LIVING CONDITION OF SENIORS IN LOWER SILESIA

The Study Report

Part II. Analysis of study results

Maryla Bogowolska – Wepsięć
Grażyna Dąbrowska
Jacek Klakočar
Zbigniew Machaj
Agnieszka Pierzchalska
Ewa Pisarczyk – Bogacka
Walentyna Wnuk

With increase in the average life expectancy,
and, as a consequence, the number of elderly people,
it shall become more and more necessary to propagate culture
which accepts and appreciates old age
and does not push it away to the margin of society.
[John Paul II „The letter to the elderly"]

INTRODUCTION

The Publication presented to you constitutes a second volume of a publication released by Marshall Office of Lower Silesian Province in 2007 (Wrocław 2007), titled "Living condition of seniors in Lower Silesia"[1]. The information contained in the previous report is expanded in form of substantial, in-depth analysis of data collected in course of empirical studies.

In 2005 the first stateLower Silesian Council for Seniors was appointed on initiative of Marshall Office of Lower Silesian Province. Two main objectives were intended by this appointment. The first one is integration of key entities (self-government institutions, government administration institutions, non-governmental organisations, universities), operating with regard to the elderly in order to increase effectiveness of these actions and expand the perspective of the topic of the society growing old and solutions proposed in this scope. The second objective of the Council's activity is searching for solutions to problems of the senior citizens living in Lower Silesia, in order to increase their chances of dignified, active and valuable life.

As members of the interdisciplinary Council we considered it necessary to commence activities in favour of the oldest citizens in Lower Sielsia by reliable diagnosis of this phenomenon. Each partner (author) of the enterprise had a clear-cut task, in accordance with professional experience.

The scope of analyses presented in this volume shall constitute a reference point for building a support system for the oldest citizens in Lower Silesia, and as a result creation of integrated gerontological care model. Therefore, obtained study results have been interpreted on the basis of subject literature and comparison with already developed system solutions in Poland and abroad.

Old age, in other words late adulthood is a multi-dimensional phenomenon, time-variable stage of life with most individualised needs. We all desire to get old in a good way.

[1] Seniors are a social category whose synonyms are the elderly, elderly persons (after age of 60)

The following question becomes a key issue for many domains of science and for every human being: what does it mean to grow old with dignity?

The process of society getting old carries a lot of problems of social, cultural, economic, medical nature, which constitute a need to develop a support program, perhaps a change of hitherto existing priorities in social policy, reorganisation of certain elements of healthcare and social aid systems. It is impossible to develop a good support system for seniors without a holistic approach to problems of the elderly, which in turn requires cooperation of specialist from many disciplines.

We hope that material which is being presented to you shall be helpful in marking direction of actions in favour of seniors in Lower Sielsia.

We would like to thank very much all partners for their efforts in execution of the research project. We give thanks to our interlocutors, surveyors, students, authorities of local governments and authorities of Marshall Office of Lower Silesian Province. Without your assistance execution of this enterprise would not be possible. We believe that our joint efforts shall contribute to improvement of quality of life of seniors in Lower Silesia.

The Authors

I. Scope and organisation of research of living conditions of seniors in Lower Silesia.

Providing the society with proper social security (including living and alimentation, health conditions, employment opportunities) falls among basic obligations of the state and is included in social policy.

On international level beginning of those actions is associated with International Labour Organisation, which was founded in 1919, an institution acting as an element of the system of the United Nations. It is this organisation, as well as other entities of regional range (in our continent – the European Union, European Council) and non-governmental organisations (e.g. Red Cross) and governmental organisations of individual countries that establish legal standards in force in individual countries. Their development requires a thorough analysis of the environment, living conditions of the population, existing health issues as well as assessment of healthcare functioning.

A particular social category is people of old age, which in various countries is considered to begin at 60 or, as in Poland, at 65. Among people in this category, from the moment of retirement safety of living decreases (threat of malnourishment, issues with affording to have an own apartment), health deterioration takes place (co-existence of simultaneous conditions, also requiring simultaneous treatment), the risk of so-called great geriatric syndromes appears, which significantly increases costs of daily living.

The phenomenon of population ageing became significantly accelerated in the previous century, which on the one hand results from decrease in fertility and number of people in pre-procreation age and on the other hand from significant progress of medicine and neighbouring disciplines. Introduction of obligatory vaccinations, discovery of insulin, antibiotics, introduction of modern water and sewage systems, reducing the spread of epidemics, introduction of new resuscitation techniques, development of transplantology, propagation of healthy life principles, proper diet, new diagnostic techniques (computer tomography, MRI), discovery of protease inhibitors against HIV, exploration of human genome – all of those have prolonged and still prolongs average life expectancy (ALE). This age, being 50 in Poland in the beginning of 20^{th} century, since that time has lengthened to 70,93 for men and 79,62 for women (data as of 2006). Respectively, the so-called further life duration (FLD) is lengthened, reaching in Poland in 2006 for 60 year old men a value of 21,77 and for women 22,84 years. That is how long, on average, the people shall live who turned 60 in 2006. Dynamics of society ageing in Poland as well as globally is very big. In the beginning of 20^{th} century the percentage of people over 60 in Poland was 6,3%, in 1955 – 8,5% and in 2000 – 16,7%. Prognoses for further years suggest that the

percentage of people above 60 shall increase, amounting to 24,4% in 2020 and 26,7% in 2050.

Problems and phenomena accompanying society ageing have aroused interest of politicians in the past, forcing them to unde3rtake concrete tasks. In its 24th session General Assembly of United Nations in 1969 ordered the Secretary General to make a report on population ageing and problems of old people. Four years later, the General Assembly in a resolution passed indicated the intensification of the process of global demographic ageing. The member states obtained recommendations to create appropriate programmes and actions for this category of people in terms of social policy, assuming economic independence of seniors as priority.

Next important stages in creating foundations for improvement of living conditions of seniors were the Global Assembly on Ageing in 1982 in Vienna and then the second one in Madrid in 2002, as well as the earlier, organised in 1995 in Copenhagen under patronage of UN the Global Summit of Social Development, propagating an idea of society friendly to people belonging to all age categories. The Action Programme, being a result of this Summit, contained an essential message referring to this issue. It was reflected in the statement: "generations invest in one another and participate in results of these investments, being guided by two interconnected principles: reciprocity and equity".

It results that development process must guarantee equal, even access of all age categories to creation of resources, rights and obligations, and people of all ages should be active and represented in social life according to their abilities and needs.

Joining the trend of initiatives undertaken in order to improve the quality of life of seniors, Lower Silesian Council for Seniors at the end of 2006 and during 2007 executed empirical studies which constitute the basis for this diagnosis of situation of the elderly living in Lower Silesia. Analysis of collected research material is an attempt at answering the question what living condition of seniors is, perceived in three aspects: economic, social-cultural and in terms of health. Moreover, its objective is also to indicate those areas in which aid of various institutions and services is needed and to specify the most vital needs of the elderly.

Old age and ageing are notions which have not been unequivocally defined, neither by social, nor by biological sciences. The first of two concepts is perceived as a phenomenon, life phase, whereas the second one is a process. Old age as a stage, state in human life is of static nature, whereas ageing is treated as developmental process, a dynamic phenomenon. According to W. Pędich [2007:3], it is a normal, long-term and irreversible physiological

process, occurring in individual development of living organisms, including a human. Ageing processes, initiated in middle age intensify with passing of years, causing decrease in capacity of organism. And the pace of this process depends on many factors and in individualised to some extent.

Onset of old age is assumed to be at 60 (according to WHO) or 65. Most frequently, for periods of old age are distinguished: 60-69 the period of initial old age; 70-74 transitional period between initial old age and period of reduced physical and mental capacity; 75-84 period of advanced old age; 85 and more – indolent senility. Another classification applied to old age is division of this life phase into two subperiods: early old age (also described as elderly age), comprising the age of 60-74 and late old age (proper senility), comprising the age of 75-89. There is also a category of longevity in persons who are 90 or older as a category of specific biological features and hereditary predisposition to long life [Golinowska et al. 1999: 8-9].

In research in Lower Silesia the definition of old person according to WHO classification was assumed, therefore the study sample included respondents at the age of 60 or above.

In order to assure that research is representative for the area of entire Lower Silesia the following procedure of sample selection was assumed. It was established that basic study unit in scope of which measurements shall be made of data and analyses, shall be a commune.

Selection of study sample had a two-stage character. In the first stage, division of Lower Silesia communes was made with regard to character of communes: rural, rural-urban and urban communes. It was calculated that the following should be selected for research, in proportion to distribution of this feature in dolnośląskie province - 9 rural communes, 7 rural-urban and 4 urban communes and Wrocław as an area of metropolitan[2] character, without which information concerning living conditions of seniors would be incomplete.

[2] Features of city-metropolis::

1. „accepts production factors from abroad, investments, labour, goods and services
2. Hosts foreign companies, main offices and branches of international enterprises, banks, non-governmental institutions, scientific and educational institutions (schools), universities with large share of foreign students as well as diplomatic posts.
3. Exports production factors: enterprises, banks and other social and economic institutions, cultural and scientific institutions
4. Is directly connected by transport network with other countries, with system of motorways, fast railway, international airports
5. Is characterised by intense communication with abroad via mail, telecommunication and touristic traffic
6. Has a developed sector of services aimed at foreign clients: congress and exposition centres, luxury hotels, international schools, high quality office spaces, international scientific institutions
7. In its area there are mass media centres of supranational range (newspapers, magazines, radio, TV) n
8. Various types of international meetings are regularly organised: congresses, exhibitions, festivals, sports and artistic events with participation of international theatre groups

Then in reference to every type of commune the share in per cent was calculated of people who are 60 or above in general population for each commune and results were put in order from smallest to largest values. Then, 5 percentage intervals were created for individual communes and on this basis proportion of communes for random selection was established.

The following communes were randomly selected for empirical studies: rural communes – Wisznia Mała, Głogów, Dobroszyce, Miękinia, Lubin, Zagrodno, Legnickie Pole, Wądroże Wielkie, Walim; urban-rural communes – Chocianów, Środa Śląska, Kąty Wrocławskie, Leśna, Złoty Stok, Węgliniec, Mirsk; urban communes: Legnica, Świebodzice, Zgorzelec, Wałbrzych and Wrocław.

It was planned that in every commune 60 people shall be examined and in urban communes Legnica, Wałbrzych and Wrocław 120 people in each. In general, it was planned to include in the study 1440 Dolny Śląsk inhabitants who are 60 and above. Persons for research were randomly selected with application of random number tables, on the basis of registration data in communes'' possession. Unfortunately, with regard to objective difficulties (lack of financial assets to conduct field research, lack of cooperation from local governments) it was not possible to completely execute research assumptions. Ultimately, research was conducted in 18 communes of Lower Silesia. In general, 1137 people were studied.

The research tool applied in the study was an interview questionnaire with majority of closed questions (where respondent chooses one of proposed possible answers). The research tool included in its subject scope three aspects of living of the elderly: economic, social-cultural and health-related.

The economic aspect involved issues concerning, among others, dwelling situation of inhabitants, composition of household, their financial self-reliance, assessment of their own financial situation, structure of expenses, network of support in difficult situations and shortage of services for the elderly.

The social-cultural aspect focused on the following issues: network of interpersonal relations of the elderly, forms of leisure, professional and citizen activity (opinions of retirement age and professional work after reaching retirement age, activity in social

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9. In its area there are national and regional institutions dealing with international relations and having international brand, like associations, sports clubs etc.
10. Paradiplomation is performed via municipal public or private institutions by agency of own representations in other cities abroad; it is also provided by membership in international organisations, like associations of twin cities, metropolies etc." (Jałowiecki, Szczepański, 2002:224 – 225)

organisations), advantages and disadvantages of old age, attitudes towards old age and life values of the elderly.

The health-related aspect concerned the subject of easy access to general practitioners and specialist doctors, barriers impeding access to healthcare, frequency of seeking medical advice3, type of conditions and diseases facing the elderly, health condition (motor, psychological and mental capacity), taking medications and frequency of health diagnostics.

II. Characteristics of study sample.

720 women were included in the study, which constituted 63.3%, and 417 men (36.7%). The largest age category was people between 70-74. 255 respondents belonging to this age category were involved in the sample, which constituted 22.7% of the sample. Furthermore, 239 people in the age of 65-69 were subject to questioning (21.3%), 221 respondents in the age of 60-64 (19.7%), 203 persons in the age of 75-79 (18.1%) and 82 persons after the 85^{th} year of life (7.3%).

Among the studied subjects there were 630 inhabitants of rural areas, which constituted 55.5% of the sample and 505 people living in towns (44.5%). Among town inhabitants the most respondents (59.7%) are people living in large cities with population above 100 thousand, 17.1% respondents live in towns with population of 21-50 thousand, 10.5% of the sample live in towns with population of 6-20 thousand and 12.6% of studied sample live in small towns up to 5 thousand inhabitants.

On the basis of obtained results it may be stated that level of education of seniors in Lower Silesia is not very high. In the sample, the most numerous category consisted of people with primary education (53.1%) and incomplete primary education (5.0%) – jointly they constituted nearly 60% of the sample. Persons with vocational education constituted almost 1/5 of the sample (17.9%). Almost the same number of respondents had secondary education (17.2%). The least numerous categories were persons with above secondary (1.4%) and tertiary education (4.6%).

Statement that seniors belong to one of the least educated categories is also reflected in results of National Census [2002]. According to information collected therein 58,7% of Lower Silesian population at the age of 60 and above had primary education at the most. Reasons for such state of things may differ, depending on individual choices and conditions, one may however indicate several system reasons at the foundations of this situation. One of

them is definitely historical time[3], in which today's seniors grew up (persons who turned 60 in 2007, the youngest among the sample, were born in 1947 and persons who turned 85 were born in 1922). The diversity of educational patterns, first and second world war, the period between wars and post-war, characterised by significant unpredictability and lack of stability – all those factors did not favour achieving high level of education.

It is also worth indicating consequences which are brought about by low level of seniors' education. One might suppose that such people face more difficulties with adjusting to changes in the modern world, particularly with regard to the fact that the world in which they functioned for most of their lives has been subject to radical change since 1989. System, economic, cultural changes, Poland's membership in the European Union have significantly modified modern reality. In societies, which Sztompka [2004] calls "hot", where changes progress quickly, reaching significant dimensions even on intra-generation scale, new technologies and inventions very quickly become outdated, pushed away by even more perfect solutions and gadgets. The elderly as a rule use civilisation advantages to a lesser extent than younger generations. On the one hand, seniors not always have need to apply complicated gear and technical novelties in daily life, on the other hand, complexity of the matter and huge range of choice is the reason for the fact that most seniors, for fear of own incompetence reduce to minimum using new technologies. It may be inferred that the lower the education level is, the more problems with understanding principles of modern world and the more resistance to apply modern solutions and technologies.

Level of education also influences a preferred lifestyle. Better educated persons more often apply principles of healthy lifestyle, try to eat properly, supplying their organisms with necessary nutritional values, take care of their health and control its condition, do sports or other kinds of physical activity and are able to avoid negative effects or minimize their adverse influence. Therefore, better educated persons are of relatively better health and live longer [compare e.g. National Health Programme for 2007-2015:10].

It is also worth remembering that civilisation changes occurring nowadays in Polish society are the reason for the possibility that in twenty, thirty years we will deal with a completely different type of senior – well-educated, active, aware of their rights, desiring to pursue their passions and hobbies also in old age. Thus, we already must consider, diagnose and propagate solutions which shall meet changing needs of this social category.

[3] Historical time (social) is construed as dimension of duration of human communities, abstract framework of social existence of individuals and communities.

