Ageing society – a review of strategies for action

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ABSTRACT

It is expected that during 1980 – 2020 the population of older people worldwide will increase by 240%. The objective of the study was to review strategies undertaken in various countries in association with the ageing of society. This analysis may be used for the selection of actions, which are necessary for the construction and performance of social and health policy in Poland. A method of choice was an analysis of academic literature. The WHO specified health promotion as the most important goal of the policy for seniors. Individual countries adopt many varied strategies of action. In Poland, the introduction of nursing insurance and development of geriatric medicine are primarily proposed. In Japan, the emphasis is placed on enabling the elderly the longest occupational activity possible, and the development of primary health care. For the Swedish, the priority is guaranteed support for family caregivers, while in the United States - an increase in the accessibility of environmental care. There are many strategies developed on an international forum whose purpose is to provide care for the growing number of seniors. The strategies adopted by individual countries are much varied. The basic postulates are a development of geriatric medicine and integration of the systems of health services and social security. The literature lacks reports on the effectiveness of the implemented strategies.

Key words: Health services accessibility, aged, old age assistance.

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INTRODUCTION

It is expected that during 1980 – 2020 the population of older people worldwide will increase by 240% [1,2]. This is a natural consequence of the improvement of living conditions, development of medicine, and increase in the availability of health services. However, an increase in the life span is not the only element of the demographic transformation. Only in combination with a decrease in the number of births, serious changes are observed in the age structure of the population [3,4]. According to the nomenclature by the World Health Organization, a population is defined as old when more than 7% of its members are aged 65 and over. In turn, by Rosset, a society is old when people aged over 60 constitute a minimum of 12% [5, 6]. The process of ageing of society takes place most rapidly in Japan, where within only 24 years the percentage of people aged over 60 increased from 7% to 14 %. In Sweden, this growth has taken place for 85 years, while in Germany and the United states – 45 years [5]. It is a satisfying fact that in Western Europe and Japan an increase in the average life span is accompanied by a reduction in the percentage of the disabled, as well as intensification of physical activity among the elderly [5].

In view of these facts the following research question arises: what strategies for the ageing society have been adopted by Poland and countries most affected by this phenomenon.

The objective of the study is reviewing action strategies to tackle the problem of the ageing population undertaken in various countries. This article analyzes Poland's strategy as well as strategies of Japan – as the country in which the ageing of population occurs at the fastest pace – Sweden, the United States and Germany (countries in which the ageing of population occurred at the earliest). Analysis of the experiences from this review may be used for the selection of actions which are necessary to be undertaken in respect of the construction and performance of social and health policy in Poland.

The article presents the analysis of health policy strategies focused on the problem of ageing society. These strategies constitute a set of actions which address epidemiological phenomena and related social needs. These actions are implemented on the basis of legislative acts of different levels. Considering differences in legal systems, the authors analyzed articles describing the implemented changes, and not the legislative acts themselves. Thus, mistakes associated with law interpretation were avoided. It should be remembered that every legal system has its own rules, according to which regulations should be interpreted. Nevertheless, this article did not aim at scrutinizing legal aspects of providing care for the elderly by the state. Therefore, a method of choice was an analysis of academic literature.

Review

The WHO has defined the goals of policy for older people. Health promotion and health education among seniors, aimed at the improvement and maintenance of their physical as well as mental efficacy is placed in the primary position [8-10], followed by prevention of health problems by their early detection. As the third goal, the WHO recommends such a way of organizing care, which will allow older people to function in their own home for the longest time possible [7].

In 2012, the European strategic partnership was developed in the area of innovation on behalf of the ageing society – *European* Innovation Partnership on Active and Healthy Ageing (EIP). This action was undertaken by the European Commission's Directorate General for Health and Consumer Protection (DG SANCO). As the primary goal of strategy, there was adopted the promotion of a positive image of 'ageing in health', and change in the way of thinking, designing, organizing, financing and providing health services and social welfare services, as well as activation of seniors in social life [11]. The performance of the above-mentioned tasks should result from cooperation between public and private institutions [7].

Poland in the face of the phenomenon of the ageing of society

In Poland, older people are provided with assistance by the systems of social welfare and health care. Social security may be in the form of cash benefits, services and benefits in kind [12]. The scope of services cover: old-age pensions, incapacity benefits, family benefits for widows/widowers, as well as the nursing benefit for people aged over 75 [13].

The system of health care ensures the seniors primary health care services, long-term care, and services in residential medical care facilities and nursing homes [13].

