GERONTOLOGIA POLSKA 2021; 29; 53-63 ARTYKUŁ ORYGINALNY / ORIGINAL PAPER
Zgłoszono 15.02.2021; zaakceptowano 20.04.2021

Women as caregivers of dependent persons in Poland

Kobiety jako opiekunki osób niesamodzielnych w Polsce

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Abstract

Introduction. *The problem of ageing society, which concerns many European countries, including Poland, has a direct impact on the increase of demand for care benefits. The majority of dependent persons receive help from family members. The aim of this research was to study the conditionings of the axiological dimension of women's understanding of the value of life of terminally ill patients and the conditionings of the functional perception of care.* **Material and method.** *The study based on the authors' own internet questionnaire (n=958) focused on two aspects of women providing care – the axiological and the functional one.* **Results.** *The results of the research indicate that the majority of respondents (73%) do not think that life should be supported at any costs. 71% of respondents believe that the quality of life is more important than its length. Merely 21% of respondents think that the care of a dependent person should rely on the family. Yet, 46% declare that they would resign from their job to care for a seriously ill family member.* **Conclusions.** *In a longer perspective the traditional division of tasks, limited implementation of systemic care solutions and low accessibility of alternative relevant services pose a great social challenge. (Gerontol Pol 2021; 29; 53-63). 10.53139/GP.20212907*

Keywords: *long-term care, family caregivers, palliative care, gerontology, social policy*

Streszczenie

Wstęp. *Problem starzenia się społeczeństw, który dotyczy wielu krajów europejskich, w tym Polski, ma bezpośredni wpływ na wzrost zapotrzebowania na świadczenia opiekuńcze. Większość osób niesamodzielnych korzysta z pomocy świadczonej przez członków rodziny, przeważnie kobiet.* **Cel.** *Celem przeprowadzonych badań było zbadanie uwarunkowań aksjologicznego wymiaru rozumienia przez kobiety wartości życia nieuleczalnie chorych pacjentów oraz uwarunkowań funkcjonalnego postrzegania opieki.* **Materiał i metoda.** *Badanie oparte jest na autorskim kwestionariuszu internetowym (n=958) koncentrowało się na dwóch aspektach sprawowania opieki przez kobiety - aksjologicznym i funkcjonalnym.* **Wyniki.** *Wyniki badań wskazują, że większość respondentów (73%) nie uważa, że życie należy podtrzymywać za wszelką cenę. 71% badanych uważa, że jakość życia jest ważniejsza niż jego długość. Zaledwie 21% respondentów uważa, że opieka nad osobą niesamodzielną powinna spoczywać na rodzinie. Jednak aż 46% deklaruje, że zrezygnowałoby z pracy, aby opiekować się ciężko chorym członkiem rodziny.* **Wnioski.** *W dłuższej perspektywie tradycyjny podział zadań, ograniczone wdrażanie systemowych rozwiązań w zakresie opieki oraz mała dostępność do alternatywnych, odpowiednich usług stanowią duże wyzwanie społeczne. (Gerontol Pol 2021; 29; 53-63). 10.53139/GP.20212907*

Słowa kluczowe: *opieka długoterinowa, opiekunowie rodzinni, opieka paliatywna, gerontologia, polityka społeczna*

Introduction

The demand for benefits in terms of long-term care has been increasing for years. It is mainly a result of a continuous process of population ageing in many countries [1,2]. Simultaneously, the demand for care benefits implemented by public entities in many countries, including Poland, exceeds the supply, and as a result families, mostly women, constitute the main care potential [3]. The determinant of family care burden continuously increases [4,5]. The experience of care of dependent family members is the subject of research and analyses, and their results show its significance and the potential of this phenomena. However, it also shows many of its negative aspects, including the risk of social isolation of caregivers, depression, health problems, earlier professional deactivation as well as the need for caregivers networking and respite care [6,7,8,9,10].

Sometimes, the care of a dependent family member lasts many years and the burden of duties related to the care increases along with the progression of the disease, as in the case of Alzheimer's disease or other dementia diseases. The caregiver ages together with the person under care, therefore their strength and resources diminish,

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which in turn increases the risk of low mood or depression and health problems [11]. At the same time, as the research indicates, the caregivers do not always have an access to psychological intervention which could contribute to the reduction of the experienced care burden [12].