III. Economic aspect

Living conditions of seniors in Lower Silesia

Living conditions of the elderly living in Lower Silesia have been specified on the basis of several indicators, both describing a living situation of this social category and constituting a subjective assessment of some of its aspects. Measurement of living conditions included dwelling situation, composition of household, financial situation, including a degree of financial independence, structure of expenses and self-assessment of material situation. Moreover, the respondents were asked about a network of support in difficult life situations and scope of services lacking for seniors.

Dwelling situation. Composition of household.

The elderly people subject to study most often lived in detached houses – such an answer was chosen by 41.8% of respondents. More than 30% (33.2) of respondents resided in own apartments, 15.3% lived in municipal apartments, and 5.0% of respondents lived in housing community flats. 6.6% of the sample lived in separate rooms in their children's places and only 1.3% shared the room with other people. The above data indicate that living conditions of seniors are good, most of them have at their disposal sufficient living space, even in the situation when, living with other family members (most often children), dwelling space is rather divided by convention than strict rules into "impact zones", only a small number of seniors (every 13th) might have problems with satisfying their needs in this regar4d.

Owning a property (building or apartment) holds several measurable advantages. It is a location of capital and form of security in case of unpredicted financial difficulties or lack of financial assets in old age, which with propagating solutions concerning various forms of providing an entity with appropriate material conditions after retirement[4] gains more significance. On the other hand, being a property owner is associated with necessity of making necessary repairs, maintenance, which is related with financial expenditure. The larger the property is, the higher the tax, problems may also arise due to high charges for use of rooms. Elderly people may have more difficulty keeping a property in good condition, especially if they live alone or have limited contact with their families.

Research shows that inter-generation bond is still strong in Polish families. A significant number of seniors lived with their families, keeping common household. Such a

[4] E.g. reverse mortgage, i.e., to simplify, life-long pension in return for property act of the estate.

response was indicated by 44.4% of the sample. More than 1/3 of the sample (34.5%) lived with their spouses. Self-reliant household was kept by 1/5 of the elderly (20.2% of indications). Only a little below 1% indicated a different living situation.

Women most often lived alone or with their families, which is probably related to the excess death rate of men in old age. After dearth of a husband/partner a woman is forced to keep own household or, which is more common, lives with her children. Also in rural areas multi-generation families keeping their join t households are a more popular phenomena than in towns, which mainly results from nature of work in the field and inheriting the household by children after retirement of their parents.

In social perception it is the family that is most responsible for assistance and care for seniors [compare Dyczewski et al. 1999], particularly in senility period, when various kinds of afflictions and disability make it difficult or impossible to function on one's own. Therefore, living with a family constitutes one of the strategies of dealing with problems of old age.

Sometimes, keeping a common household by the elderly is not a matter of choice, but necessity. Various family problems (like poverty, lack of employment, single parenthood, high prices of purchase or renting a flat, various pathologies) cause children not to leave family home, to start their families and then both parties are "forced" to live together. On the one hand, such a situation may be favourable for a senior, when younger family members take care of them and fulfil their needs, on the other hand however may bring about tensions and problems, including family violence.

Living conditions of seniors. Equipment of household.

It results from research that living conditions of seniors are good, and access to basic installations is almost common. Apartments of 86.7% of the sample have bathrooms, 80% of the sample had access to hot running water, 86.9% of households had gas and 73.7% used water and sewage system. At the same time, more than 1/5 of the sample reported that they have access to toilets in a staircase – 15.1% and toilet outside – 7.6% of indications. Comparing this number with a number of indications specifying having a bathroom, discrepancies in received results are visible. Probably it is the effect of such a situation of a respondent, that having a bathroom in the apartment they additionally have access to toilets in the staircase or outside. Such a situation sometimes happens in old buildings or in rural areas. Therefore it may be supposed that in fact lack of direct access to bathroom refers to 10% of the sample (9.4%).

Also research of GUS [2008] confirms that most households of retired persons is equipped with necessary installations. Having a bathroom with a bathtub or shower was declared by 85.7%, access to hot running water by 86.8% and to gas from grid or the bottle even up to 82.3% of general number of households of retired people.

It may be observed that place of residence differentiates access of respondents to basic installations. Seniors living in towns more frequently indicate access to gas and sanitary system, whereas people living in rural areas more often have a toilet outside, and independently of place of residents, percentage of respondents indicating access to bathroom is comparable.

Equipment of household in household appliances may be an indicator of satisfying and at the same time differentiation of needs of various categories of respondents. There are several goods which also for seniors are basic household equipment. These are: a refrigerator (98.8%), colour TV (93.4%), vacuum cleaner (88.9%), automatic washing machine (82%) and telephone (82%). Nearly 1/5 of the sample use a mobile phone (17.3%). Fewer people, because only every 7^{th} person uses a VCR (13.4%) and every 10^{th} – a DVD player (10.8%). The smallest number of respondents also uses such equipment as CD player (6.1%), computer (6%), dishwasher (4.9%). Internet access is indicated by lea than every 20^{th} respondent (4.1%). Therefore, respondents distinguished two main categories – basic goods, used by majority of the sample and "luxury goods", serving satisfaction of needs associated with culture, entertainment (so-called higher needs) or showing good economic situation of the household.

Men more frequently and more eagerly use "technical novelties". ¼ of them have a mobile phone (women – 12.87%), 1/5 a VCR (women – 9.51%), 15.42% - a DVD player (women – 8.11%). Almost 10% of men have a CD player (only 4.34% of women), 8.19% a computer (7.76%), 6.51% a dishwasher (women – 3.92%). 5.3% use Internet (3.36% of women). Moreover, town residents more frequently declare using "luxury" equipment than inhabitants of rural areas. Also education level has impact on possessing "luxury goods" – e.g. up to 44.23% of people with higher education use a computer (and only 1.79% of persons with incomplete primary education and 2.03% with primary education). The older the respondents are, the more seldom do they use various household appliances.

Also GUS research concerning living conditions in Poland indicate that the most popular household appliance among the retired is a fridge – 96.4%, colour TV – 95.7%, stationary telephone – 77.5% and automatic washing machine - 69,7%. Nearly 40% of households of the retired have a mobile phone and 18.8% cannot afford it to due to lack of

financial assets. Computer is in every 7th household and almost every 4th household would like to have it, but has no money for its purchase. It is similar with other equipment which may be specified as "luxury" goods. In many cases the elderly would like to use technical facilities and entertainment devices but have no such possibility with regard to budget limitations. And so, 35.1% would equip their house in home cinema sets, 30.6% with DVD players, 30.7% with dishwashers, nearly the same number would buy a microwave oven if they could afford it and 22.9% would like to have Internet connection. It results from these data that also seniors are a social category who would gladly use many consumption goods if it was not for insufficient financial assets at their disposal.

Financial condition of the retired persons in Lower Silesia.

Sources of income. Types of expenditure.

In assessment of seniors' economic situation its relative stability is often emphasized, resulting from the fact that retirement benefits are granted for life, so the elderly have certainty that they shall receive monthly a certain amount which will allow them to satisfy their needs to a lesser or greater extent. Almost all examined persons declared financial self-reliance. For majority of respondents the source of income was retirement benefit (80.4%) and pension (15.6%). Employment as source of income, basic or additions, as declared by only 3.3%. a small percentage of seniors, not having their own income, were supported by their spouses (1.8%) or by closest relatives (0.3%). Only 2.2% indicated other sources of income.

However, it must be remembered that households of the retired and pensioners usually have average or low income. According to data from GUS [2008], average annual net income per person in households of the retired amounted to 10.234 PLN, which gives 852.8 PLN monthly. ZUS quotes that in 2007 average monthly retirement benefit was 1346.52 PLN, which constituted 59.2 of average remuneration and this value decreased in comparison with 2006 by 4.4%.

Such financial situation of the elderly causes limitation of purchasing capacities of their households. It results from the study that seniors in Lower Silesia most frequently spend money to satisfy basic needs – food, charges and medications. More seldom do they assign financial assets to purchase of garments and footwear and appointments at specialists. Even less money is spent on fulfilling cultural and entertainment needs – purchase of books, magazines, theatre, cinema or concert hall. A remote place in household budgets is also occupied by expenses on alcohol and tobacco. The most seldom was assignment of a part of household budgets to holiday trips or to sanatorium.

Among medications, the most often bought were those prescribed by doctors, much more rarely the examined subjects bought medications from TV commercials or recommended by others, family, friends or neighbours.

Financial condition of seniors from Lower Silesia does not differ significantly from a general situation of this category of society. Also other research concerning structure of expenses confirms that most expenses of seniors' households are expenditures on food, residence and utility charges, medications and other health needs. The elderly, due to limited financial capacity rarely use gastronomy services (90% of the retired never or hardly ever eat main meals outside [CBOS 2005], rarely use active forms of leisure and tourism. In 2005, the retired spent nine days on average relaxing outside their place of residence [CBOS 2005]. The most frequent purpose of the journeys outside place of residence is visiting relatives or friends, recreation, religious purposes. Elderly people rarely are clients of travel agencies. Tourism of the elderly, so popular in Western countries, in Poland still is a marginal phenomenon.

With regard to limited budgets, basic criterion taken into account by the elderly when making consumer selection is price. Food shopping is most frequently done in small shops where goods are handed by a shop assistant, then in self-servicer stores and supermarkets, garments and shoes are purchased in small shops and markets [CBOS 2004].

More than 62% of the retired would not be able to cover an unexpected expense of 500 PLN from money at their disposal, 75% declare no possibility to finance a week-long recreation with family once a year, 83% - replacement of worn furniture and 64.5% - buying clothes of better quality [GUS 2008].

Almost a half of households of the elderly had to reduce their expenses assigned to treatment and expenses related to cultural life, purchase of books, magazines, theatre, cinema, concerts etc. [CBOS 2006]. Having limited assets, seniors in the first place fulfil basic needs, reducing expenses on higher needs. It is worth remembering that in some cases benefits received by an elderly person is the basis of income of a multi-generation family, and sometimes its only source, which significantly decreases possibility to fulfil needs, even basic ones [see Zabłocki et al. 1999, Tarkowska 2000, Laskowska – Otwinowska 2000, Halik 2002, Korzeniewska 2002]. We may then talk about "prolonged parenthood" [see Dyczewski et al. 1999: 33], which is based on systematic financial and material assistance of seniors towards their adult children.

At the same time seniors are the social category which with regard to financial stability is less threatened by poverty. Most indicators of social consistency show a privileged position of the elderly in this regard in comparison to other social categories.

Looking into the future it seems however that also behaviour in terms of consumption shall evolve. People from middle and g=higher class shall also enter retirement age, being better educated and situated, with aroused consumption needs. One should suppose that such a situation shall contribute to development of market of goods and services aimed directly at this age category. At the same time, for those seniors who cannot afford self-reliant fulfilment of higher needs the cultural, entertainment and touristic offer should be created which would enable them to actively participate in social life, which certainly could contribute to improvement of life quality.

Assessment of own material situation

Research authors consciously resigned from questions concerning income amount and other indicators allowing for estimation of objective material situation of seniors in Lower Silesia, adopting an assumption that subjective assessment of own financial condition is an equally good criterion and does not cause discomfort in respondent, which sometimes happens with financial and property issues. Thus, respondents were supposed to assess their financial situation choosing one of five options. Each option was supported with explanation of how it should be understood. And thus, "very good" situation means that a person fulfils all their needs without paying attention to prices and is able to save money for future; "good" – a person fulfils all their needs but is not able to save money; "average" – a respondent lives modestly but their assets are sufficient to fulfil all needs; "bad" – a person only fulfils the most essential needs, pays bills and purchases only the most needed articles and products; "very bad", when a respondent does not have enough money even for basic needs.

Most respondents assessed their financial situation as average (47.2%), they live modestly and therefore are able to fulfil their needs. At the same time, 1/3 of respondents (33.6%) assessed their situation as economically unfavourable, assessing it as bas (27.6%) and very bad (6%). Percentage of people who positively assess their financial situation is 19.2%, 17% expressed opinion that their household is in good condition and only 2.2% said that their situation is very good. Taking into account results it may be said that about 80% of the respondents must rationally dispose of their budget and to a larger or lesser extent limit fulfilment of life needs with regard to limited income at their disposal.

Men more frequently with greater optimism than women assess their financial condition, probably because on average retirement benefits and pensions are higher for men, therefore it is easier for them to fulfil their needs. As good and very good financial situation was assessed by 22.76% of men and 17.15% of women, bad and very bad by 28.08% of men and 36.82% of women. Seniors in the age of 60-64 and persons after 80 are most satisfied with their financial condition. Also, education level is also in favour of being satisfied in these terms – persons with secondary or higher education are generally more satisfied with living conditions than persons with lower education level.

Also national research confirms that the retired live on average (money is sufficient for daily expenses but they must save for more serious ones) and modestly (they must very carefully manage their assets on a daily basis) [CBOS 2006]. 82.9% of the retired indicated smaller or greater difficulties associated with "making ends meet" with income at their disposal, only 17.2% stated that it is relatively easy [GUS 2008].

Strategies of coping with difficult living situation

Research team, considering various aspects of life of seniors in Lower Silesia also searched the answer to the question, what the support system of elderly people in their local communities is like, whether seniors have someone – a person or institution – where they can turn for help in case of difficulties.

The answers to this question paint the following picture. Persons in difficult situation in the first place would seek support with family members, it is a statement consistent with other results obtained in course of this study. Which confirms a strong position of family in the framework of value system and its almost constant presence in seniors' everyday life.

In the second place a social aid centre would be found, and this result should be approached with certain reservations. One should remember that in most communes research was performed by employees of social aid centres, which could be the reason for respondents to somehow "politely" more frequently choose this answer. Supposition that obtained result did not come from the so-called "researcher effect" seems to be supported by results of other research conducted in Lower Silesia, where commune and its structures were indicated as one of basic sources of support in case of life problems [see Kurzępa, Lisowska, Pierzchalska 2008]. Still, in order to unequivocally establish to what extant public services, including local government units are perceived as a support link, in-depth studies should be conducted.

As next in turn the respondents indicated that they would not turn to anyone, probably because they do not have persons trusted enough to ask them for support or they do not want

to cause trouble to others with own problems. In the fourth place there was the answer "friends". Seniors would also try to solve their problems on their own, not including any third parties in the process. In further places there would be entities belonging both to informal "order" (neighbours, former colleagues) and formal (doctor, priest). Most seldom would elderly people seek for help in non-governmental organisations and with environmental nurse.

In particular, low position of a priest and NGO as links of social support may come as a surprise. It seems that the elderly relatively seldom perceive a parish priest as someone to whom they may turn for help. Perhaps it results from shyness or reluctance to "bother a clergyman with own problems", although it seems that in social awareness a gradual division takes place of sacral functions of the Church and its representatives from its aid/charity functions and identifying church institutions exclusively with former ones [see also Kurzępa, Lisowska, Pierzchalska 2008]. It is an interesting issue, yet it would require in-depth exploration in order to formulate clear conclusions. Also NGOs do not constitute an essential element of support system for seniors. It may be assumed that this observation constitutes a sort of failure for NGOs, which were unable to reach seniors and remain a poorly recognised component of social reality. Perhaps it results from the fact that a relatively small number of NGOs directs their actions at the elderly, although also in this regard the situation slowly changes.

Shortage of services for seniors

Quality of life is a derivative of ability to fulfil various needs in one's everyday environment. Fulfilling needs relates to existence of proper infrastructure, due to which it becomes possible. Thus the elderly were asked what services in their opinion are lacking in their environment, assuming that the answer shall also constitute an intermediate indicator of life satisfaction of seniors in Lower Silesia.