In Poland, there is no complex policy concerning senior citizens, and their health demands are not secured in a different way than for the rest of the society [14]. In order to implement a policy which would comprehensively cover the problems of seniors, in the first place, long-term goals of this policy should be defined and institutions founded responsible for their achievement. It is necessary to develop a legal and organizational framework, which would enable cooperation between health and social care [7]. The Government Population Council, an advisory body of the President of the Council of Ministers, drew

attention to the fact that, at present, the systems of health and social care for the senior citizens are incoherent, dispersed and disintegrated, and the services offered are not adjusted to the needs of the elderly [15].

A new procedure has already been contracted – the Overall Geriatric Assessment (OGA); however, this solution is still insufficient. The procedure is being implemented only in hospital geriatric wards, which limits its application [15]. In addition, a system of financing care services and a system of support for significant others – those who provide care for their elderly – should be implemented [16]. It is very important to educate medical staff and employees of government and self-government administration in the area of gerontology. There is also a need for the development of long-term and rehabilitation care [7].

Plans to implement nursing insurance are proposed for those who have no resources to secure care for themselves. This insurance would concern the risk of incapability for independent existence. It should be emphasized that neither social welfare, nor health care or non-government organizations, are able to fulfill all demands of this type. The implementation of a special system of social security may contribute to an improvement of the situation. In 2007, a bill on social nursing insurance was submitted. The bill called for the foundation of a proper institution – the Nursing Care Insurance Fund. The bill also proposes introducing a definition of a person who is not independent as someone who for a period longer than 6 months needs assistance from others with the activities of daily living. This solution has already been implemented in some of the European Union member states [17].

A subsequent group of actions are indispensable in Poland for the development of geriatric care.

In Poland, geriatric medicine belongs to a niche of medical specialties. This is due to a system of financing unfavorable for this specialty, based on Homogenous Patient Groups (HPG). The system consists in the reimbursement of the costs of treatment of a single disease, which is disadvantageous for geriatric medicine considering its specificity [18,19]. In order to accelerate the development of geriatric medicine it is proposed to start a short specialization path which, within 5 years, would allow an increase in the number of geriatricians in Poland by another 500. For specialists in internal medicine, specialization courses would take one year, while for the primary health care (PHC) physicians – two years. Training courses in geriatric medicine are also proposed to PHC physicians, and placing an emphasis on them conducting prophylactic examinations and general health assessment of people at late old age. Also, abolition is postulated on the obligation to possess a referral to geriatric outpatient departments so as to facilitate access to ambulatory care for those who are incapable. Geriatricians should be authorized to prescribe rehabilitation equipment and orthopaedic aids. In addition, it is postulated to create a network of geriatric outpatient departments which would deal with co-morbidity and complex disability [7].

Japan facing the phenomenon of the ageing of society

Within the last 50 years in Japan the percentage of the elderly has increased four times (from 5.7% in 1960 to 23.1% in 2010). This pace of change was almost the fastest worldwide. Moreover, as early as in 2008, the percentage of the population aged over 75 exceeded 10%. It is estimated that in 2030 every third Japanese citizen will be aged over 65 and by 2055 the percentage of people in this age group will be 41%. Still in 2005, per one elderly person there were 3.3 individuals at productivity age. In 2030, there will be 1.8 people at productivity age per one senior. According to Japanese data, medical expenditures per person aged over 70 are four times higher than for younger people. In view of such a rapid process of the ageing of society, the Japanese pay special attention to ensuring senior citizens the possibilities to enjoy a healthy, wealthy and active life. It is noteworthy that the actions undertaken by Japan – with its society at a more advanced age – are carefully observed by the rest of the world [20,21].

In 2011, the sub-committee of the Science Council of Japan prepared a proposal of strategy for the phenomenon of the ageing of society. In this strategy, work was put on the first place. Efforts are made to enable Japanese seniors to maintain occupational activity for as long as possible. The actions undertaken are mainly aimed at the elimination of social seclusion of the elderly, and minimizing the decrease in the number of occupationally active population. The actions to obtain this state of things would be, e.g. re-education and creating various jobs and the main recipients would be primarily the group of so-called young elderly. This solution, apart from an increase in the work force, is aimed at maintaining both to-date consumption indices and activity of the older population in order to delay the necessity for nursing services [20]. Other future prospects are as follows: retirement age delay by 5 years (from 60 – 65), postponing the receipt of the old-age pension from 65 to 70, increase in monthly insurance payment, and tax increase [21].