Caregivers of dependent persons in the families

The degree of patient dependency notwithstanding, in the demographic structure of informal related caregivers, women are a dominant group. As demonstrated by the studies conducted in six European countries within the Eurofamacare project, the percentage of women who are caregivers of a dependent person in the case of high dependence of the patient is 78.8% in Poland and 77.8% in Europe; in the case of moderate dependence – 76.7% in Poland and 75.6% in Europe, and in the case of slight dependence – 71.7% in Poland and 74.5% in Europe [13]. In the US, according to the research of the National Study of Caregiving (NSOC), implemented within the framework of the National Health and Aging Trends Study, about 62% of caregivers of the elderly were women, and over a third of them were daughters, mothers-in-law or stepdaughters of the dependent person. More than a half of the NSOC caregivers (50.5%) were aged between 45 and 64 years, but almost a third of them (32.3%) were older [8,14].

The presented problem concerns Polish circumstances discussed in the article as well as the conditions in other countries [14] which struggle with a growing demand for care services for dependent persons, mainly the elderly. It can be therefore concluded that this is a common situation. The research conducted in the Netherlands demonstrated that the average age of caregivers in families was 62 years—and ranged from 40 to 86 years. Approximately two-thirds of them were women [15]. Similar results came from the research conducted in five Canadian cities (Montreal, Quebec City, Saskatoon, Toronto, Vancouver), measuring family carer quality of life in case of caregivers to cancer patients. Two-thirds of the studied caregivers were women; the majority of whom were spouses (63%) or daughters (20%) of the patient [16]. Similar results were obtained during the study in Sweden, where women constituted 61% of caregivers [17].

Caregivers of dependent persons in systemic understanding of the family

A broader theoretical context of the understanding of the family while caregiving introduces its analysis in a systemic perspective [18] with particular focus on the interactions within it, which determines the fulfillment of particular roles, including the care role. The whole family is therefore something greater than the sum of its parts, and only such understanding of it enables one to explain the processes and interactions occurring there [19]. Nevertheless, it should be noted that the way the family is organized remains based on the principles of family life and has an influence on the implemented distribution of work and power which consists of cultural and specific styles of family life [19]. They determine the division of care tasks in the family to a great extent. Thus, both the individuality of particular family members and the family's cultural standing constitute the family system as a whole. What is important in the context of understanding the functioning of a family with care tasks towards its ill member, is the awareness of the importance of such a structure matter, since it secures the mechanisms of homeostasis, maintenance of tolerance and the ability to stabilize [20]. The chaos brought to the structure of the family as a result of an illness disrupts achieved homeostasis and requires a restructuring of functioning so as to enable one to reestablish the balance [20]. According to the family stress theories, family resilience, the analysis of protective factors and processes which improve the family's functioning, including family cohesion and flexibility [21,22], as well as the ambiguity of family system boundaries [23] are significant. The boundary is particularly disrupted in the event of a long-term illness of a family member, which questions their presence/absence in the family structure. The new needs appearing in the family exacts selective opening of boundaries through developing relations with social institutions, posing particular demands, including the demands on the care [23]. Therefore, the analysis of the family functioning as a system with particular roles is impossible in isolation from its cultural context of functioning, whilst taking account of individual characteristics of their members. In particular due to the fact that socio-cultural context repeatedly expects women to perform care functions in the family, and the individuality of features and experiences of family members may result in the transfer of norms and values as a part of generation transfer or may be a beginning of attempts of its disruption.

The system of long-term care in Poland

Poland as a young democracy is an arena where the traditionally strong position of a family, deeply rooted in Christian values, clashes constantly with the impact of globalization and neoliberalism on the life of individuals.

Another significant aspect is the still functioning post-communist model of social policy [24]. Public support in care of a dependent person, particularly in end-of-life situations, is marginal and in most cases limited to help during acute health crises [25]. The political, social and economic changes so far have not altered the model of family care of an ill person. Although there are many principles according to which Polish society can be divided into categories – e.g. place of residence (urban vs rural), income structure, or a region of the country – due to the absence of suitably developed support infrastructure of home care and institutional care, it is the families who in most cases have to ensure care for persons with long-term illnesses, including people at the end of their lives [3]. The system of long-term care in Poland is based on four main pillars: family care, services and benefits provided by social security and by health service institutions, as well as the private care sector. In the case of the social services sector, the organization of services and their co-financing (both in the form of home help and care institutions) is the responsibility of the local authorities.