In their answers most people (26.67%) stated that no services are in shortage and elderly people may fulfil all their needs. Simultaneously almost the same number of people (24.69%) indicated lack of places where the elderly could meet. This answer indicates that seniors are no different than other categories of society in their need to contact other people and yet they have fewer opportunities to initiate and maintain those contacts. Thus, entities responsible for execution of local social policy should take it into account. 1/5 of the sample complain about lack of healthcare centre in place of residence, 1/6 (14.38%) indicate lack of social aid centre, almost the same percentage (13.44%) would like local offer aimed at the elderly to be expanded with house aid, 9.79% would like to be able to order a meal to their

house, almost the same number believe that medical pedicure is the lacking service. Other proposals were much less popular.

Thus, it may be stated that about ¼ of the sample did not have problems with fulfilling their needs in social surroundings where they live. At the same time in reference to almost ¼ of the sample it may be said that they have problems fulfilling their need of affiliation, one of basic human needs. Having a bond with others, desire to belong to a group, social acceptance also for seniors is an issue of basic significance. Exclusion from local community or loneliness are very painful for the elderly. Seniors also indicated deficits in fulfilling needs in terms of health and care. It is worth remembering this information while shaping local social space.

Inhabitants of rural areas emphasized that there are no healthcare centres in their localities. At the same time it is noticeable that deficit in fulfilling infrastructural needs was paradoxically, more often indicated by inhabitants of towns rather than rural areas. People living in towns more often indicated a necessity to supplement this offer with such services as phone shopping, medical pedicure and creating a social aid centre. At the same time, both respondents in rural areas and in towns emphasized a need to create places of social meetings where seniors could spend time, exchange views and participate in life of local communities.

Feeling of safety.

Need of safety id one of basic needs of human beings. In Maslow's hierarchy of needs [2006] it is in the second position, just behind physiological needs. Anyway, most psychologists dealing with needs place it in one of the first positions, considering its fulfilment as main condition of proper personality development [see e.g. Murray, Obuchowski].

It results from the studies that majority of the elderly in Lower Silesia have a feeling of safety. It was not precisely put what is understood by a researcher by notion of safety, respondents were allowed to assume a definition on their own, therefore various definitions of safety are possible: economic, emotional, lack of threats in public or everyday life. Threat was experienced by every 10^{th} respondent (10.4%). Town inhabitants in a slightly larger extent indicated that they do not feel safe. The highest level of threat was perceived by persons in the age of 65-69 (14.22%) , and the lowest – those in the age of 85 and more (4.94%). Perhaps in the former case we deal with a situation when suddenly many life circumstances change (retirement, sometimes losing someone close, illness), a person feels a clear boundary between stage of life "which ends" and the one "which begins". Many people experience the

end of relative stability, entering a period of uncertainty, when they have to define anew their situation, which may be associated with feeling of threat and lack of safety. The elderly in turn have a stabilised life situation, therefore they may not feel as many tensions as "younger" seniors.

Most people who do not feel safe as a reason gave a threat of crime, aggression from which they could not protect themselves (47.12%). Another reason for lack of safety is fear of health deterioration – 20.19%. those people on the one hand are afraid of suffering and on the other would not want to be a burden for close relatives, who would have to give up or limit some of their needs because of their condition. Certainly, these fears are supported by fear of deterioration of financial condition (9.62%), also with regard to increased treatment expenses.

Other reason for loss of feeling of safety is fear of loneliness (5.77%) and for 2.88% it is fear of losing someone close. Men more frequently expressed their fear of health deterioration, whereas women are more worried by their financial situation and trouble which may appear in this area, they also more frequently express fear of loneliness and abandonment. Significant percentage of town inhabitants express their fear of exposure to criminal act or aggression, whereas inhabitants of rural areas feel fear of health and material situation deterioration.

Conclusions

1. Living conditions of seniors in Lower Silesia are good and living situation stable. Owning a property (a house or apartment) may be a location of capital and form of security. Most apartment are equipped with basic installations and household appliances. The situation is worse with the so-called "luxury" equipment.
2. Family is one of the most important elements of seniors' life and precious support in case of a disease or limitation of ability. However, one must consider the fact that structure of modern family evolves, family bonds are loosening, particularly in case of labour migration to faraway locations in county or abroad. In perspective such a situation may cause an increase in demand for care services, provided by public institutions and NGOs.
3. Financial conditions of households of seniors in Lower Silesia is stable, although most respondents define it as average and bad. The elderly cannot fully satisfy their needs, with regard to budget limits they must reduce them. In the first place they assign them to food, exploitation charges and health expenses, they limit or give up satisfying higher needs.
4. In case of life difficulties seniors would turn to families first, which confirms its key significance for seniors.

5. In general, seniors are satisfied with infrastructure existing in their place of residence. An important need, the realisation of which faces some problems in local community is need of affiliation. Seniors report a necessity of creating places of social meetings, where they could initiate and maintain relations with others, feel affiliation with a group and build bonds with local community. Creating possibilities in favour of social integration should constitute an important element of local social policy, realised for seniors.
6. Most seniors have feeling of safety. Threat is experienced by every 10^{th} respondent. Among the threats danger of crime and aggression was mentioned most often, along with fear of health deterioration and financial situation.
7. An important factor influencing functioning of seniors in Lower Silesia in the modern world is low level of education, causing problems finding one's place in changing reality. In the perspective of 20, 30 years this situation shall probably improve, which shall pose new challenges to social system to create such solutions and opportunities which shall meet needs of a senior of "new type" – well-educated, aware of their rights, active, wanting to realize their passions also in old age.

IV. Cultural aspect

Social-cultural world of an elderly person, filling his living space gives a deeper meaning to existence, raises its value, building a feeling of relatively high quality of life. Social-cultural world of an elderly person is created not only by the external environment of care and aid centres, cultural institutions, cultural offer in place of residence; it is also created by human internal environment: their life philosophy, preferred values, attitude to own old age, executed model of life, activities in free time, social contacts.

Elderly people should also feel responsible for this picture. Their attitudes, lifestyle shall determine this image, as a result a subjective impression of own health. In practice, seniors generally lose in confrontation with ever-present "cult of youth". They also lose with their own awareness which makes it impossible to build "psychological wellbeing".

The world changes fast. The roles and place of the elderly in society also change, once granted due to age. Civilisation development, IT revolution, social-cultural changes have nowadays become a source of change of a role and social status of the elderly.

The negative stereotype of old age is a harmful image of this stage of life, functioning in social mentality. As a consequence, an elderly person is identified with lack of orientation in the modern world, inability to solve own problems, inability to use modern technology, as a result with withdrawing from active social life, i.e. executing a passive model of life.

It is one picture – social assumption which is a contradioction, to some extent, of cultural value of old age.[5]

But there is also another image, in which an elderly person is identified with activity, life wisdom, resulting from experience and knowledge of life, still wanting to participate in social-cultural life. This second image articulates positive attributes of old age.

Those two ways of thinking are also confirmed by the position of gerontologists, who besides "theory of activity" propose "theory of withdrawal" as two, somehow opposed strategies of ageing.

Nowadays, activity is socially appreciated value. Therefore, leaving a choice to an elderly person, one should create a model of active old age, confirming the theory of "constructive old age" proposed, among others, by theoreticians.

Activity of an elderly person is becoming a fundamental factor determining size and shape of living space. This living space, besides own activity, is built by social environment, i.e.: world of other people, local, neighbouring, family environment. Nowadays drastic limitation is observed in dimensions of living space of elderly people in which they have functioned so far, mainly caused by pace of changes occurring in "hot" societies [Sztompka 2003].

It is a serious social problem, because social age is for old people an expression of their social situation. Unquestioned authority, professor S. Rembowski in the book titled "Psychological problems of ageing" wrote: "a really old person is the one who ceased their social contacts". Thus, old age is also a problem of changes caused by reaction to all things happening in social environment of an ageing person. Scopes, nature and hierarchy of social activities change. In other words, an elderly person must adjust to new social and cultural situation. Therefore it is so important that elderly people participate in social life, serving solving generation conflict (building "generation bridges"), counteracting alienation ("social death"), giving chance to activity.

What image of social-cultural life of seniors in Lower Silesia is presented by analysis of collected data? Research in this scope was supposed to give answers to the following questions:

What do respondents associate old age with?

What attitudes have they assumed towards this stage of life?

What social contacts do they maintain – in what forms of social activity do they participate?

[5] Cultural value of old age is construed as life experience, considerate judgment, distance to all changes, objectivity in perceiving reality, finally analytical reflection.

How do they spend their free time?
What values do they prefer in life?
How do they assess their own psychological condition?
What needs require social support?
What would they like to change in their lives?
Would they still like to work (potential professional reactivation)?
What changed in their life after retirement?

Definitions of old age. Attitudes toward own old age

Old age, in other words late adulthood, elderly or senior age is an inconclusive notion, not uniform for everyone, it is a movable period of life. Nowadays a phenomenon may be observed of 'deferment of old age", which means moving it to a further plan of life. Therefore, old age is a relative concept, difficult to specify conclusively. Certainly one must take into account three dimensions of old age in the process of ageing: physiological, psychological, social. One can feel physically old (with regard to regressive changes in the organism) and psychologically young (with regard to good psychological condition).in course of history one can certainly specify two images of old age: negative and positive, which is mentally confirmed by this environment.

The examined persons see old age as a period of deserved rest (57.51% of responses), award for effort put in life so far, for professional family and social activity undertaken until retirement. Thus, respondents perceive old age mainly as a period of withdrawal from certain elements of life and slowing down existence. This opinion however does not mean that a senior is ready to totally give up activity, it is rather a rejection of strenuous and tiring duties in favour of focusing on pleasant sides of daily life. For 41.41% of the sample old age means health deterioration. Reaching a certain age "favours" increased occurrence of various conditions. Multi-disease condition is characteristic for old age, seniors pay attention to this disturbing aspect of old age. 36.49% of the sample do not give any connotations to old age, treating it as yet another stage of life, neither better nor worse than the previous ones. Almost the same percentage (36.23%) assumed that old age is time for family and close ones. Seniors also demand their life wisdom, wanting to share their experience (over 1/5 of responses). Development possibilities are confirmed by perceiving this stage of life as a period of reflection (also more than 1/5 responses).

Much fewer persons (11.36%) perceive old age as the time when one can devote themselves to free development of interests and hobbies, passions which there has been no

time for until now, seeking new forms of self-expression, own humanity. It seems that old age as the period when one is not too burdened with duties and has a lot of free time should favour development of various forms of intellectual/cognitive activity.. discovery and nurturing passions favours "good ageing", keeping organism in good physical and mental condition. Therefore it is worrying that such a small percentage of people who see old age in this way.

On the other hand, however, some hope is brought about by the fact that even fewer people see this period in a negative way as time of abandonment and loneliness (8.5%) and period preceding death (7.25%).

Women more often perceive old age as the time when their health deteriorates, period of reflection and time for family and the close ones. Men favour possibility of developing interests and hobbies (5.64% of difference). Older respondents more rarely chose the answer that old age is a period of sharing life experience. Perhaps persons on old age more often are not self-reliant, dependent on others and as such cannot see themselves in a role of authority or mentor whose opinion counts for others. With age also a number of people decreases , for whom old age is time of development of interests and hobbies. Even persons who are 70-74 and older marginalise significance of this aspect of old age. Together with age also negative perception of old age increases – a number of people grows for whom it is a period of health deterioration, period preceding death, there are fewer people who believe that this is the time devoted to family and close ones – here relation is rather reverse, it is the family that starts being responsible for fulfilling needs of elderly persons.

With higher level of education of respondents larger emphasis is put on seeing old age as period of development of interests and hobbies, period of sharing life experience and assume this time to be another stage in life. It seems that high level of education favours perception of old age through activity – persons with higher education most rarely answered that this is time of deserved rest, time of loneliness and abandonment, a period of health deterioration, time devoted to family and close ones and period preceding death (only 1.92%).

Residents of rural areas emphasized such definitive areas of this notion as health deterioration (less access to healthcare, more bothering afflictions etc.) and more time for family and close ones, which probably is associated with a structure of rural family, which more often consists of many generations. Therefore persons professionally inactive have possibility to take care of grandchildren or other family members who need such care. Town residents on the other hand more often treat old age as another life stage, no worse and no better than others and see it as time of development of interests and hobbies.

In summary, it must be emphasized that the sampled respondents present definitely passive way of life, characterised by: dependence attitude, defensive (claiming) attitude. To a small extent do they confirm a constructive attitude. Place of residence (rural area or town) does not differentiate a position in this matter. A little better image of old age appears in responses of women, which confirms study results so far, where women more easily adapt to this period of life. Developmental image of old age most often refers to better educated people.

Changes for better after retirement

Over 20% of the sample declare that nothing changed in their life after retirement. Lack of significant changes is emphasised by about 1/3 of the sample (32.06%). Can we interpret this fact as feeling of satisfaction with life, continuation on the same level as previously? The respondents are glad about regained freedom, lack of burdens (26.3% of responses), emphasise value of free time (20.07%) gained for themselves (18.68%), for family and friends (18.68%) for 12.73% a change for the better is possibility to devote time to rest. Every 10th respondent emphasises gaining financial stability. Only 6.69% of the sample say that they can devote themselves to developing their passions and hobbies and 3.81% have more time for their pleasures and entertainment. Similarly as in the case of defining old age also here percentage of persons seeing changes in the context of personal development is limited.

Men more often than women said that they have more time and possibility to focus on own interests and hobbies after retirement, and women said that they have more time for themselves. Certainly reaching retirement age favours decrease in number of duties associated with professional and private life. Women may also think about fulfilling their own needs.

Town residents more often stress possibility of developing hobbies and more time for family and friends. Residents of rural areas indicate financial stability obtained when retiring. It is a special value for them, particularly with regard to the fact that work in field is associated with fluctuation of income, derived from weather conditions, crop and demand for products.

Changes to worse after retiring

Bad consequences of retiring most frequently refer to health deterioration (49.53%) and deterioration of financial situation (41.98%). What is interesting, lack of changes to the worse is confirmed by more than 1/5 respondents, here men are in advantage. Every 6th

respondent (15.95%) indicated loneliness and limitation of contacts with others as an aspect of professional passivity/turning 60. Only 4.1% of the respondents indicated boredom and lack of activities, whereas mood deterioration, bad mood was shared by 2.33% of the respondents. Loss of the close ones referred to 2.05% of the respondents.

Women more often mentioned health deterioration, men were more optimistic, declaring that they do not see any negative changes in their lives. Town residents more often complained about health deterioration, residents of rural areas perceived stability of their life situations, frequently not seeing changes to the worse.

In order to diagnose moods of seniors in Lower Silesia the respondents were asked the question if they had a period in their lives longer than 2 weeks during which they were unable[6] to perform free time activities. Almost 40% (37.8) said yes.

Town residents more often indicated such problems than those from rural areas. At the same time nearly a half of the respondents (46.7%) indicated that there are periods (more than two weeks) when they worry about future – own, close ones and surroundings without a specific reason. Answer yes to this question more often was given by women and town residents. The older the respondent, the more often they answered yes to the question. More than 40% (41.7) respondents indicated that for a longer time they felt sad, upset, thought about death. Women more often were subject to such thoughts and feelings.

It is worth mentioning that feeling sadness, depression refers to over 41% of respondents, women to a larger extent. Place of residence does not differentiate this phenomenon. It may prove not very good psychological condition (psychological health) of seniors.

Preferred values

Values in broader meaning are life goals, objectives. As a result they answer questions about desires or aspirations of the elderly. Values of seniors shape their needs. A source of a person's needs are their values.

