orientation)

Hygiene

Condition in which the patient is maintained (clean and neat, dirty etc.) ....

The patient is under the care of:

Family doctor ....

data, address, contact phone number

Specialists ....

data, address, contact phone number

3. Description of the home *(based on info from the hospice or a social worker or info from the community)*

☐ heating – what kind ....

water: ☐ hot ☐ cold ☐ from a well ☐ from a water supply system

☐ other media /gas ☐ bathroom ☐ toilet ☐ other amenities

☐ washing machine ☐ telephone ☐ Internet ☐ cooker

☐ refrigerator ☐ own room ☐ own bed

facilities for a person with disabilities / a dependent person

☐ medical equipment, products ☐ bed, anti-bedsore mattress

state of the home:

☐ clean and neat ☐ dirty, neglected or due for a renovation ☐ very worn, ruined

4. Data of the caregiver of the patient (dependent person)

first name ....
surname ....
date and place of birth ....
relationship to patient ....
does the person live with the patient ....
state of the caregiver's health (physical, emotional) ....
how the caregiver functions (fitness, independence, mobility, activity level etc.)

....

Access to basic services (shop, transport, health centre, pharmacy etc.; distance and how it's all organised)..

5. Family situation

Information about members of the patient's (dependent person's) family

No.	First name and surname	Place of residence (do they live with the patient?)	Do they keep in touch, provide support?	Contact

Other persons living with the patient ....

(first name and surname, contact – tel.)

Relationships between the people living with the patient (good sides, conflicts in the family – *based on info from the hospice or a social worker or info from the community*) ....

Abuse in the family, addictions *(based on info from the hospice or a social worker or info from the community)* ....

Other information that the person filling in the questionnaire sees fit to provide:

a. Monthly household income, regular expenses, source of financial support and the amount of such support

....

b. Other types of material support – what kind, how often, is it enough?

....

6. Support in the community (HOSPICE, help from neighbours, informal groups, institutions)

Patient (dependent person)				
No.	First name and surname / institution	Type of support	Frequency of support	Contact
Dependent person's caregiver				
No.	First name and surname / institution	Type of support	Frequency of support	Contact

PART II
SUPPORT PLAN

The patient's expectations and needs, expressed by themselves or by the caregiver on behalf of the patient (dependent person)

....

....

The caregiver's expectations and needs, expressed by themselves or by someone who lives with them

....

....

Needs of the patient (dependent person) and their caregiver submitted by, for example:
the FHPE doctor caring for the patient
the FHPE nurse
the FHPE psychologist
the FHPE caregiver
other members of the FHPE team

➔ to be collected, for example, during a meeting of the team or individual conversations

....

....

other members of the network
(GOPS, clergyman, family doctor, community nurse, other)

....

....

SUPPORT PLAN DATE ....

Patient (dependent person)					
No.	First name and surname /institution	Type of support	Frequency of support	Contact	Execution, remarks
Dependent person's caregiver					
No.	First name and surname /institution	Type of support	Frequency of support	Contact	Execution, remarks

The authors decided to study a very important but also difficult social problem – the negative consequences of ageing Polish society, focusing on long-term care in hospices. Elderly people more often need institutional help, because of singularization of senility and lack of family care. This group of rural inhabitants, ill, often with disabilities need special care. (...)

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