Health insurance in Japan guarantees patients free access to every specialist [21]. However, health care resources are exhausted and its provision insufficient. Remodeling of the health

care system will focus on the following actions. Firstly, the role of a family physician will become more important. Secondly, there is a need for increasing the number of nurses and feeding assistants. The third step will be the combination of the efforts of physicians, nurses and other experts [21].

The Japanese also perceive the need for supporting medical specialists and a complex view of many disorders with which seniors struggle. The implementation of a system is proposed in which the PHC physician will be able to share patient's examinations results with clinics and hospitals, while maintaining the confidentiality of data. Attention is paid to raising awareness of medical staff in respect of the most common geriatric problems, and a holistic approach to the patient. Expansion of the system of diagnosing diseases typical of the elderly and development of multidisciplinary care received by a patient at home are also very important. Gerontology focuses mainly on the health promotion of those ageing, from the psychological, environmental, as well as social standpoint. Emphasis is also placed on geriatric medicine. The Japanese are developing a complex system of trainings for specialists engaged in work with the elderly [20].

The United States facing the phenomenon of the senescence of society

At present in the United States, 10 million people, including two thirds who are seniors, need assistance with the basic activities of daily living. The majority of them remains at home and are helped by family and friends. They are usually not insured, which generates tremendous care costs. Even those covered with the Medicare project designed for the elderly, or with private insurances, cannot count on total financing of long-term care. Only a small percentage of senior citizens have purchased a separate insurance for these services. Those poorest may rely on support from the Medicaid programme. It is noteworthy that in the United States, in long-term care, the role of the insurer is almost minimal, whereas an informal caregiver is of the greatest importance [22].

American expenditures on long-term care of the elderly are anticipated to double in the subsequent 30 years. Facing these facts, Americans must answer some basic questions: What is the place of long-term care in the system of financing of health services? Should the sources of financing long-term care be homogenous? Should this care remain the area of responsibility of individual states, or become a system of federal nature? And: What is the relationship between public and private services in this respect? Undoubtedly, each solution will mean the relegation of a part of the responsibility from informal caregivers to the government [22].

Similarly to Europe, in the United States long-term care is usually provided by informal, unpaid caregivers, who are usually family members. The public sector plays an important role in the context of securing the demands of people with the lowest income. At present, the federal programmes which provide care for older people are Medicare and Medicaid. Medicare is a federal programme of medical insurances for the elderly, which covers almost all Americans aged over 65. Medicaid is characterized by closer inclusion criteria and is designed for people with low income. Medicare finances acute and respite care, while Medicaid is the main source of financing long-term care in the USA – it finances almost a half of this care. Medicare and Medicaid together offer health services to seniors in the following areas: hospital care, ambulatory care, financing prescription drugs, organizing nursing homes services, as well as home and environmental health care services. In literature, the lack of coordination of payments between these systems is indicated. In addition, it is noteworthy that Medicaid focuses mainly on the financing of nursing homes. These days, in view of increasing costs of nursing services for the elderly, there is a tendency to support seniors at their place of residence and develop environmental care [23]. Studies were conducted aimed at selecting the strategy for action which would lead to widening the availability of care services for the elderly. In the studies, several scenarios of organizational solutions were analyzed, and it was estimated how many hours of care they will provide for those in need [23].

It was found that the organizational solution which provided the highest percentage of patients receiving a high or medium number of hours and the lowest percentage of people receiving the lowest number of hours was social environmental care. With this policy, the percentage of people who receive the lowest assistance was from 6.2% - 9.1%, according to individual states. This discrepancy results from the different number of people covered by the Medicaid programme. If the solution was adopted consisting in a greater financing of nursing homes than environmental services, the percentage of people who receive the smallest number of hours of care would increase to 16.0% – 28.9% [23].

On 23 March 2010, President Obama signed a complex health care reform: Patient Protection and Affordable Care Act (PPACA), which implements organizational solutions in the area of provision of services for the elderly. The Act focuses on the dissemination of the provision of health services among Americans, control of health care costs, and improvement of health care by

increasing its availability. The Act also contains changes to the organization of long-term care, mainly concerning its coordination and homogeneity. Five areas of activities are distinguished in long-term care: introduction of a national insurance which would cover long term care, development of long-term care guaranteed by Medicaid and by other institutions, and the reform of nursing care homes [24].