Most generally, we can talk about primary needs of biological nature, about higher needs, i.e. psychosocial and cultural needs (need to experience creation, beauty) the fact is undoubted that elderly people to live and feel well need more than fulfilment of primary needs, no less important are higher needs, which build a meaning of life. Cultural world, filling the living space gives a deeper meaning to existence, raising its value.

[6] Term „was not able" does not mean an objective situation, e.g. lack of time, but subjective attitude, psychological lack of disposition, lack of will and power.

And what is the list of needs, expectations of respondents, resulting from preferred values? Family, including friends is the most important (82.21%), in the second place is health and feeling well (62.1%). Then respondents indicated peace and rest (35.14%) and religion and religious values (34.79%) among the most important values 1/5 respondents mentioned money and financial stability (21.53%), honesty and sincerity (19.75%). For 11.12% the value was hard work and professional conscientiousness. In the end values were mentioned associated with homeland and patriotism (9.96%) and the fewest people, only 7.21% indicated love as important life value.

It turns out that having family and good relations with family gives people in Lower Silesia most satisfaction. Family environment plays a determining role in fulfilling needs of the elderly. It seems that this is not the money as it is generally believed, are the most important to have a good life according to seniors. And in accordance with negative stereotype of old age it is believed that senior mostly want higher retirement benefits and medications for free.

Emotional life of respondents may be disturbing, since love as value came at the end of choices. Perhaps this is why the elderly are said to be "emotionally impoverished". And psychological wellbeing is built through ability to exchange emotions. Still respondents might have understood this notion as love between a woman and a man, seeing it as a part of sexual life. And "love has many names". In life of the elderly people emotional life, exchange of emotions and closeness is undoubtedly just as important in building life satisfaction as for people in other age categories.

Women more often indicated health and feeling well as precious life value, higher than men they valued religion and religious values. For men hard work and professional reliability had large significance. Those differences may result from different socialisation patterns of women and men. According to those women are closer related to a private sphere and its values and men are closer related to a public sphere.

No significant differences are noticeable between responses of residents of towns and rural areas, certain traditionalism of rural communities shows through giving more significance to religious values. Religion as value is also indicated by the eldest persons (85 or more), at the same time they least value money and financial stability. Education of respondents differentiates answers to this question more strongly. Persons with higher education emphasize meaning of hard work and professional reliability and put more emphasis on patriotic values. They do not see rest and peace and material stability as so important human values.

Postulated changes in seniors' lives.

Respondents asked what they would like to change in their lives, most often answered "nothing". One might wonder whether such a response results from satisfaction of respondents with own life situation or from any other motivation.

Aspirations or dreams seem modest. 1/5 (21.2%) would like to improve their health, almost the same number (18.7%) would want improvement of their material situation. Basically, those answers exhaust the catalogue of postulated changes. a much smaller number of respondents answered differently. 5.93% do not want changes since they are satisfied with their life situation. 5.56% would like to be able to go on a trip, have possibility of travelling, see something new. 4.26% dream about changing their place of residence, 2.87% would like to "be young", 2.78% would like to improve their relations with others, family, close ones, 4.44% declare that they cannot change anything, assuming attitude of helplessness with reference to own life.

Women more often would like to improve their material and living situation (they usually have lower retirement benefits, so they may more often face economic difficulties). Men do not want to change anything. The older the respondents, the more seldom they would like to improve their material situation, at the same time the eldest persons, 85 or more, more often than other respondents believe that they cannot change anything. Town residents would wish to imp[rove their health and residents of rural areas more often would not change anything in their lives. People with higher education more often than others would like to be able to travel, to actively spend autumn of life.

It seems that 1/3 of respondents show tendencies to a rather positive life balance, their expectations refer to basic needs of adults: health, material safety. Not always do they reveal their dreams, hidden needs, do not see chances for a change.

Social activity

Life satisfaction of the elderly is a derivative of broadly understood activity, also in social sphere. In this area, study results confirm earlier mentioned passive way of life of this social category, as almost 90% of respondents do not participate in any social organisations. Only 4.01% of respondents actively take part in social organisations, it mostly refers to men, town residents. This low activity in associations is complemented by work in church organisations, which by definition are reserved for the elderly, here only 3% operate, mostly women living in rural areas.

Only 3.6% attend places with offer for the elderly –the so-called senior clubs. It refers to both women and men. Persons relatively younger. Low result may be explained by frequent lack of such an offer in a place of residence.

The requirement to join in peer group for health and feeling well does not deliver in case of seniors from Lower Silesia. Research confirms the fact that frequent physical and mental regression of the elderly is not only a result of inevitable ageing processes but has its reasons in lack of activity, also social, contacts with others. Alienation, lack of participation in life of local community leads to marginalising this age category. Life of the elderly is most often limited to the circle of the closest family, friends and neighbours. Most seniors do not seek contact with local community and need to take part in a broader social circle is not stimulated. On the one hand it results from a stereotype that a retired person is way past period of activity and cannot give anything valuable to society. It is a view which limits both sides: the elderly have no need to exceed a narrow circle of issues of the closest surroundings and community cannot notice the potential of elderly people and advantages which their participation could give community they live in. Thus a senior, even if they want to join a social organisation, faces lack of opportunities or lack of ideas to manage their initiative, which causes their discouraged withdrawal from this area of life. It results from pilot research concerning voluntary work in Wrocław, conducted in 2007 by Social Policy Office in Dolny Śląsk (Lower Silesian Centre for Social Policy?) and Municipal Office in Wroclaw that persons above 65 constitute the least desired category of volunteers. Entities using work of volunteers would rather accept a minor volunteer than the one who is 65 or older.

It is true that among factors limiting social activity one may distinguish internal ones (dependent on the elderly) and external, of social and cultural nature (independent of them). It is mainly lack of appropriate offer in the environment and lack of openness of existing associations towards the elderly ("cult of youth"). In order to change this unfavourable situation it is important to undertake local initiatives which may change passive way of life to active one, opposing obstacles increasing with age, sometimes only apparent, which impede previous spontaneous activity. Difficulties also result from lack of ability to bond with others. Sometimes the elderly see relations with others through the image of deeply rooted division to "own people" and "strangers", treating the latter as a potential threat to own safety. Therefore it is necessary to create for them occasions to pursue reasonable psycho-physical activity, often described as "youth potion". Because affiliated people live longer .[7]

[7] Report from the research by professor Borysławski, presented in the conference (book in print).

Social contacts. Network of interpersonal relations

Undoubtedly, in order to realise most needs of the elderly it is necessary to maintain social contacts. We could enumerate all advantages of that for seniors. Therefore, what is the network of interpersonal relations of seniors in Lower Silesia like?

Describing frequency of contacts with other people one can notice that seniors most often have contact with persons with whom they bond informally: with closest family, neighbours and friends. As a criterion of frequent contact the following responses were assumed: everyday, several times a week, several times a month, which means that a given person at least once a month met a mentioned subject in a cafeteria. And so, 88.84% frequently meet family and children, sporadically – 8.99%, never – only 2.18% family environment is closest to the elderly, its significance is undisputable. Ordered family allows for easier adjustment to changing life conditions. It gives sense of safety, allows being useful and needed, is the best "care institution".

84.92% often contact their neighbours, sporadically 5.64%, every 10^{th} person has no contact. For more than a half of seniors friends play an important role in everyday life – a frequent contact is declared by 55.89%, sporadic – ¼ (24.55%). At the same time almost 1/5 of respondents (19.75%) have no friends, which may be disturbing, since friends are an important link of support in a difficult situation, they give advice, help and emotional support, and research shows that every 5^{th} senior is without such support.

Persons who are past the period of professional activity rarely maintain contacts with former colleagues – frequent contact is declared by only 19.21% sporadic – by 32.8%, never – 47.99%. loss of former social roles and associated status often is the reason for expiration of those contacts.

Analysis of relations with formal subjects (priest, employee of healthcare centre, social aid worker) shows that contacts with them are rather sporadic. The elderly most often meet workers of healthcare centres – frequently 37.83%, rarely 41.63%, never 20.54%. here we can ask how well general practitioners are prepared to take complex care of the elderly. It seems that so far a complex preparation of doctors in public healthcare centres to work with the elderly is not very common yet.

1/5 of seniors (22,96%) declare frequent meetings with a priest, sporadically – 57.31%, never – 19.72%. Most rarely the elderly meet social aid workers. Only 3.55% declare a frequent contact, sporadic – 14.36 and 82.09 % declare no meetings at all. Taking into account manner of organisation of social aid system in Poland, such rare contact of the elderly

with social aid workers indicates that in general seniors in Lower Silesia do not face big life difficulties and are self-reliant. This statement results from the fact that intervention of social aid system usually takes place when someone cannot solve life problems on their own. However, it is also a sign that local community does not create situations in which such a contact would take place. The role of social worker should be not only intervention during crisis but also initiating and taking actions of integrating nature, which shall enable the elderly to take bigger part in life of local community. However, social worker not always is aware that they should animate local environment and lacks preparation to perform such tasks.

These not very varied social contacts confirm previously mentioned passive, home-centred lifestyle. And closer and further social environment constitutes a significant element of life space of the elderly, counteracting their alienation, feeling of exclusion (is it real or apparent loneliness?).

Furthermore, new areas of social exclusion appear, resulting from civilisation development, including IT domain, inaccessible with regard to deepening "IT illiteracy" among the elderly. In this case first of all members of a close family may be helpful breaking stereotypes and barriers that the elderly cannot learn anything new and new technologies are foreign to them by definition. A good example of this phenomenon is application of computer, Internet and Internet communicators by the elderly, whose children emigrated abroad looking for a job. Spatial distance and need to maintain contact somehow "forced" the need in seniors to use modern ways of communication, and their first and often only instructors in this area are younger family members.

It is worth emphasizing that seniors express an immense need to obtain skills in terms of computers, Internet, mobile phones, multimedia equipment or ATM service, wanting to more fully use technological novelties in daily life.

Transmission of cultural values is not a one-way process in this case. Also seniors have their life experience, knowledge of family and national traditions, knowledge and skills to offer to younger generations. Building "generation bridges" not only in own families seems to be one of the key elements of integration of the elderly with local community. It is worth creating initiatives in terms of which the elderly will be able to meet the youth, both parties will have the opportunity to meet one another gain a chance to eliminate mutual stereotypes and build attitudes based on respect. It would allow avoiding or softening the effects of generation conflict, intensifying in the period of fast cultural changes, when a younger generation internalises new cultural patterns, different than patterns typical for the older generation [Sztompka 2003].

Forms of spending free time

Free time is an important resource of an elderly person, who should devote it to themselves, to family and others (social contacts). Its value is measured with forms of activity filling it. literature of the subject assigns it several functions, like developmental (foreground), recreational and entertaining. Leisure of the elderly should not be "empty" but "experienced".

The most frequent form of spending free time by seniors is watching TV 82.7% chose this option. Almost 60% (58.6) devote their free time to walks and resting outside. Almost the same number read books and magazines (57.8%) and meet family and friends (55.41%). Form of activity of the elderly is also being in the garden (46.73%). Almost 40% use their free time for resting (36.9%). Some devote their free time to family, taking care of grandchildren (24.29%), helping children run a household (20.04%) or taking care of a sick person in the family (7.98%). Every 6^{th} senior meets friends in their free time, every 10^{th} indicates that they are bored, every 10^{th} declares that they do sports and watch videos or DVDs. Only 3.46% of seniors declare that they actively participate in social activity. Other forms of spending free time were not appreciated by seniors. Only 3% go to cinema, theatre, concert hall, spend time in a cafe, restaurant or takes care of their hobbies. Men more frequently indicate watching TV and recreation outside as forms of spending free time, they also more often suffer from boredom and do sports. They more often than women spend time in restaurants, cafes and pursue their hobbies. They also are more involved in social activity. Women on the other hand are more devoted to family life, take care of grandchildren and help children run a household and do handiwork. Town residents more frequently devote their free time to reading books, magazines, watching films and contacts with family and friends. In the free time they also take care of a sick person in the family and actively participate in the life of local community. Residents of rural areas more often declare that they stay in the garden, rest (sleep) and help children run the household. Life in rural areas certainly entails fewer opportunities of active spending free time, therefore, in comparison to town residents, seniors from rural areas more often complain about boredom.

Views of seniors on professional activity

Life of an elderly person focuses in most cases on family and fulfilling family roles. Other social roles move to the background at this stage of life. In Poland retirement is not treated as unpleasant obligation, moving away to the background, but rather as a privilege [see Halik 2002]. Retirement is perceived as a reward for hard work and a guarantee of

financial stability, although the amount of benefit does not always allow for release from financial problems.

Ageing of the society poses new challenges for European countries. It is estimated that in 2050 a half of Europe's population shall reach retirement age, which means that in labour market 160 million employees will go missing. This situation becomes an impulse to discussion concerning functioning of labour market in the future and problems which are carried for social systems by increase in a number of people in post-production age. Questions such as decreasing number of the professionally active, low birth rate , growing expenses for benefits for a growing number of professionally passive people, growing expenses on healthcare benefits deepening marginalising of the elderly slowly become most important in discussions concerning the future of Europe, as elements threatening stability of social and economical systems of European countries. In order to eliminate unfavourable influence of those factors EU accepted Lisbon Strategy, in which it included a requirement of increase in employment rate up to level of 70% in 2010 and in category of workers at the age of 55-64 up to the level of 50%. Increase in employment should be aided by various kinds of activation programmes aimed at professionally passive persons, trainings, workshops and other activities aiming at raising qualifications of working people and motivating them to function as long as possible in the labour market. Poland, as EU member state also participates in execution of Lisbon Strategy and scale of challenges facing our country in this domain is enormous. Employment rate in Poland is about 53%, whereas an average for the EU is 64%. At the same time, employment rate of people in the age and other proposals aiming at keeping an employee as long as possible in the labour market, appearing in discussions, are not supported by Polish society.

Views of seniors in Lower Silesia concerning employment at retirement age are divided. More than a half – 53.1% assumed that the elderly should not work after reaching retirement age, however an opposing opinion was presented by 46.9% of seniors.

Studies of opinions on retirement age show that the elderly are not in favour of increasing a statutory period of professional activity. Most seniors believe that retirement age should be set earlier – 46.9% and as it is now, women at 60 and men at 65 – 48.8%. only 1.6% said that retirement age should be set later. Women more often than men indicated that people should retire at an earlier age, whereas men more frequently said that current retirement age is a good solution. Concept of lowering the limit of retirement age found followers among town residents, residents of rural areas more often expressed opinion that present solutions are optimal.

With reference to common opinions on shortening the period of professional activity or keeping it on existing level, an opinion of persons with higher education is different. 12.24% of seniors with higher education believe that people should retire at a later time (whereas indications of other education categories were about 1%). Large majority of respondents believe that women should retire at 50 (70.2%). Almost 20% even further lowered the limit of retirement age down to 50 (19.2%). Current retirement age (60) had only 5.4% of supporters. Only 2.5% of seniors expressed opinion that women should retire at 65. Women more frequently said that retirement age of women should be established at 55 and 50, men also expressed a similar view but to a greater extent they supported maintaining retirement age on a current level. Opinion that women should retire at 55 was dominating among residents of rural areas. Only persons with higher education were in favour of rising retirement age of women to 65.

Also with regard to retirement age of men most respondents said that current retirement age should be lowered by 5 years, down to 50. At the same time a requirement of lowering retirement age of men down to 55 was expressed by almost 20% (18.9%) of seniors. Women more often than men lowered their retirement age by 10 years, men in turn assumed a position that employment period should be shortened by 5 years. The concept of increasing retirement age up to 70 was not very popular, only persons with higher education more often than others chose this option (12.5%), also they more frequently than others indicated 65 as limit of retirement age.