In 2018 in Poland the residential care homes (Domy Pomocy Społecznej, DPS) had 79 thousand places, with over 46 thousand occupied by persons aged 60 and older [26]. As the population of Poland is dynamically aging, the demand for care services is going to increase. The waiting time for a place in a DPS is between several weeks and two years, depending on the region and the type of care institution [3]. In the year in question, 0.71% of senior population resided in DPSs. Considering care services provided by the social service sector at patients' homes, in 2018 there were 112,930 beneficiaries. It is worth noting that according to the report of the Supreme Audit Office [27], 20% of communes do not provide benefits in this form.

The national health service sector provides for persons requiring care after hospital treatment, which includes hospice and palliative care. Care-at-home services are provided by long-term-care nurses and community nurses following the guidelines from a patient's general practitioner. Resident care services are offered in nursing care units (*zakłady pielęgnacyjno-opiekuńcze*, ZPO) and health care and curative units (*zakłady opiekuńczo-lecznicze*, ZOL). These institutions together have 31 thousand places at their disposal [28]. In 2018 health care budget expenditures were merely 6.3% of the GDP, including 0.4% for long-term care, while the average for OECD countries is 8.8% GDP [29]. According to the research by Iwański, Sielicka, and Jarzębińska [25], the access to palliative and hospice care is limited due to insufficient financing of this sector by the main state insurance institution – the National Health Fund.

Due to the abovementioned factors related to organization and financing of services and benefits provided by public institutions, it is the families who shoulder the main burden of providing dependent persons with care and support in everyday functioning. It is estimated that family members help in about 80% cases, and the main caregiving roles are played by women, mostly aged 55–64 years. Poland is among the states where the population aging processes will be very dynamic. Between 2016 and 2070, the percentage of people over 60 will grow from 16.3% to 33%. The population of people over 80 will also increase significantly, from 4.2% to 16.2% [4]. The caregiving potential of families will be decreasing due to the negative birth rate that has persisted since the early 1990s. In 2017 the total fertility rate was around 1.4 [30]. Poland has also negative migration balance, particularly with regard to long-term trans-boundary migration; in 2017, 2.5 million Poles remained abroad [31]. Moreover, in 2016 the retirement age was lowered and currently is 60 years for women and 65 for men.

Research methodology

In the context of the described cultural and systemic conditions, the authors focused in the article on the social role of women as caregivers for persons requiring long-term care. The systemic approach adopted in the study proves that there is a distinction of the conducted research into implemented areas – the conditionings of axiological understanding of illness in the family, resulting from the individuality of professed values and norms by the family members [19], and the conditionings of functional dimensions of care perception, which are implemented by undertaking socially expected care roles [21]. Therefore, the study formulates the following research question: do the female respondents' education, place of residence, age, religiosity and the experience in caregiving of an ill person influence the perception of axiological dimension of terminally ill persons' value of life, and the duty of care for them. For the needs of verification of the adopted research assumptions the following hypotheses were adopted:

The women's perception of axiological understanding of terminally ill persons' value of life is influenced by their place of residence, age, education, religiosity and the experience in caregiving.

The women's perception of functional family care role towards terminally ill persons is influenced by the place of residence, age, education, religiosity and the experience in caregiving.

The first dependent variable is the experience in caregiving for the chronically ill. It is a particularly important factor since it affects the process of shaping the attitudes towards the performance of care tasks which result from the feeling of being in control over the care situation or the feeling of self-efficacy [31]. Another important variable is the age of respondents. The division of duties in terms of care for an ill person is not equal in families and the main burden is borne by women aged 50 or over [8,15,14]. In the case of the variable "education", the assumption has been adopted that persons with higher education find it more difficult to resign from professional activity in order to fulfill care tasks in the family. The place of residence may have a great importance in terms of accessibility to public forms of support, which in the case of rural areas and small towns in Poland are lesser than in bigger cities [32,3]. The last variable to be included in the article is the religiosity of the respondents. It is a significant factor because the influence of Catholic Church on cultural norms in Poland is great, and according to the Catholic doctrine in terms of social policy it is the family who constitutes the main resource in the care.