The influence of the State on long-term care may be seen in the document Community Living Assistance Services and Supports (CLASS) Act. The Act creates a new national programme of voluntary insurance of a public-private character. This insurance concerns social insurances for long-term care and other types of support. In order to become a services recipient of this insurance one should pay insurance premiums for a period of 5 years, declare not being an independent person for at least 90 days, and in addition, fulfill functional and cognitive criteria. Efforts are being continued on the determination of the states-the State relationship in the performance of this programme [24].

The subsequent goal of the PPACA is the development of accessibility of long-term environmental care provided within Medicaid. Individual states will have the possibility to remain with their to-date Medicaid programmes; however, they will be also able to select other options. The states will be supplied with other programmes, such as the Program of All-Inclusive Care for the Elderly (PACE), not included in Medicaid, which are intended as financial stimuli to change the present conditions of the provision of long-term care. In order for a given state to become a beneficiary of such a programme, it will have to submit an application form to the Secretary of the Department of Health and Social Welfare [24].

The exemplary, effectively performed programme is PACE – Program All-Inclusive Care for the Elderly). This programme integrates respite and constant care. The objective of this programme is to avoid placing seniors in hospitals and nursing care homes, unless necessary. Whenever possible, medical services are provided at the patient's place of residence, i.e. at home or a proper facility. Patients may use assistance from a multidisciplinary team under the condition that they resign from using other forms of assistance not included in the programme [25].

Achieving better coordination of care for patients with many concomitant diseases is the next goal of the PPACA. This coordination will simplify the procedure of transition from one form of care to another. Bearing this goal in mind, the Federal Coordinated Health Care Office's task will be to elaborate on the criteria of admission to various forms of care. Another proposal is the Independence at Home Demonstration Program which is planned to simplify the procedure of a patient's transition from in-patient to home care [24].

The reform of nursing care homes is regulated by the Nursing Home Transparency and Improvement Act. The regulations adopted are aimed at increasing the accessibility of information which regards the functioning of facilities, and greater response to the demands of care recipients [24]. The PPACA Act places emphasis on the education of the nursing staff in the specialty of geriatric medicine. This task will be performed by the Geriatrics Nursing Workforce Development Programs, managed by the Health Resources and Service Administration. The goal of this programme is to create a complex programme of geriatric education. The programme intends training of both nurses and geriatric medicine tutors. Internships for nurses are also planned in the area of gerontopsychiatry. The Health Resources and Service Administration also manage the Geriatrics Health Professions Programs. This programme offers financial resources for the development of the remaining studies and trainings in geriatric medicine [24].

It is noteworthy that the above-mentioned programmes and strategies are changes in law; however, the sources of their financing have not been indicated [24].

Sweden tackling with the problem of the ageing of society

Some countries, such as Sweden and other Scandinavian states, have replaced inter-generational agreement of care of the significant others with a 'social agreement'. One of the fundamentals of the Swedish post-war social welfare system was overtaking by the State of family duties in the name of the principle of solidarity. Therefore, the problems concerning family as caregivers were not included in the national family policy. Legal obligations with respect to parents were removed from social welfare in 1979. From then on, the responsibility for care of the elderly was overtaken by the public sector. The basic principle in the provision of social services in Sweden is maximizing an individual's independence from the family and closest relatives, even when an individual needs support in activities of daily living [26].

The 1980s Act on the care of seniors stressed the importance of respect and the autonomy of an individual; but also clearly indicated public responsibility for the care of seniors. This care was based on the principles of independence and leaving the elderly at their place of residence. In this regulation, the role of informal caregivers was omitted. Nevertheless, in the 1990s