Views of seniors in Lower Silesia on this issue area similar to opinions in Poland. Most people interviewed during other studies share the view that retirement age should be lowered, almost a half of respondents believe that men should retire at 60 and 67% would like women to end their professional activity at 55 or earlier. At the same time a large majority, 80% believe that retirement age of men and women should not be equal [CBOS 2005].

In order to change those deeply rooted beliefs in social awareness (research from 2003 gave almost identical results), one should create several instruments motivating the elderly to remain in labour market. First of all employee potential should be strengthened by creating an a constant education system, enabling raising qualifications, acquiring new skills and providing employees with psychological support, opposing professional burning out and discouragement. An important element supporting activation of the elderly in the labour market should be propagation of introducing in companies and institutions elements of age management (like adjusting work positions to needs of the elderly, creating training packages, adjusting scope of duties to capacities of the elderly, skilled use of experience and

competence of a worker, in other words: a redefinition of an elderly worker). An important strengthening of activation of seniors in labour market should also be creation and promotion of new, more flexible forms of employment (part-time work, telework, work on weekends, work from home). As it is shown by Finnish experience, with involvement of public entities. Employers and social partners, creating a system combining elements of labour market, education and health deterioration prevention a country may significantly increase professional activity of the elderly which contributes to lowering risk of economical and social destabilisation.

Conclusions

In order to improve a social and cultural condition of seniors in Lower Silesia one should focus on the following tasks:

1. Environmental activation in compliance with EU standards, requiring a rich offer serving maintaining and stimulation of activity (all kinds of clubs, associations, support groups, activity centres etc.) together with voluntary work. A reactivation of the elderly should be facilitated, as autumn of life may be a period when new tasks are organised and executed, new goals are assumed and new interests pursued. It is searching for an adequate and satisfactory replacement of lost roles.
2. Free time, very often "empty", occupied by TV, must become "experienced". Here free time centres are needed, advisory and information in this scope.
3. Access to information and various legal services, due to which protection of autonomy of the elderly shall be possible, as well as using care and right to social support, particularly in cases for more and more violations against them on the predatory service market.
4. Building a new awareness – education to old age, being work on consciousness, involving preparation for retirement. A change of retirement act is required. It demands maximum prolongation of professional activity, according to EU standards (incapable of working receive pension). Almost half of the sample would like to work. Keeping ability to live independently is prolonging activity period in all dimensions: biological, psychological and social. It also must take into account modern technologies to counteract deepening phenomenon of "IT illiteracy" (hence important Universities of Third Age created in the Lower Silesian towns as posts of education in old age).
5. Gerontological advisory as giving support which shall enable creative life, solving everyday problems. Developing mutual help with a formula "an elderly person for an elderly person" as social self-aid in place of residence.

6. In prevention programmes psychosocial content should be more prominent next to medical content. Elderly people should be granted conditions in their place of residence to have reasonably independent life, on appropriate level and help solving crisis situations, characteristic for this stage of life (like spouse's death, bad medical diagnosis, acquired disability)
7. Reorganisation of environmental social aid. Particular attention should be paid to cooperation of GPs with social aid workers. Information on rights and social aid must come from both these sources.

V. Health-related aspect

Ageing society poses a challenge for health policy of the state and requires taking proper actions. Firstly, some attitudes of younger social categories are disturbing with regard to seniors, intensified by changes resulting from transformations after 1989. It was expressed by members of Minister's Geriatrics Team in the meeting in April this year with Minister of Health Ewa Kopacz. Vitality of the young and fit, still healthy and working is contrasted with small presence and activity of old people in Polish society. Many times, seniors are automatically segregated to the professional inactive category, which intensifies helplessness and results in dependence on the younger generation. These categories in an essential way differ in opportunities to work for consumption goods. In societies ageing so fast as in Poland, leaving decisions to the young may lead to discrimination resulting exclusively from the difference in age.

This phenomenon of discrimination with regard to age, so stereotypical – negative thinking about the elderly as people characterised by mental rigidity in their views, limited incorporation of skills and may other behaviours caused by growing old was called ageism by Butler in 1969 [Derejczyk, 2000]. A subtle bong identifying "us the young" with "us the old" vanishes. Subconscious fear of old age causes enjoyment of the young when they realise differences between them and "the old". A radical attitude is negation of necessity of helping the elderly and duties associated with caring for them, as well as criticising economic privileges which are demanded by the elderly.

In societies of Western civilisation this situation, because of increasing number of the elderly forces some solutions which aim at limiting such discrimination. If we treat accumulating health disasters and diseases of old age as predictable state, then actions of the state, caretakers or family, leading to improvement of senior's life should be perceived as family and social debt which society repays to its ageing citizens. Realising this aspect

of ageing gives all society members a chance to have dignified old age and decreases risk of ageism.

We must be aware of the fact that change in approach of society towards old age shall not be easy. Loosening bongs in multi-generation families, growing zone of poverty among unemployed, more prominent consumption attitude among Polish people and deficits of assets for healthcare and social aid shall cause violations of old people's rights.

Ageism is painfully visible in medicine. Its symptoms are limitations of access to diagnostic methods, negligence in treatment and rehabilitation, bad conditions for hospitalised patients (dying rooms), treatment without accounting for variances in impact of medications, negligence in executing recommended treatment, neglecting lack of patient's consent to applied treatment. All this leads to infantilism, depersonification and full social degradation of an old sick person. Senior with multiple conditions, often poor, without established system of financing healthcare has great difficulty finding a place where they would be treated subjectively and obtain proper medical care. Often such care comes too late.

Thus, holistic, complex approach to an elderly person is needed, guaranteeing understanding their problems and giving a basis for effective help. As soon as in kindergarten children must be taught that they must fully accept old age in others. If child understands early enough what mechanisms they shall be subject to while ageing and how they can modify them with their conscious behaviour, then instinctive fear of old age of his own and of others shall weaken.

Diseases encountered in people after 70 have other form, epidemiology and require broadened interdisciplinary knowledge to be effectively treated. Elderly sick patients are the greatest economic burden to healthcare systems. They have tendencies to overusing medications, their large consumption, improper self-treatment, frequent use of counselling, frequent hospitalisations. They have multiple conditions and are subject to more traumas. In the oldest categories (85 and older) and even earlier diseases coexist requiring participation of a caretaker in daily functioning of a sick person. These are: dementia, depression, diabetes, infections, blindness/partial blindness, Parkinson's disease, deafness and motor disability. Need of home care permanently increases costs of monthly care, regardless of medications.

Principles of proper social care of seniors are contained in Standards of Geriatrics prepared by leading Polish specialists in geriatrics:

National consultant professor Tomasz Grodzicki, M.D.; Vice-President of Polish Gerontology Association: professor Barbara Bień, M.D.; geriatrics consultant for Silesian province Jarosław Derejczyk, M.D.; head of Szpital „Dziekanka" in Gniezno: Andrzej Jóźwiak, M.D.; President of Committee of Specialist Doctors in Geriatrics in Poland: professor Katarzyna Wieczorowska – Tobis, M.D.; employee of Faculty and Clinic of Internal Diseases and Geriatrics of Collegium Medicum UJ in Cracow: Alicja Klich, M.D. and president of Wielkopolskie Association of Palliative Care Volunteers Anna Jakrzewska – Sawińska, M.D..

Both demographic, social and economic arguments (separation of old age pathologies) pose particular requirements to all medical practice, and in particular to GPOs, the fulfilment of which depends of observing basic principles of geriatric care: These are:

COMMON CARE, i.e. access of all old people to benefits of healthcare system on equal rights with younger age categories.

ACCESSIBILITY OF CARE (physical and economic), i.e. proximity of healthcare facilities to place of residence and free provision of diagnostic, treatment and rehabilitation services including highly specialised procedures.

LONG-TERM CARE, i.e. constant care resulting from long-term ageing process and chronic nature of co-existing conditions.

QUALITY OF CARE, i.e. application of professional gerontological knowledge, regardless of type of healthcare facility. It requires raising professional qualifications of doctors and nurses in terms of geriatrics, both in undergraduate and postgraduate studies.

COMPLEXITY OF CARE, i.e. HOLISTIC APPROACH TO SOLVING SOCIO-MEDICAL PROBLEMS OF THE ELDERLY [Comprehensive Geriatric Approach]. It is based on a complex approach to solving problems of the elderly with participation of specialists from various domains (GP and specialists, environmental nurse, social workers, therapists etc.) this approach is aimed at assessment and improvement of functional state of an old person (functions of daily life, motor, emotional and cognitive), which allows them for self-reliance and autonomy in environment and better quality of life. Additional principle is respecting patient's autonomy and providing them with access to social aid system.

Only a general practitioner, practising on level of basic healthcare is able to face all principles of geriatric care. GP takes care of all persons who trusted them, they are or should be most accessible on a daily basis, as they practise in local community, they care

in a constant and long-term way, so they are obliged to have at least minimum competence in terms of geriatrics and knowledge of standards of gerontological assessment. Regardless of motivation, willingness or skills GP in fact becomes a geriatrics specialist of the first degree. Faculty and Facility of Family Medicine of Medical Academy in Wrocław organises courses, trainings, symposiums and geriatric sessions in Assemblies of Family Medicine and Geriatric Academy.

Coexistence of multiple conditions, multi-organ changes with effects of operations and traumas increases diagnostic difficulties, particularly with patients who are mentally or physically disabled. An additional factor impeding early diagnosis and treatment is concealed and atypical disease presentation. It is a result of weakening defence mechanisms of ageing immune system, slowing down or decreasing inflammatory response to pathogens (like lack of increase in body temperature) which leads to delay in symptoms and atypical clinical course.

For the same reasons slowing down and limitations in recovery period must be taken into account, as well as being prepared for complications and unfavourable effect of medications applied in course of co-existing conditions.

Another feature of pathology of elderly age are nutrition disorders, particularly with regard to vitamins, macro- and microelem4ents. These are favoured because of mistakes in nutrition of the elderly, absorption disorders or medication interactions, and symptoms of vitamin and mineral deficiency may mimic diseases or be attributed to symptoms of ageing.

Iatrogenic syndromes, i.e. unintended effects of pharmacological treatment are particularly dangerous for the elderly, with regard to the well-known fact of overusing medications by seniors.

Environmental conditions are an important factor responsible for many pathologies in the elderly. Neglecting medical history concerning living conditions, nutrition, material, care situation, functional capacity may lead to breakdown of even most properly planned medication therapy. Diagnosis of environment with assessment of degree of self-reliance in daily life (making meals, shopping, purchasing and control of proper medication intake, sense of safety, using facilities at home etc.) is a basic condition of appropriate therapy.

The Geriatric Giants belong to particularly difficult therapeutic and care-related situations in place of residence of the elderly. They are typical for late old age polyetiological syndromes of senile disability. Among them are motor impairment, balance disorders, falls, depression, dementia, sphincter function disorders, mainly incontinence

and iatrogenic post-medication syndromes. Their presence, often complex, to a large extent absorbs attention of a GP and entire team of environmental care. Moreover, in many cases requires a carer for a sick senior. Diagnosing causes jointly responsible for their presence is difficult in terms of basic care, as it requires many additional tests and specialist consults, only available in higher reference facilities.

Currently works are in progress concerning change of approach to care of elderly people and creating a system which would provide its optimal and balanced functioning. One of planned actions is introduction of mandatory nursing insurance, assets from which would be assigned to nursing care of disabled patients. Nursing security would involve both benefits in kind and nursing allowance for organising care in own scope. Seeking system solution is a necessity, because for the last 20 years we have been observing shortening of period of professional activity, which on one hand is associated with late starting a job (around 20) and with its interruptions (maternity leaves, nurturing leaves, unemployment periods), as well as relatively early retirement and acquisition of pension rights. On the other hand, prolongation of average life expectancy (ALE) consequently causes shortening the period of paying insurance premiums and prolongation of period of their use, and decrease of the amount of collected assets [Błędowski 2006]. One should also remember that last three years of human life consume 2/3 of all life health costs [Derejczyk].

In searching for new solutions, combining rational spending of assets with quality of healthcare, with current demographic indicators ageing of society and development of geriatrics becomes a necessity, also for economic reasons. In the study "Prospective comparative analysis of effectiveness and costs of treatment between internal diseases wards and geriatric wards" authors, analysing and comparing only 2000 patients, indicated vital differences in favour of properly organised geriatric care [Derejczyk et al. 2008] on the basis of data of RUM of Silesian Division of National Healthcare Fund for 2004-2006.

Health-related aspect, which is supposed to answer the question how elderly people assess functioning of healthcare system (including its availability) and own health its risks and assistance obtained in scope of the system, constituted one of the basic issues of conducted studies.

Assessment of health of the elderly is a complex issue and requires discussion of various data concerning not only morbidity rate, but also fitness and physical capacity. Authors decided to assess health by intermediate data, i.e. data resulting from demand for healthcare services and subjective impressions of respondents. Subjective sense of comfort

or discomfort is assessed in the aspect of availability of healthcare and type of the subject's condition. Objective data are results of fitness tests and tests assessing respondent's self-reliance and their awareness of suffering from defined diseases (diagnoses by a doctor) and amount of taken medications.

Availability of public healthcare doctor. Frequency of using help of public healthcare doctor.

Results show very good availability of a GP (93.4%), identical in rural and urban areas, regardless of age and sex of a studied subject. Only analysis with regard to education indicates that people with higher education relatively more often assume that their access to GP is more difficult. This result may indicate higher expectations and requirements from this category of respondents with respect to healthcare system.

Obtained results are satisfactory with regard to the earlier studies by Bieniowa [1995] and Wąsiewicz [1995], which indicated lack of acceptance in case of about 50% of elderly people of the current healthcare system and intended changes. perhaps the differences result from the period of quoted research (the nineties).

It is not known if prese4nt result signifies a particularly high quality of services of a GP in Lower Silesia or if it is a general phenomenon in Poland. One might suppose that result from Lower Silesia rather does not differ significantly from general results in Poland [see Halik 2002], but confirmation of this judgment would require a thorough exploration.

More than a half (54.1%) of the sample use assistance of GP once a month or more often. ¼ of the sample has appointments with GP once a quarter, 12% once or twice a year, only 10% (9.1) visits a doctor more rarely than once a year. Most frequently people at 60-74 visit the GP, rarest appointments are with the youngest – 60-69.

One may wonder if such a high percentage of people visiting a GP at least once a month reflects real needs of the elderly to obtain basic medical services or whether doctor appointment fulfil also other needs of patients, outside medicine. Of course obtaining a clear answer exceeds capacity of this study. It seems however that this is an important matter, requiring further thorough studies, because knowing real reasons of seniors visiting a GP and attempt at "management" by other subjects of extramedical needs might take some burden off the healthcare.

Main reasons for visiting a GP.

Leading reasons of visits at GP are afflictions associated with diseases, believed to be most frequent in old age: circulatory diseases – 70.2%; motor system- 35.0%; diabetes – 14.2% and disorders of digestive system – 9.1%. If answers concerning the awareness of suffering from chronic diseases are subject to analyses, then distribution of 4 most common diseases is different: circulation diseases – 82.1%, diabetes – 22.7%, kidney failure 11.0% and pulmonary diseases 10.8%.

Polish data [Kocemba, Życzkowska 2000] show that four leading health problems of population above 65 are: heart and vascular diseases – 75%, motor system diseases – 68%, pulmonary diseases – 46% and digestive system – 34%. Differences in comparison of those studies may have several reasons.

- Differences in methodology of discussed studies,
- Differences in defining diseases and conditions by respondents, like bone pains or using orthopaedic equipment may not be identified with motor system disease,
- Constantly progressing detectability of diseases, including e.g. kidney conditions.