The study was based on an internet survey, using the authors' own questionnaire, which was distributed through social media and mailing lists. The questionnaire consisted of 47 questions. Between September and December 2018, 1238 questionnaires were completed, out of which the 958 correctly filled were accepted for further analysis. The target respondent group were women aged 18 and more, residents of Poland. What was particularly significant for the scope of the analysed issues were personal factors connected with age, religiosity, place of residence (rural areas, towns up to 20,000 inhabitants, 21–100,000 inhabitants, 101–200,000 inhabitants, 201–500,000 inhabitants and 501,000 and more inhabitants), education (primary school, junior high school, high school, higher education) and experience in providing care for a dependent person (lack of experience/previous experience). To verify the assumption about the significance of differences between the medians, the Mann-Whitney U test was applied for those variables that had only two groups (religiosity and experience in caregiving), and the Kruskal-Wallis test for variables with several categories (place of residence and age). In order to test the dependence of qualitative features, the Spearman rank coefficient was calculated. The analysis used Statistica 13 Software.

Description of the sample group

In the group of 958 respondents whose questionnaires were accepted for comparative analysis, 73.4% had higher education, 25.5% – secondary and 1.1% – primary. The respondents' average age was 38.3 (SD 12.7). 13.1% respondents lived in rural areas, 9.4% in towns up to 20,000 inhabitants, 14% in towns with 20–99,000 inhabitants, 8% – 100–199,000, 31% 200–499,000, and 23.1% in towns with more than 500,000 inhabitants. 37.2% had previous experience in looking after a terminally ill person. More than a half (53.7%) declared themselves as religious.

Results

The survey results made it possible to conduct analysis according to the adopted premises.

The majority of respondents (73%) do not agree with the statement that it is right to provide futile medical care; 46% expressed a decisive opinion, 13% had

Table I. Number and percentage distribution of answers to the survey questions

Statements*	Answer categories									
	I strongly disagree		I disagree		I have no opinion		I agree		I strongly agree	
	n**	%	n	%	n	%	n	%	n	%
1. It is right to support life at any cost.	443	46	254	27	123	13	77	8	61	6
2. A person in a vegetative state should be kept alive at any cost.	384	40	250	26	212	22	65	7	46	5
3. Quality of life is more important than its length.	58	6	60	6	161	17	233	24	444	47
4. Care of a dependent person should be the responsibility of their family.	243	25	292	30	231	24	155	17	34	4
5. Financing the care of a dependent person should mainly be the responsibility of their family.	507	53	273	28	121	13	40	4	16	2
6. I would resign from work to take care of a severely ill family member.	103	11	167	17	248	26	216	23	221	23

1,2,3 – axiology-oriented questions; 4,5,6 – functionality-oriented questions
**n – the number of respondents

no opinion, and 14% were in favour (table I). Based on a Mann-Whitney U test, statistically significant differences in the distribution of answers depending on religiosity (p = .00) were observed (table III) as well as a statistically significant correlation rho = .26 p <.05 (table IV). In the case of respondents who defined themselves as unreligious, 84% did not agree with the analyzed statement; among religious persons, such answer was given by 64%. 21% religious respondents and 6% non-religious ones expressed their support. No statistically significant differences were observed in the distribution of answers when the factor of experience in caregiving was considered (p = .506). The results of the Kruskal-Wallis test show that there are statistically significant differences in answers given by people of different ages (table II) (p = .0063). Among the respondents from the oldest age group (55yo and more) 61% disagreed and 25% agreed; in younger age groups there were on the average ca. 74% of negative answers and ca. 14% of positive ones, with the highest results (19%) recorded for the youngest age group (18–24yo). Regarding answers to these questions, place of residence was not a statistically significant factor

Also in the case of another axiological question – whether a person in persistent vegetative state should be kept alive at all costs, statistically significant differences were observed in the categorized groups considering such factors as respondents' religiosity p=.00 (table III) and age (p=.0332) (table III). In turn, lack of significance for answer distribution was observed in the case of place of residence (table II, based on the Kruskal-Wallis test) and for experience in caregiving (table III, based on a Mann-Whitney U test). The clear majority (60%) of respondents disagreed with the statement, and 40% of them expressed strong disagreement (table I); 18% of respondents describing themselves as religious agreed with the analyzed opinion, while only 4% of non-religious persons expressed acceptance. Furthermore, 54% of non-religious persons strongly disagreed with the opinion that life should be prolonged at any cost, and 28% of religious persons shared that view.

For 71% respondents, the quality of life was more important than its length; 46% of them strongly agreed (table I), 17% were neutral and 12% disagreed. The results of a Mann-Whitney U test show that the analyzed factor has statistically significant impact on the answer distribution (p = 0.000). In the case of persons declaring themselves as non-religious, 56% strongly agreed, while among religious ones – 39%. Experience in caregiving had no statistically significant influence on the respondents' answers (table III). The support for the analyzed opinion decreased with age (rho = -.09 p <.05): in the oldest age group (55yo and more), every third respondent (34%) strongly agreed, 27% agreed and almost a quarter of them (24%) were neutral (p = .022). In the case of place of residence (table II) and experience in caregiving (table III), the test results demonstrated no significant differences.