it occurred that 2/3 of seniors were mainly assisted by family caregivers. This was a clear sign that it was necessary to support informal caregivers. A greater significance of family caregivers resulted from several phenomena. First of all, Sweden experienced economic recession. Secondly, in 1992 European Union reforms were implemented, which increased the importance of the environmental care of the elderly. Thirdly, the traditional 'Swedish model' of long-term care, financed from public resources, was based on the assumption that a constant development and economic growth of the country will continue to last. However, the recession led to a decrease in tax revenues and increased costs associated with unemployment. Encouraging the families and volunteers to assume a greater responsibility for care of the elderly became the method of saving. The year 1992 brought about a considerable change in the organization of care of seniors, when due to social welfare reform communes were made more responsible for care of the elderly, also for institutional care. The fact that this reform came into effect during the economic recession in the country added difficulties to communes which had problems with fulfilling the demands of the elderly, with social welfare and the housing situation. In order to cope with this situation, communes increased restrictions concerning the provision of care and reduced the number of places on the list of institutional care facilities. Such actions meant that the relatives had to assume a greater responsibility for the care of the elderly in their families. In emphasizing the role of family caregivers, three major goals were established: awareness rising in families, improving the families' quality of life, and decreasing the risk of burn-out among family members. However, it was stressed that the obligation of the commune to provide support for informal caregivers should not mean forcing families to look after relatives who are not independent. In legal regulations, a family caregiver was defined as a family member, relative, neighbor or friend, who supports an elderly person, irrespective of whether they live with this person or not. After 2000, the Standing Committee on Social Issues claimed that communes should be legally obliged to provide support. At first, the government rejected this idea. Although the government resigned from any other further legislative changes, the Standing Committee requested an analysis of the economic effect of compulsory aid for caregivers. In 2004, the Ministry of Health and Social Issues presented the results of studies which showed that the provision of such support would not be a burden for the State from the economic standpoint. Considering these data, in 2005 the government presented a new Act with a 10-year plan for the development of medical and social services for the elderly. A number of changes were proposed, including increased help for informal caregivers. An obligation for communal social services was introduced, consisting in the provision of support for those who take care of their closest relatives with chronic diseases, at old age, or those with disability [26].

One of the principles of the 'Swedish model' is guaranteeing the elderly financial independence and safety by providing proper and inexpensive lodgings and socially supported medical services. In exchange for paying taxes, seniors are offered a wide scope of nursing care services, which guarantee a minimum life standard. The recipient pays a fraction of the costs (about 4% – 5%). Approximately 90% of the costs of care are covered by local taxes (in Sweden, regions and provinces are the parties responsible for health care and social welfare), and the remaining costs are covered by government donations [26].

Although services considerably differ in individual communes, in all communes the greatest importance is ascribed to the principle: 'ageing at place'. Therefore, there are many services which enable the elderly to remain at home. Moreover, all communes offer nursing homes which provide services 24 hours daily. There is also domestic help which assists with household activities, such as shopping, cooking, cleaning and washing, taking a bath, using the toilet or getting dressed/undressed. Other services bring meals, install alarms, adapt lodgings, or transport. Institutional care is generally available; however, the number of residents living in these facilities has significantly dropped in recent years. In 1990, due to economic difficulties costs of care of the elderly were reduced. In 1993, approximately 23% of people aged over 80 received assistance at their homes, whereas in 2008, this percentage decreased to 21%. During this period, as for more expensive institutional care, this rate decreased from 24% – 15% [26].

Germany facing the phenomenon of the ageing of society

Based on a literature review, it was observed that in Germany, contrary to the United States, the debates concerning the future of health care for the older people are carried out primarily in the context of their financing, and to a smaller degree, expert opinions, demands and social needs are taken into consideration. In Germany, the specialty of geriatric medicine plays a minor role. Insufficient coordination and cooperation is being indicated between the parties engaged in health care of the elderly. Reinforcement of the effect of scientific circles on the changes undertaken is also needed [27]. Among the to-date strategies for the ageing of society, attention should be paid to insurance in the case of loss of independence [28].

In 1994, German system of care of people who are not independent became inefficient. This situation had already been foreseen in Germany in the 1970s. In association with an increase in life span and standard of living, higher expectations of citizens with regard to guaranteeing care became obvious. In 1994, social insurance was supplemented by nursing insurance [29].

Below are presented the basic principles of German nursing insurance. Furthermore, 24-hour nursing should be preceded by partly in-patient and short-term nursing. Prevention and medical rehabilitation are also priorities. The subsequent principle concerns the responsibility of an individual for their own health. Everyone should look after their health and cooperate in the process of treatment. However, the principle of joint responsibility for one's own health has also been introduced, according to which the whole society is accountable for care of the elderly. Nursing services should lead to the most independent life possible. These services should be provided with respect for human dignity and the maintenance of gender equality. Every citizen has a right to choose an insurance provider and the type of nursing agreement. Financing of services takes place in accordance with the principle of solidarity, and their performance – according to subsidiarity principle. The scope of services received does not depend on the amount of insurance premium paid. The insurance premium secures the right to receive services [29].

Nursing services cover: benefits in kind, nursing allowance for those who organize their own nursing, a combination of benefit in kind and cash benefits, nursing at home with limitations on the part of a caregiver (e.g. vacations, caregiver's illness), nursing auxiliary and technical aids, daily and night nursing, short-term nursing, entirely in-patient nursing, nursing in an in-patient care home for the disabled and those who are not independent, social benefits for caregivers, additional services in the form of leave from work during the nursing of a significant person, nursing courses for family members and care giving spouses, additional nursing care services, and personal budget services [29].