Leading position of circulation diseases does not require comments and is a commonly known and recognised condition of the elderly. However, differences between Polish data, quoted by Kocemba [Kocemba, Życzkowska 2000], and those obtained in study in Lower Silesia, indicating increase in frequency of visits and diabetes incidence may result from two causes. One of them is improvement in detectability of this disease and better control. It is known that inaccurate glucose tolerance is diagnosed in every second patient in the age of 60-85 and that it generates three times more doctor's visits in comparison with people of the same age without diagnosed diabetes [Sinclair, Croxon 2003]. The second cause may be a co-existing atherosclerosis and/or obesity, influencing a relatively high percentage of diabetes patients among seniors in Lower Silesia– unfortunately, it cannot be established on the basis of a tool applied in the study[8]. Global data estimate diabetes incidence on the level of 9-30%, but upper values refer to a race other than Caucasian [Klich – Rączka, Obiorek 2000, Koczorowski 2008]. Above 80 incidence decrease is noted and thus decrease in doctor's appointments in the world and in data obtained in research in Dolny Śląsk, which is associated with higher earlier fatality rate of people suffering from diabetes [Sinclair, Croxon 2003].

[8]Research of obesity issue in Dolny Śląsk, conducted in 2002 on the basis of data given by respondents have shown that threat of overweight and obesity grows with age. Normal BMI was noted in 34.3% of the examined persons in the age of 65 and older, overweight – 42.9% and obesity – 21.7% [Zatońska, Waszkiewicz, Bolanowski 2006].

Access to a specialist. Frequency of the visits.

If accessibility of a GP is high for all categories of age and place of residence, situation is completely different in case of visiting a specialist. 37.7% of interviewed persons have problems with getting to the specialist. Basic difficulty in free access to a specialist is lack of places and long waiting period – such a view is expressed by a large majority of respondents (80.1%). Much fewer people complain about other difficulties – problems moving around (28.1%), too high costs of the visit (20.9%), lack of specialist in the area (17.9%) and difficulties with transport (11.9%). Women more often indicated difficulties associated with movement, transport difficulties and too high cost of a visit which makes access to a specialist difficult. Town residents more often complained about lack of places and long period of waiting, while residents of rural areas emphasized lack of specialists in their area and transport difficulties. Residents of rural areas are often forced to travel long distances because there is no particular specialist in their area, and lack of proper transport infrastructure additionally limits their possibility in this scope. Therefore accessibility of specialists such as: neurologist, gastrologist, oncologist, endocrinologist and rheumatologist is better in towns.

Respondents much more rarely use help of specialists in comparison with GPs. Once a month or more often every 10^{th} respondent visits a specialist (11.9%), once a quarter 1/5 (20.7%), once or twice a year 28% and less than once a year – 39.3%.

Main causes of specialist appointments are cardiological and movement problems. In the next place are the needs of oculist and neurological consults, than kidney functions. There is a strikingly small demand for dentist consults, shown regardless of analysed age, gender, education of place of residence. It is compliant with reports on health of Polish seniors, whose lack of teeth, lack of dentures and lack of hygiene of oral cavity are common [Koczorowski 2008]. With regard to obtained results there is a small percentage of the sample visiting an oncologist. Statistical data show that neoplastic diseases are the second cause of death, after circulatory diseases, of people over 65 [see GUS 2007]. Such a result may prove too late diagnoses of neoplastic diseases or neglecting such diagnostics with elderly people, which is the reason for the fact that relatively small number of people have a chance for oncological treatment. It seems to be an important area to change health policy in this scope.

Respiratory diseases.

Pulmonary diseases are declared by 105 seniors from Lower Silesia which is 9.2% of the sample. Bronchial asthma prevailed, than chronic bronchitis. Bronchial asthma more often

referred to women. Women also more often suffered from lung cancer. No substantial differences were noticed between rural and urban environment, except for higher lung cancer incidence in urban population. Global tendency was visible in the study of increased incidence of neoplastic lung diseases in women. The phenomenon is on the one hand explained by quicker decisions concerning quitting smoking among men, and on the other hand – underappreciated issue of passive smoking, definitely more frequent in women [Connolly, Gosney 2003]. With increase of lung cancer incidence rare lung X-rays are disturbing, as a basic diagnostic test. In the year of the study only 6.8% of respondents had lung X-ray performed, in the last two years – 31.5% of seniors and 17.1% in the last 4 years.

342 interviewed seniors admitted to smoking habit (30.7%), three times more often these were men. Number of smokers is the same in urban and rural population, decreases with age and, what is interesting – increases in proportion to education. Now it is believed that obturative pulmonary disease (COPD), often referred to as "bronchitis" resulting mainly from exposure to cigarette smoke affects over 40% of elderly smokers [Connolly 2003]. A global problem is its average thirty-fold underestimation in all age categories. In our study this problem is noticeable: smoking was declared by 111 elderly women and 231 elderly men – and only 11 persons stated that they suffer from bronchitis, but from COPD up to 197 persons!

Besides increase risk of pulmonary neoplastic diseases COPD is a second, after a trauma to muscle and bone system reason of serious deficit of seniors' physical agility [Connolly 2003], which is not commonly taken into account in healthcare policy.

Gender

On the basis of obtained results we can state that women are more prone to fall ill than men. Perhaps it may be explained by excessive mortality rate among men in earlier age categories, therefore those who live until old age are healthier than women, who are nowadays characterised by longer average life expectancy, but not necessarily in complete health. More serious health problems of women cause increase demand for health and social benefits. Those and other economic aspects, associated with advantage of female gender among the elderly create a phenomenon of feminisation of old age – term used to describe current demographic changes [Błędowski 2008]. Women more often used advice of GPs than men. The reasons for those were circulatory and motor system diseases, diabetes, than digestive system disorders and neuroses. Women more often suffer from diabetes and higher mortality rate is quoted due to vascular complications [Sinclair, Croxon 2003]. Women also

report a greater demand for endocrinological, orthopaedic and rheumatologic consults, whereas men – urological and pulmonologic.

Age

People most often seeking medical advice are seniors in the age of 70 – 74 (65,5%), then people in the age of 75 – 80 (about 57%). The reason for consults are circulatory diseases, then degenerative changes in joints, diabetes, digestive system and pulmonary diseases. Frequency of heart and vascular problems increases with age, requiring the most assistance from GP in people at the age of 70-80. It is similar with conditions of motor system – almost a half of seniors older than 85 seek help of GP for this reason. This age category needs most health benefits in terms of specialist consults (orthopaedic, rheumatologic). Mobility and transport difficulties are a problem more often reported by seniors older than 80. Risk of fall, dizziness and gait disorders are also a frequent feature of ageing, hence these vents increase with age and are one of the important elements determining lack of self-reliance of elderly persons.

Frequent visits with GP for diabetes mainly refer to people in the age of 70-85 and decrease by a half in people older than 85 (earlier mortality due to the disease). Pulmonary and digestive system diseases are reasons for visits mainly in younger age category (60-69). What is interesting is the increase in frequency of visits at GP due to diseases of the eyes in age category 80-84, which also correlates with the greatest demand for oculist consults among people of this age.

Education.

Data analysis with regard to education reveals significant influence of education on health and kind of healthcare services.

Only 37,5% of persons with higher education frequently seek advice of a GP, as compared to seniors with secondary and primary education. Persons with higher education however show the highest percentage of sporadic visits – it may mean that they contact a GP only when specific problems appear: planned control, sudden condition, necessity to obtain a referral. Perhaps high percentage of GP visits from people with lower education results from their helplessness in interpreting symptoms or lack of discipline in application of doctor's recommendations. Better educated seniors indicate a greater demand of specialised care – particularly oncologist and gynaecologist. Persons with lower education more frequently report transport and cost difficulties with regard to reaching a specialist. Also the category of

seniors with lowest education is most exposed to falls, fractures and dizziness. Data of study authors are not sufficient to explain such a significant impact of education on mobility, susceptibility to traumas and thus self-reliance of seniors. Moreover, such diseases as diabetes or kidney conditions also show dependence on education level – diabetes most often referred to people with lowest education, kidney failure – people with vocational and secondary education.

One can only speculate that the reason for such a state may be a less active lifestyle, harder work or worse social conditions of less educated people.

Common performance of basic tests

EKG is a basic test in circulatory diseases. Circulatory diseases are a leading pathology of old age. In our study within the last year EKG was performed on 13.4% of seniors, and in the last 2 years almost on a half of respondents.

Chest X-ray – in the year of the study it was only performed on 6.8% of respondents, in the last 2 years on 31.5% and in the last 4 years on 17.1%.

Basic lab tests (urine, morphology, sugar) were performed in the year of the study only on 21.5% of seniors, in last 2 years on 46.5%. at the same time 18.4% of respondents could not remember if they had ever had such tests performed.

Presented data indicate insufficient basic diagnostics of seniors in Dolny Śląsk, comparison if numbers of performed tests with frequency of diseases of old age which should be monitored by these results shows insufficient control of health of the elderly.

Taking medications by seniors in Lower Silesia

Up to 75,7% respondents regularly take medications. No differences were shown with reference to place of residence, but there is a slight difference in terms of gender – women more often declared regular pharmacological treatment. Almost 98% of the sample declared that they take medications prescribed by a doctor. However, percentage of herbal medications (available over the counter) in the analysed issue of regular treatment increases after the age of 70 and most frequently concerns women, persons with secondary and higher education, living in towns. 292 persons regularly take 1-3 medications, which constitutes 25.7% of the sample and 34.4% among those reporting regular medication. 257 respondents regularly take 4-6 medications, which constitutes 22.6% of the sample and 30.4% among those reporting regular medication. 108 respondents regularly take more than 7 medications daily, which

constitutes 9.5% of the sample and 12.7% among those reporting regular medication. More women were among those taking more than 4 medications a day.

It results from this list that the greatest threat of polypragmasia was shown among people with higher education and among females. Polypragmasia is a very dangerous phenomenon in old age, since it generates a lot of side effects, which subsequently may be treated as another disease. For example: improper treatment of hypertension may cause orthostatic hypotonia, which in turn increases risk of falls. Tranquilizers may lead to increased risk of falls and dizziness, which in turn may lead to taking other medications for improvement of cerebral circulation and so on. Grodzicki quotes studies of drug interaction in elderly patients: taking two medications is associated with slight risk of interaction and side effects – only 5.6% cases, but with 5 medications – every second person shall experience adverse effects and with 8 medications – side effects are inevitable [Grodzicki, Kocemba 2000]. Another aspect of polypragmasia is increased risk of errors in proper execution of treatment. American study, quoted in geriatrics course book [Abrams, Beers, Berkow 1999] has shown that even 60% among 220 persons after 60 made mistakes taking medications, of which 40% of errors might have caused serious complications, including hospitalisation.

Conclusions

Assessment of healthcare services in Lower Silesia

1. Research has shown very good availability of GP in the assessment of seniors.
2. Availability of specialists however is not satisfactory for seniors – the problem is particularly noticeable in rural areas and in particular refers to such specialists as neurologist, gastrologist, oncologist, endocrinologist and rheumatologist.
3. Availability of rehabilitation is worse in rural areas.
4. Frequency of performing basic diagnostic tests in old age is insufficient for proper control of circulatory, pulmonary, kidney diseases and diabetes.

Assessment of health of seniors in Lower Silesia

1. Seniors in :Liower Silesia very frequently suffer from circulatory diseases – up to 82.1% of the sample reported problems with circulatory system, which seems to be too high percentage in comparison to global estimates [Aronow 2003]. It would be recommended to find reasons for such frequent incidence of circulatory diseases and implement prevention programmes.
2. Seniors in Lower Silesia have a lot of problems with motor system which only partially result from physiology of ageing. Improvement in mobility may be obtained

by propagating active lifestyle, fighting obesity and education of doctors in terms of causes of falls.

3. Disturbingly low demand for dentist services was shown – this state may partially result from economical problems of the elderly but also from the low awareness of damage caused by lack of teeth and hygiene of oral cavity.
4. Women of elderly age require more attention in terms of education and treatment with regard to worse health than men of the same age. Involvement of the elderly women in prevention programmes and screening examinations shall allow to lower costs of healthcare among women of elderly age, particularly in case of multiple diseases.
5. Clear connection was shown between the level of education and seniors' health and their demand for medical services. People with lower education level generate more visits at GPs and show higher incidence of such diseases as: kidney conditions and diabetes as well as larger number of falls and fractures. Explanation of the presented connection of education with demand for medical services requires further studies.

Physical activity of seniors

Many years of observations, both by gerontologists and specialists of physical education indicate significant of regular physical activity in lives of the elderly.

In numerous studies involution changes were shown in terms of motor capacity of the elderly, whose symptoms are reduction of physical effort, also in daily life, striving at kinetic inertia, lack of movement drive, decreasing pace of performed movements and actions, time of reaction to stimuli, liquidity of movements. Decrease in ,motor dynamics is often accompanied by decreasing social status [see Szwarc 1996, Łobożewicz 1995, Stryła 1977, Kocemba 2000, Pędich 2000, Jopkiewicz 2002, Osiński 2002, Synak 2002, Bień 2003, Skrzek 2005, Drabik 2006, Drygas 2006].

Physical activity of the elderly should be understood as a factor maintaining health, conditioning prolongation of life, maintaining physical capacity, psychomotor and social agility and source of joy and pleasure [Łobożewicz 1995, Drabik 1997, Pędich 2000, Kabsch 2001, Kostka 2001, Szczepańska 2004, Jaskólski 2005].

It has been proven that systematic physical exercise performed by seniors have significant impact on physical capacity, neuro-muscular coordination, enabling maintaining a range of movements in joints necessary in daily life. [Łobożewicz 1995, Jopkiewicz 1996, Kabsch 2001, Dąbrowska 2002, Osiński 2002, Żak 2002, Skrzek 2002, 2005, Ignasiak 2007].

According to guidelines of WHO experts, concerning promotion of physical activity among the elderly, physical activity is defined as all activities in daily life associated with movement, including work, rest, exercises and doing sports. It is emphasized that preventive and rehabilitation effects of regular physical activity are more favourable if patterns of physical activity are shaped at an early stage of life rather than when they are initiated in elderly age (WHO, Heidelberg 1996).

Advantages resulting from regular physical activity in the elderly are:

- Improvement in general wellbeing (providing pleasure and joy),
- Improvement in physical and psychological health,
- Supporting primary and secondary prevention of specific states (like stress, pain) and diseases (circulatory and vascular diseases, obesity, diabetes, degenerative disease of joints, spine, osteoporosis, depression),
- Minimising effects of disability,
- Prevention against falls and balance disorders,
- Change of stereotypical prospects of old age (disability) and maintaining independence,
- Providing functionality in terms of everyday activities
- Improvement of quality of life.

Therefore, physical activity is an important element of lifestyle, conditioning health, functionality and quality of life of the elderly.

Negative effects of low level of physical activity and effects of hypokinesia were the basis of actions of global organisations: WHO (World Health Organisation), FIMS (Fédération Internationale de Médecine du Sport), CDDS (Committee for the Development of Sport), UNESCO, which since 1995, executing a modern strategy of public health have been encouraging promotion of pro-health physical activity, also of the elderly.

In many countries (Finland, Ireland, Great Britain, USA) systematic research and monitoring of physical activity level are conducted. In assessment of population's physical activity mainly research with help of a questionnaire is applied, i.e. assessing subjective opinions about physical activity of the examined subjects. For example, the following are assessed: type of work performed in free time, household chores, activity associated with work as well as recreation (Questionnaire IPAQ).

It seems justifiable to aim at uniformisation of research procedures objectively assessing physical activity with help of physical agility tests, e.g.: Fullerton Test, as a measure of physical agility [Różańska-Kirschke et al.2006].