Questions important for the investigated problem were related to the right to cease futile medical care. The respondents could mark any number of answers. 86% of the surveyed persons indicated that the decision should be made by the patient, 57% would accept a decision made by family members, and 37% – by doctors. Only 7% of respondents did not answer this question and 1% selected other persons.

The second part of the presented study focuses on the respondents' opinions regarding the role of the family when the need to take care of a terminally ill person arises. To present a complete picture, it was important to include not only axiological questions but also those that referred to system care solutions, including the role of the family in caregiving (functional dimension). In answers to the question whether it is the family that should take the main responsibility for providing care to a dependent person, more than half of the respondents

Table II. The Kruskal-Wallis test for the place of residence and age variables

	Kruskal-Wallis test	
Statements	**Place of residence**	**Age**
It is right to support life at any cost.	H (5, N= 957) =7.840756 p =.1652	H (3, N= 958) =12.34550 p =.0063
A person in a vegetative state should be kept alive at any cost.	H (5, N= 956) =10.87042 p =.0540	H (3, N= 957) =8.721206 p =.0332
Quality of life is more important than its length.	H (5, N= 955) =5.876032 p =.3185	H (3, N= 956) =9.637848 p =.0219
Care of a dependent person should be the responsibility of their family.	H (5, N= 954) =23.02652 p =.0003	H (3, N= 955) =50.45481 p =.0000
Financing the care of a dependent person should mainly be the responsibility of their family.	H (5, N= 956) =4.732992 p =.4493	H (3, N= 957) =28.21189 p =.0000
I would resign from work to take care of a severely ill family member.	H (5, N= 954) =16.40334 p =.0058	H (3, N= 955) =.3644638 p =.9475

Result as statistically significant for p < .05

Table III. Mann-Whitney U test for the experience in caregiving and religiosity variables

Statements	Variables	U	Z	p	Z adjusted	p
It is right to support life at any cost.	Experience in caregiving for a terminally ill person	103931.5	-0.6234	.533	-0.66471	.506
	Religiosity	80969.5	-7.58326	.000	-8.08824	.000
A person in a vegetative state should be kept alive at any cost.	Experience in caregiving for a terminally ill person	105473	-0.1767	.859	-0.18561	.852
	Religiosity	73986	-9.19054	.000	-9.65412	.000
Quality of life is more important than its length.	Experience in caregiving for a terminally ill person	105807	-0.08215	.934	-0.08758	.930
	Religiosity	90048	-5.40006	.000	-5.757	.000
Care of a dependent person should be the responsibility of their family.	Experience in caregiving for a terminally ill person	94567	-2.7224	.006	-2.81311	.004
	Religiosity	101121	-2.6752	.005	-2.76404	.005
Financing the care of a dependent person should mainly be the responsibility of their family.	Experience in caregiving for a terminally ill person	93099	-3.18639	.001	-3.5083	.000
	Religiosity	111512	-0.32654	.744	-0.35914	.719
I would resign from work to take care of a severely ill family member.	Experience in caregiving for a terminally ill person	95524	-2.48886	.012	-2,55075	.010
	Religiosity	89005.5	-5.55127	.000	-5.68962	.000

Result as statistically significant for p < .05

Table IV. Spearman rank order correlation

Statements	Age	Religiosity	Place of residence	Experience in caregiving for a terminally ill person
It is right to support life at any cost.	0.04	0.26*	-0.07*	0.02
A person in a vegetative state should be kept alive at any cost.	0.05	0.31*	-0.10*	-0.01
Quality of life is more important than its length.	-0.09*	-0.19*	0.03	0.00
Care of a dependent person should be the responsibility of their family.	-0.23*	0.09*	-0.14*	0.09*
Financing the care of a dependent person should mainly be the responsibility of their family.	-0.17*	0.01	-0.07	0.11*
I would resign from work to take care of a severely ill family member.	0.02	0.18*	-0.12*	-0.08*