The services are provided on application within the necessary dimension. The insured apply for the provision of services to the services providers with whom the nursing care fund signed a contract.

The insurance is financed from premiums which are paid by the insured and the employers. The amount of insurance may be changed only by legislation, and depends on the amount of income. It is subtracted by the employer from the salary and passed to the employees' sick services fund. In order to compensate the employers for the increasing costs of employment, one day free of work has been eliminated. The amount of a premium is 1.95% of income; those who are childless pay a higher premium of 2.2% [29].

CONCLUSIONS

The phenomenon of the ageing of society is a fact, the effects of which are experienced in many countries. It is necessary to adjust national policy to the increase in the percentage of the elderly in society. There are many strategies which have been developed internationally aimed at providing care for the growing number of seniors [30]. Countries adopt various, frequently different strategies for the elimination of negative effects of the ageing of society. It is worth paying attention to the processes taking place in Sweden and the United States. In Sweden, efforts are undertaken to emphasize the role of a caregiver in the care of significant others, whereas in the United States the reforms take the opposite direction – we observe the increasing role of the State in exercising care. In the majority of countries, similar postulates may be noted, mainly the development of geriatric medicine, and integration of the systems of health care and social welfare. This diversity, and at the same time, repeatability of strategies in individual countries underlines the fact that reforms related with the phenomenon of the ageing of society should be multi-dimensional. There is no ideal solution in the provision of care for the growing number of seniors, and countries should implement parallel solutions, introducing cooperation among the public, private and self-government sectors.

Summarizing the analysis of Poland's, Germany's, Sweden's, the USA's and Japan's strategies it should be noted in the first place that they do not respond to the strategy objectives adopted by the WHO and the European Union (EU). In their strategies the WHO and the EU focus on promoting health among older people and building a positive image of senescence. However, the strategies of these countries concentrate on social welfare and health care as well as on access to restorative medicine.

Thus, the main strategies of Japan aim at enabling people to maintain professionally active for as long as possible and strengthening the roles of primary health care physicians and geriatricians. The United States is committed to the development of environmental care and the implementation of social insurance for long term care. On the other hand, Swedes place emphasis on supporting informal caregivers. Germany is seeking sources of funding care for the elderly and also developing cooperation among health care organizations for seniors. In Poland constructing strategies of action for the ageing society is still underway. In respect

of the above, both examining the needs of the elderly and conducting public consultation seems necessary.

Described strategies can be divided according to two criteria. The first one determines whether the strategy is implemented widely or whether it is state-specific. There is a group of actions which are taken by all countries, such as the development of geriatric care. Some strategies, however, are extremely varied and state-specific. Examples of this are the aspirations of Sweden and the USA. In Sweden, supporting informal caregivers is in the center of attention whereas actions in the United States are aimed at increasing the role of the state in the care of the elderly. All these differences are conditioned by political and economic factors as well as efforts which have been made so far by each country.

The second criterion of strategy division that should be paid attention to are the motives for their implementation. On the basis of the collected material, two main reasons for selecting these and no other strategies can be noted: the economic motive and study results. The choice of strategy was preceded by research carried out in Sweden, USA, Germany.

When making critical evaluation of the literature on the strategies for the ageing population in selected countries, first and foremost it should be observed that these are descriptive works. They present the strategies which have been adopted or which are to be implemented in the near future as well as actions which should be adopted. Unfortunately, the available literature does not elaborate on the decision-making process of selecting these, and not the other strategies. Also, there are no reports on the effectiveness of the implementation of each strategy. It's probably due to the fact that obtaining the effects of such actions is a long-lasting process. Another obstacle may be the lack of indicators or tools which would enable to assess whether the given strategy is effective or not. And it seems that this is a huge, undiscovered area of research. It is a pity indeed, because evaluation of the actions taken by the United States, Germany, Sweden or Japan could prove very useful for other countries – such as Poland for example – in which creating a strategy for action towards the ageing population is still underway. However, the effects of each strategy need to be watched closely and it is necessary to build the right tools in order to do so.

It is worth noticing that even though literature presents a lot of facts and figures concerning the ageing society phenomenon, they are only shown in the context of epidemiological data. Researchers are aware of the problem, but there are no suggestions how to resolve it. Original research into these strategies is an introduction to future studies to be performed when the implemented strategies are reflected in real life.

Conflicts of interest

The authors have declared no conflicts of interest.

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