According to WHO experts there is a need for constant strategy of development of physical activity in all groups of the elderly, supported by health promotion policy, emphasizing importance of physical education in life of an elderly person. Executed on every level of administration: national, regional, local.

„Physical education is an expression of a specific attitude towards own body, conscious and active care of own development, agility and health and ability to organise and spend time with the greatest possible use of physical and mental health". In broader meaning physical education is a part of general culture of a society, heritage enabling participation in this domain. It involves views, attitudes, theory, organisation and infrastructure [Demel, Skład 1974].

Mass physical culture is a multi-value phenomenon, common humanisation of life, school of working on oneself, on one's body, physical fitness, agility and appearance.

Due to social demands and research on development of physical culture it is assumed that at the age of late adulthood it should be on the one hand treated as generally available area of consumption, satisfying human aspirations in terms of rest, pleasure and bodily perfection. On the other hand, as an instrument of positive shaping and maintaining biological powers of a human being, necessary to fulfil important social roles. Attitudes of seniors towards physical culture should be related to their active and creative participation.

Forms of participation of the elderly in physical culture are physical exercises, sport, tourism, physical recreation and motor rehabilitation, undertaken both spontaneously and in an organised manner.

Among numerous obstacles impeding participation of the elderly in physical culture, many gerontologists mention the so-called "stereotype of an old man". Old age in social consciousness appears as decrease in physical and mental powers, stet of disease and disability, inability to live independently. Breaking this stereotype is the most important task for organisers and promoters of physical culture among the elderly, also among seniors in Lower Silesia.

In Poland, promotion of physical culture was taken care of by B. Starski – a doctor, founder of Geriatric Sanatorium in Inowrocław (1959), in those days unique place in Europe. Snarski believed that "Physical exercise as well as involvement in various disciplines of sport and tourism – are immensely important factors for maintaining physical and mental capacity, which should be performed throughout whole life and particularly in pre-retirement and post-production periods"..

According to H. Szwarc, precursor of UTW in Poland, physical culture, and mainly recreation and rehabilitation play important roles in gerontological prevention, perceiving systematic motor activity as necessary factor preventing from premature senility [Szwarc 1996].

Nowadays, physical activity is often described is motor capacity, It involves both external visible forms of motor activity and physiological mechanisms and psycho-social conditions of motor human actions [Drabik 2006].

Level of physical activity is a positive measure of health and estimation of physical activity in a group of seniors in Lower Silesia and conditioning factors is not only important, but necessary.

Physical capacity is one of the components of complex geriatric care, whose objective is multi-organ and functional diagnostics and analysis of health-related, psychological and social needs of the elderly. At the same time, physical activity directly conditions functioning in everyday life , has impact on gait and balance disorders and risk of falls included in "Geriatric Giants" [Żak 2002].

Presented studies analyse assessment of physical activity of seniors in Lower Silesia. P?

Chosen scale assessing physical agility:

Katz's scale

For rating general physical agility of older people, so called ADL scale was used – activities of daily life alias Katz's scale. It defines basic ability of self – service and includes ability connected with getting dressed, eating, locomotion and using the bathroom. Duration of the test is 2 to 4 minutes. Maximum number of points is 6:

- 6-5 points – basic every day activities are preserved, nursing care at home is not required,
- 4-3 points – medium disability, nursing care is required,
- 2 or less – high disability, help of third persons is absolutely required 12 – 24 hours per day.

The subject gives **YES** or **NO** answers to the following questions:

Are you able to independently:

- wash yourself (possible help with washing one part of the body),
- get dressed (except laces),
- deal with physiological needs (without sporadic episodes of incontinence),
- walk (may use a cane or walker),
- control your behaviour,

- Eat meals (except complex activities such as slicing meat or buttering bread).

Using this scale it is possible to evaluate if a person is able to live without outside help, or if he / she needs constant care at home or in special facility.[9]

Lawton's scale.

To evaluate complex every day activities, Lawton's scale (IADL) was used. It rates ability of basic functioning in modern society, it makes possible to bring closer patient's needs in scope of help or care. Test lasts 3 to 5 minutes. To every question there are three possible answers: first deals with independency, patient's independency in scope of performing given actions in everyday life; second – ability to perform these actions with help of third person; third shows patient's dependency from environment. Maximum available 10 points:

- 10-8 points. – completely preserved ability of basic functioning,
- 7-5 points. – medium level disability of basic functioning,
- 4 and less – high level disability of basic functioning.

In questionnaire respondent gives **yes** or **no** answers to questions:

Are you able to:

- write.
- read,
- walk the stairs,
- clean around yourself,
- prepare meals,
- go out of home on your own,
- use public transport,
- use money,
- take medication,
- use telephone.

Number of points has reference to a particular person, increase in this number with passage of time means that patient's state has worsened. Some of the ADL and IADL scales are in form of questionnaire, which can be filled in by a respondent. Others require presence of a person carrying out the test, his / her judgement or observation of the way that some actions are performed.

[9] http://medforum.pl

Tinetti`s test

To evaluate risk of falls and equilibrium disturbance, simplified Tinetti`s test is used. Test lasts 4 to 5 minutes. During changing the position from standing to sitting and the other way round, senior is sitting on the chair with the back but without armrests. While walking 3 metres patient should keep straight line, and then turn back and quickly return to origin point. If investigated person is using aids in everyday life, such as canes, he should also use it during this test. Assurance is necessary if person is in risk of equilibrium disturbance. Examination contains following tasks:

- transition from sitting to standing position,
- immobilization for 5 seconds,
- walking 3 metres,
- 180 degree rotation,
- transition from standing to sitting position.

Test uses following scale of points:

- High risk of fall – person needs assistance of a third person while performing these tasks.
- Medium risk of fall – person uses technical help (cane, stilt, zimmerframe),
- Minimal risk of fall – person does not need any help while performing above – mentioned tasks.

It is agreed, that this test should be a supplementing element for patient's general internist examination. In case of negative results, it is possible to undertake early rehabilitation treatment, which prevent senior from falls, which in old age usually result in dangerous consequences. .

Physical and psychomotor condition of seniors in Lower Silesia.

Studies have shown that on average 94,8% patients are fully able – bodied seniors, amongst whom:

98,8% declare that they are able to eat on their own,

97,7% deal with physiological needs,

95,6% independently dress up,

94,6% move independently,

93,8% control own behaviour,

and only 88,7% are able to independently take a bath.

Studies have shown that seniors in Dolny Śląsk are mostly independent and able – bodied, also in sphere of physiological and everyday life activities.

On average, 89.39% of the persons examined according to Lawton's scale are fully capable. The greatest deficits of independence were shown in using means of transport and walking the stairs.

Geriatric physiotherapy is one of basic medical disciplines. It is a way of restoring psychophysical capacity lost during the disease, as well as secondary prevention, aiming at reducing the risk of relapse.

To the question: "Are you using rehabilitation procedures?" even 63.5% of the examined persons answered that they do not and have no such needs, only 19.1% gave a positive answer and 17.4% did not use rehabilitation procedures, because they had no such possibility. Women use rehabilitation procedures more often – 21.38% and most often these are patients between 65-69. 20.52% of residents of rural areas and 13.45% of town residents do not use rehabilitation, because they do not have such a possibility.

To the question: "How often do you usually use rehabilitation procedures?" majority of respondents (85.4%) answered "1-5 times a year", 114 examined persons live in towns, and 61 in a rural area. 10.7% of the examined persons used rehabilitation procedures 6-10 times a year, where 15 persons are women and 7 are men; 9 live in rural areas and 13 in towns. Very low percentage, only 1.5% (only 3 persons out of 205 examined ones) used rehabilitation procedures 11-15 times a year (1 man and 2 women). Most often, 16 and more times a year women use rehabilitation procedures, which constitutes 2.4% of population – 23 live in rural areas and 2 in towns.

Unfortunately tests show inaccessibility of rehabilitation services in the offer of healthcare benefits. It refers to rural and urban environment of seniors in Dolny Śląsk, but rural areas are affected in particular. Half less elderly people use rehabilitation procedures in rural areas. Perhaps in those areas there is insufficient access to rehabilitation infrastructure.

To the question: "Do you use orthopaedic equipment?" 80.3% of the respondents answered that they do not have such needs, whereas 18.1% answered "yes, I have it recommended" and 1.6% - "yes, I have it recommended but I cannot afford it". Mainly rehabilitation equipment was used such as: cane (46,5%), crutch (35,2%), walker (9,9%), and most rarely rehabilitation bicycle – 1,9%.

In category of gender division both women and men use crutches in similar percentage – 35.2%. the largest percentage of the sample among crutch users (54.55%) occurs among 65-69 year olds. 60.98% of the examined persons in the age of 75-79 use a cane. The oldest respondents, 85 and older also use cane most often (65,12%).

It results from the study that a small percentage of geriatric patients uses rehabilitation procedures, also in Dolny Śląsk, and they are most often used by town residents and residents of rural areas – twice as rarely. Perhaps it proves lack of awareness of the need , lack of financial assets or difficulties accessing rehabilitation clinics. This aspect was confirmed in the study conducted by A. Chwałczyńska et al. Average time of waiting for rehabilitation was 125 days with 77 waiting persons on average and the largest number of centres with waiting queues was found in Wrocław – 54% of the centres [Chwałczyńska 2007].

Risk of falls is a common phenomenon in old age and results from progressing ageing as a physiological process and diseases. The ageing process itself causes worsened functioning of nervous system, visual control, time of impulse reactions gets prolonged, gait pattern changes [Kędziora – Kornatowska, Biercewicz 2008].

Among diseases, leading role is played by changes in motor system, circulation (dizziness), cognitive disorders, visual disorders and side effects of applied medications. There are also external factors (bad lighting, improper shoes, obstacles, furniture etc.). to the question: "Do you sometimes experience falls?", some more than a half – 51.3% answered "never", 37.32% answered "seldom" and 11.6% "often". Most often women were subject to falls, in 130 positive answers 102 were women. Men were 6.78% and only 28 cases. In the age category the oldest examined persons fell most often – in the age of 85 or older.

On the basis of analysis of shortened Tinetti test, 48.7% of the sample are characterised by minimal risk of fall. 28.1% of examined persons have medium risk of fall and 23.2% - large risk of fall.

For many elderly people falls are the most disturbing symptoms of ageing, releasing fear of serious trauma and loss of independence. M. Żak in his study proves that actual risk of fall increases with age and out of every 100 persons 47 fall yearly among people in the age category 70-74, and many more among the 80 year olds, which confirms analysis of Lower Silesia study [Żak 2002].

According to M. Żak most falls take place during performing simple everyday activities, such as standing up, sitting down, walking or bending over. Only 5% of falls take place during potentially hazardous activities, such as climbing the ladder or doing sports. Falls which do not result in serious traumas very often lead to development of post-fall syndrome and as a consequence to worsening of physical and mental capacity. Results of falls are broken legs (neck of femoral bone), arms and pelvis, a result of 10-20% of falls are hematomas, contusions, muscle pulls. The next place is occupied by head traumas (concussions, intracranial haemorrhages), whose consequence appear later. Treatment of fractures from

medical point of view is not as complicated as various kinds of complications associated with immobilisation of an elderly person. Pneumonia, peripheral circulation disorder, bedsores, deep vein thrombosis are diseases in result of which quality of life significantly deteriorates. [Żak 2002, Grodzicki, Kocemba 2006].

In the conducted study 26.2% of the seniors had proximity fractures in the past. The largest percentage of fractures occurred between 50 and 60. According to analyses fractures happen more often to women (30,27%), and to men only in 19,12%. The reason for this state of things is more frequent incidence of osteoporosis among women, in result of which bones are less resistant to influence of external forces. In elderly people trauma incidence is associated with poor health, balance disorders because of slowing down of controlling movements, poor sight using many medications and orthostatic disorders [Kabsch 2001, Żak 2002, Skrzek 2005].

Since which period of life should physical culture be implemented in lives of the elderly? Because seniors do not form a uniform group, it is difficult to generalise. Actions of geriatric prevention recommend possibly early initiation of regular physical activity, with regard to constancy. The higher the agility and physical capacity of an individual aged 60-70, the higher level regression and disability shall start from.

Promotion of physical activity among seniors does not require costly equipment and devices but rather methodically properly prepared health programme. Accurate selection of exercises, their proper dosage are a responsible task for physical culture specialists, conducting prevention and rehabilitation activities for the elderly [Osiński 2002, Drygas 2003, Jegier 2003, Kuński 2003, Kozdroń 2005].

Issues of physical activity of the elderly should in Poland belong among priority matters, particularly because we have a significant scientific reference on the subject [Drabik 1996, Pędich 1996, Szwarc 1996, Kostka 2001, Dąbrowska 2002, Osiński 2002, Kuński 2003, Szczepańska 2004, Skrzek 2005, Chomiuk 2007].

Industrialised countries may be a pattern to follow, having common access to physical culture, where elderly people are socially encouraged to take care of their health – e.g. Scandinavian countries, Great Britain, Japan or USA [WHO 1996, Bień 2003].

Demand for physical culture of the elderly is increasing, demographic tendencies have their impact here:

- Earlier retirement (50-55)
- Longer life expectancy.

This task should be undertaken by healthcare education, doctors, physical culture specialists, media, magazines, TKKF, pensioners clubs.

Promotion of physical culture among seniors should take into account 5 categories of motives: health-related, utilitarian, social, ludic and cognitive.

Physically active lifestyle helps seniors maintain functional independence, optimising degree of their active participation in society**.**

Conclusions

1. Research has shown that seniors in Lower Silesia are, in subjective opinion, a social category of relatively good physical capacity, they rarely use orthopaedic equipment and help of family and caretakers in performing activities of daily life.
2. In terms of forms of recreation and spending free time actively, in senior's quality of life the following are the most prominent: walks and recreation in fresh air, being and working in the garden and sport.
3. It is recommended to increase senior's access to use rehabilitation procedures both in urban and rural areas of Lower Silesia.
4. In physical culture of seniors promoted models of "healthy lifestyle" too slowly permeate everyday practice, both in individual and social preferences and behaviours. Therefore the elderly should be encouraged to understand need for movement, its meaning for health, physical and mental capacity, to pursue recreation and use rehabilitation procedures.
5. Activation of seniors in Lower Silesia for physical culture should take place in many directions, influence human intellectual and physical sphere, simultaneously providing them with sense of safety and own usefulness and friendly surroundings.
6. Education of seniors in terms of physical activity, e.g. in UTW, senior clubs, including sharing knowledge about healthy ageing, access to recreation , creating environment favouring physical culture, supported by family, social aid and healthcare workers, non-governmental organisations, profiled education of physical culture specialists, creating rehabilitation centres – should be a basis of programmes promoting physical culture among the elderly in Lower Silesia.
7. Modern idea of physical culture for the elderly, also inLower Silesia, should entail principles of modern conception of a human being, i.e. respect for dignity, tolerance to weakness and appreciation of psychological values.

VI. Summary

In scientific considerations about old age dynamic approach has prevailed. Such an attitude towards old age has already been understood by the modern societies of Europe, the world. In recent years many facilities were introduced associated with quality of services and nature of care for the elderly. Care, in order to actually contribute to a change in quality of life of the elderly, must consider in systemic solutions three elements: integration, activation and education of the elderly. Demographic changes require new facilities and more involvement of resources aimed at support, providing psychological and social stimulation enabling active lifestyle. Here psychological assistance (besides geriatric) shall be very important, enabling defeating depression (stress of old age), and necessity to refocus feeling towards oneself. Dealing with crisis, maintaining internal integrity (psychological wellbeing) in face of life's balance.

Social policy towards the e3lderly should constitute a system of actions aimed at quality of life, which would involve versatile compensation of decreasing with age abilities to independently fulfil needs, integration with local community and preparation for old age. Social policy towards the elderly should be based on three principles: autonomy, in order for seniors to maintain independence in making decisions concerning their lifestyle at this stage of existence; integration – providing the elderly with possibly full participation in social life and care – creating a system of support and help for people who as a consequence of age or disease lost ability to independently fulfil their needs.

Actions undertaken in this framework should enable adjustment of the elderly to a changing image of society, so that they could follow with "course of life", have an opportunity to use potential they represent. We should oppose to their absence in life of local community, social exclusion, marginalisation of life of the elderly, reducing their living space, finally minimisation of needs and expectations causing deepening depression, passive attitude to own life. The mentioned phenomena to a larger or lesser extent are confirmed by the conducted study.

Analysis of the entire research material has shown that currently seniors in Lower Silesia are subject to social exclusion with regard to three main reasons. The first one is difficult financial situation and limited budget at seniors' disposal, making it impossible for them to fulfil all needs. The second reason is strongly rooted stereotypes in social consciousness, concerning the old age, which renders society as a system unprepared to create conditions guaranteeing high quality of life for the elderly. It may be said that public discourse on this subject is still in initial phase, just like creating instruments and solutions

providing integration of this social category with the rest of society and achieving life satisfaction. The third reason, equally important, is a process of seniors' self-exclusion. The elderly, among others with regard to low income but not only, withdraw from social life, limiting themselves to the closest family and friends, they sentence themselves to a passive lifestyle. This situation is further worsened by low education level of seniors, lack of patterns of active spending time and social competences in order to fully take advantage of the possibilities brought by modern world. We can assume that phenomena and processes indicated above constitute border conditions, indicating current condition of seniors in Lower Silesia and directions of future actions.

Prevention activities should distance themselves from instrumental and condescending treatment of the elderly. Combine nursing actions with educational impact. This is when a human being reaches the state of psychological homeostasis, is emotionally balanced, more easily withstands health conditions and various dysfunctions, deals with everyday life. This is what constitutes the essence of the ageing prevention. In this way it shall be possible to achieve increase participation of the human being in restoring and achieving proper health balance, and in consequence – life balance. It is confirmed by the position of gerontologists, who among predicatives of successful ageing mention the following: autonomy, self-acceptance, positive relations with others, control over life environment, having a goal in life and finally personal development.

L**iterature:**

Abrams W.B., Beers M.H., Berkow R. (ed.), (1999), *MSD – Podręcznik Geriatrii*, Wrocław: Urban&Partner.

American College of Sports Medicine Position Stand. Exercise and physical activity for older adults, (1998), "Med. Sci. Sports Exerc.", no. 30, pp. 992-1008.

Aronow W.S. (2003), *Effects of aging on the heart*, [in:] R.C. Tallis, H.M. Fillit (ed.), *Geriatric Medicine and Gerontology*, Elsevier Science.

Bień B. (2003), *Ochrona zdrowia ludzi starszych w Polsce wyzwaniem dla polityki społecznej*, „Praca Socjalna", no. 2, pp. 93-107.

Bień O., Pędich W. (1995), *Wpływ transformacji społeczno – politycznej w Polsce na jakość życia ludzi starych*, „Gerontologia Polska", no. 3/4, pp. 27-29.

Błędowski P. (2006), *Społeczeństwo wobec demograficznego procesu starzenia się ludności- wyzwania dla Polski i doświadczenia zagranicy*, Ogólnopolski Zjazd Naukowy Sekcji Geriatrycznej PTL Gdańsk.

Błędowski P. (2008), *Charakterystyka procesu starzenia – aspekt socjoekonomiczny*, [in:] K. Wieczorowska-Tobis, K. Talarska (ed.), *Geriatria i pielęgniarstwo geriatryczne*, Warsaw: PZWL.

Chomiuk T., Mamcarz A. (2007), *Bezpieczne formy aktywności ruchowej stosowane w treningu zdrowotnym osób starszych*, „Kardioprofil", no. 6, pp. 451-455.

Chwałczyńska A., Górska-Kłęk L. (2007), *Dostępność świadczeń rehabilitacyjnych w wybranych miastach wojewódzkich w 2006 roku*, „Fizjoterapia", no. 15, suppl. 1, p. 26.

Connolly M.J. (2003), *Asthma and chronic obstructive disease,* [in:] R.C. Tallis, H.M. Fillit (ed.), *Geriatric Medicine and Gerontology*, Elsevier Science.

Connolly M.J., Gosney M. (2003), *Nonobstructive lung disease and thoracic tumors*, [in:] R.C. Tallis, H.M. Fillit (ed.), *Geriatric Medicine and Gerontology*, Elsevier Science.

Dąbrowska G., Skrzek A., Mraz M. (2002), *Rehabilitacja lecznicza i jej znaczenie w życiu seniorów na podstawie badań własnych*, „Advances in Clinical and Experimental Medicine", no. 11, suppl. 1, pp. 129-133.

Derejczyk J. et al. (2008), *Gerontologia Polska*, in print.

Dochody i warunki życia ludności Polski, (2008), Warsaw: GUS.

Drabik J. (1997), *Aktywność, sprawność i wydolność fizyczna jako mierniki zdrowia człowieka*, Gdańsk: Wydawnictwo AWF.

Drabik J. (2006), *Ruch i wysiłek fizyczny*, „Antropomotoryka", no. 34, pp. 121-123.

Drygas W. (2003), *Trening zdrowotny: bilans 50 lat. Czy znamy odpowiedzi na najważniejsze pytania?,* „Medicina Sportiva", no. 7, pp. 9-14.

Dyczewski L., Adamczuk L., Szatur – Jaworska B., Pałaszewska – Reindl T., Ozimek I., Niepokulczycka M., Halicka M., Halicki J. (1999), *Potrzeby ludzi starszych; uniwersalne i specyficzne*, [in:] S. Golinowska (ed.), *Ku godnej aktywnej starości. Raport o rozwoju społecznym. Polska 1999*, Warsaw: UNDP.

Evans W.J. (1999), *Exercise training guidelines for the elderly*, "Med. Sci. Sports Exerc.", no. 31, pp. 12-17.

Golinowska S., Holzer J., Szwarc H., Pędich W. (1999), *Starzenie się i starość: pojęcia, tendencje, cechy i struktury* [in:] S. Golinowska (ed.), *Ku godnej aktywnej starości. Raport o rozwoju społecznym. Polska 1999*, Warsaw: UNDP.

Grodzicki T., Kocemba J. (2000), *Farmakoterapia w wieku podeszłym*, [in:] J. Kocemba, T. Grodzicki, *Zarys gerontologii klinicznej*, Kraków: MCKP UJ.

Grodzicki T., Kocemba J., Skalska A. (2006), *Geriatria z elementami gerontologii ogólnej*, Gdańsk: Via Medica.

Halik J. (ed.) (2002), *Starzy ludzie w Polsce. Społeczne i zdrowotne skutki starzenia się społeczeństwa,* Warsaw: ISP.

Ignasiak Z., Dąbrowska G., Żurek G. (2007), *Poziom otłuszczenia u kobiet starszych, słuchaczek UTW aktywnych i nieaktywnych ruchowo*, „Antropomotoryka", no. 37, pp. 67-72.

Jałowiecki, B., Szczepański, M.S. (2002), *Miasto i przestrzeń w perspektywie socjologicznej,* Warsaw: Wydawnictwo Naukowe Scholar.

Jaskólska A., Jaskólski A. (2005), *Zmiany fizjologiczne u osób w wieku średnim i starszym a zdolność wykonywania wysiłku fizycznego*, [in:] *Podstawy fizjologii i wysiłku fizycznego z zarysem fizjologii człowieka*, Wrocław: Wydawnictwo AWF.

Jegier A. (2003), *Kwalifikacja lekarska do treningu zdrowotnego osób dorosłych*, „Medicina Sportiva", no. 7, pp. 27-35.

Jopkiewicz A. (1996), *Aktywność ruchowa osób starszych*, Kielce: Wydawnictwo WSP.

Kabsch A. (2001), *Niepełnosprawność towarzysząca procesom starzenia wyzwaniem dla fizjoterapii*, „Fizjoterapia", no. 3, pp. 3-20.

Kędziora-Kornatowska K., Biercewicz M. (2008), *Upadki i zaburzenia lokomocji*, [in:] K. Wieczorowska-Tobis, K. Talarska (ed.), *Geriatria i pielęgniarstwo geriatryczne*, Warsaw: PZWL.

Klich-Rączka A., Obiorek A. (2000), *Zaburzenia endokrynologiczne*, [in:] J. Kocemba, T. Grodzicki, *Zarys gerontologii klinicznej*, Kraków: MCKP UJ.

Kocemba J., Życzkowska J. (2000), *Osobnicze i populacyjne starzenie się człowieka*, [in:] J. Kocemba, T. Grodzicki, *Zarys gerontologii klinicznej*, Kraków: MCKP UJ.

Koczorowski R. (2008), *Opieka stomatologiczna nad starszym pacjentem*, [in:] K. Wieczorowska-Tobis, K. Talarska (ed.), *Geriatria i pielęgniarstwo geriatryczne*, Warsaw: PZWL.

Korzeniewska Katarzyna (2002), *Biedni (i) emeryci: o ekonomicznej zależności biednych rodzin od pomocy z zewnątrz i o „underclass po polsku",* [in:] K. Korzeniewska, E. Tarkowska (ed.), *Lata tłuste, lata chude... Spojrzenie na biedę w społecznościach lokalnych*, Warsaw: Wyd. IFiS PAN.

Kostka T. (2000), *Rola aktywności ruchowej w promocji zdrowia u osób starszych*, „Medicina Sportiva", no. 5, pp. 147-150.

Kozdroń E. (2005), *Program rekreacji ruchowej osób starszych*, Warsaw: Skrypt AWF.

Kuński H. (2007), *Trening zdrowotny osób dorosłych stosowany w praktyce*, „Medicina Sportiva", no. 7, pp. 15-25.

Kurzępa J., Lisowska A., Pierzchalska A. (2008), *Prostytucja 'nieletnich' w perspektywie Dolnoślązaków*, Wrocław: Agencja Wydawnicza „ARGI".

Laskowska – Otwinowska Justyna (2000), *Człowiek stary w ubogiej rodzinie polskiej wsi współczesnej*, [in:] E. Tarkowska (ed.), *Zrozumieć biednego. O dawnej i obecnej biedzie w Polsce*, Warsaw: Typografika.

Łobożewicz T. (1995), *Samopoczucie psychospołeczne ludzi starszych a ich aktywność ruchowa*, „Gerontologia Polska", no. 3 (1-2), pp. 25-36.

Maslow, A. (2006), *Motywacja i osobowość,* Warsaw: Wydawnictwo Naukowe PWN.

Narodowy Program Zdrowia na lata 2007 – 2015. Załącznik do Uchwały 90/2007 Rady Ministrów z dnia 15 maja 2007r.

O wieku emerytalnym kobiet i mężczyzn raz jeszcze. Komunikat z badań, (2005), Warsaw: CBOS.

Ocena sytuacji materialnej. Komunikat z badań, (2006), Warsaw: CBOS.

Osiński W. (2002), *Aktywność fizyczna podejmowana przez osoby w starszym wieku*, „Antropomotoryka", no. 24, pp. 3-24.

Pędich W. (1996), *Aktywność ruchowa osób starszych*, Kielce: Wydawnictwo WSP.

Pędich W. (2007), *Gerontologia i geriatria*, [in:] T. Grodzicki, J. Kocemba, A. Skalska (ed.), *Geriatria z elementami gerontologii ogólnej*, Gdańsk: Via Medica.

Raport z wyników Narodowego Spisu Powszechnego Ludności i Mieszkań 2002, (2002), Warsaw: GUS.

Rocznik Demograficzny (2007), Warsaw: GUS.

Różańska-Kirschke A., Kocur P., Wilk M., Dylewicz P. (2006), *Test Fullerton jako miernik sprawności fizycznej osób dorosłych*, „Rehabilitacja Medyczna", no. 10, pp. 9-16.

Sinclair A.J., Croxon S.C.M. (2003), *Diabetes mellitus*, [in:] R.C. Tallis, H.M. Fillit (ed.), *Geriatric Medicine and Gerontology*, Elsevier Science.

Skrzek A. (2005), *Trening zdrowotny a procesy inwolucyjne narządu ruchu u kobiet*, Studia i Monografie, Wrocław: Wydawnictwo AWF.

Skrzek A., Woźniewski M., Wnuk W. (2002), *Czy kultura fizyczna jest potrzebna osobom w podeszłym wieku?,* „Advances in Clinical and Experimental Medicine", no. 11, suppl. 1, pp. 123-129.

Stryła W. (1977), *Ruch jako profilaktyka procesu starzenia się*, „Nowiny Lekarskie", no. 66, pp. 30-35.

Synak B. (2002), *Polska starość*, Gdańsk: Uniwersytet Gdański.

Szatur – Jaworska B. (2000), *Ludzie starzy i starość w polityce społecznej*, Warsaw: Oficyna Wydawnicza ASPRA – JR.

Szatur – Jaworska B., Błędowski P., Dzięgielewska M. (2006), *Podstawy gerontologii społecznej,* Warsaw: Oficyna Wydawnicza ASPRA – JR.

Szczepańska J., Greń G., Woźniewski M. (2004), *Wpływ systematycznych ćwiczeń fizycznych na samopoczucie i zaburzenia nastroju osób w podeszłym wieku z niewielkim deficytem poznawczym*, „Fizjoterapia", no. 12 (3), pp.37-46.

Sztompka P. (2003), *Socjologia. Analiza społeczeństwa*, Kraków: Wydawnictwo Znak.

Szwarc H. (1996), *Sprawność fizyczna i zdrowie osób starszych*, „Kultura fizyczna", no. 9 (10), pp.7-10.

Tarkowska E., (2000), *Zróżnicowanie biedy: wiek i płeć*, [in:] H. Domański, A. Ostrowska, A. Rychard (ed.), *Jak żyją Polacy*, Warsaw: Wyd. IFiS PAN.

Upodobania kulinarne, nawyki żywieniowe i zachowania konsumenckie Polaków. Komunikat z badań, (2005), Warsaw: CBOS.

Wąsiewicz E.P. et al. (1995), Opinie pacjentów o planowanych zmianach organizacyjnych w podstawowej opiece zdrowotnej, „Zdrowie Publiczne", no. 1, pp. 19-24.

WHO. Wytyczne dotyczące programowania aktywności fizycznej wśród osób starszych (1997), „Rehabilitacja Medyczna", no. 4, pp. 53-57.

Wiek emerytalny kobiet i mężczyzn. Komunikat z badań, (2003), Warsaw: CBOS.

Wyjazdy Polaków na wypoczynek w latach 1992 – 2005. Komunikat z badań, (2005), Warsaw: CBOS.

Zabłocki G., Sobczak M., Piszczek E., Kwiecińska M. (1999), *Ubóstwo na terenach wiejskich Północnej Polski*, Toruń: Wyd. UMK.

Zakupy – gdzie i co kupujemy. Komunikat z badań, (2004), Warsaw: CBOS.

Zatońska K., Waszkiewicz L., Bolanowski M. (2006), *Samoocena stopnia otyłości kobiet i mężczyzn zamieszkałych na Dolnym Śląsku*, „Endokrynologia, Otyłość i Zaburzenia Przemiany Materii", no. 1, vol. 2, pp. 12-18

Żak M. (2002), *Ocena ryzyka upadków u osób starszych i możliwości prewencji*, „Gerontologia Polska", no. 8, pp. 18-21.