* Result as statistically significant for p < .05

(55%) thought that such care should not be the responsibility of the dependent person's family; almost a quarter of the respondents (24%) were neutral and 21% agreed with the analyzed opinion, but only 4% agreed strongly. A Mann-Whitney U test revealed statistical significance in answer distribution with regard to religiosity (p = .005) and experience in caregiving (p = .004). A Kruskal-Wallis test pointed to a statistical significance in answer distribution due to age (p = .00). Young persons from the 18–24yo group were more inclined to entrust the care of a dependent person to the family (34%) than other age groups (25–39yo – 20%, 40–54yo – 16% and 55yo and more – 12%). The older the respondents were, the more pronounced disagreement with the presented opinion they expressed (rho = .23, p <.05). Over 70% of the people in the oldest age group disagreed with burdening the family with responsibility for care, including 40% who disagreed strongly. Statistically significant differences in relation to the place of residence were demonstrated as well (p = .0003). Residents of rural areas (28%) and small towns (26%) considered the family role as more significant. The smaller the settlement, the less support the opinion had among the respondents (rho = .14, p <.05), while in the case of cities with 500,000 or more inhabitants, the support dropped to 18%.

As to the question whether the financial burden of care of a dependent person should be borne by the family, the overwhelming majority of the respondents (81%) disagreed with this statement, and more than half of them (53%) disagreed strongly. Only 6% of the respondents held the opinion that the family was to bear the costs of care of a dependent person (table I). Regarding the distribution of answers in relation to the respondents' age (p = .00) (table II), three quarters of the respondents from the youngest age group (18–24yo) disagreed with the statement, and 36% disagreed strongly. Among the older age groups, the answers "strongly disagree" were much more frequent – 89% people aged 55yo and more disagreed, and as many as 67% disagreed strongly. In the case of answer distribution in relation to experience of care (p = .00) (table III), people who had taken care of a chronically ill person expressed more decisive opinions: 60% strongly agreed that the family should bear the costs of care, and 25% disagreed, while one in ten did not have an opinion. In the case of people without such experience, the vector was similar but the answers were slightly less decisive: 49% strongly disagreed, 31% disagreed and 15% were neutral. The test results did not demonstrate any statistically significant differences in answer distribution in relation to the place of residence (table II) and religiosity of the respondents (table III). As to declarations about taking care of a terminally ill person and family members simultaneously shouldering the financial responsibility, the respondents were asked whether they were ready to resign from their job to look after an ill family member. The substantial majority of respondents declared readiness to make such decision – 46% agreed or strongly agreed. However, 26% were unable to declare whether they were ready, and 28% knew they were not (table I). The Mann-Whitney U test showed that being religious (p = .00) and having experience in caregiving for a chronically ill person (p = .01) has statistically significant influence on the readiness to leave one's job in order to take care of an ill family member. Considering experience, respondents who had already provided care for a chronically ill person declared more readiness to resign form their job (51%) than those without such experience (43%) (rho = 0.11, p <05). The answer distribution was similar when religiosity of the respondents was considered: 53% of those declaring themselves as religious announced their readiness to leave their jobs (38% of non-religious) (rho = 0.18, p <05) (Tab. IV). With regard to age, the results of the Kruskal-Wallis test displayed lack of statistically significant differences in answer distribution, but the size of the dwelling place was significant (p = .007). A weak but statistically significant correlation was discovered for place of residence. The highest readiness to resign from their jobs was discovered among women living in rural areas (56%), towns up to 20,000 inhabitants (54%) and cities with 100–200,000 inhabitants (51%). 40%–47% residents of other towns/cities declared their readiness. At the same time, the number of women from towns with 200–500,000 inhabitants (32%) and the cities with more than 500,000 inhabitants (32%) who declared their readiness was the lowest.

Discussion

Acknowledging the need for a debate on the value of life in terms of a person's health and independence is not automatic; it is influenced by cultural-geographical and social factors as well as individual ones. The presented research focused on opinions of women and the conditions that impact the axiological dimension of perceiving life that is nearing its end and the notions regarding the scope of family care of terminally ill persons as a realization of the basic function of a family.

The research has led to a conclusion that in the axiological areas the dominant feature diversifying women's answers is their religiosity. Religious persons to a larger degree declared convictions on the absolute value of life, independently of the person's state of health. The dominant group presenting the views that futile medical care is necessary and that the length of life is worth more than its quality were women aged 55 and more, which, according to the ISKK, are corresponding factors. Women aged 55 and more declare themselves as more religious. Significantly, the surveyed women held the opinion that if there are grounds for ceasing futile medical care, such a decision should be made by the patients themselves (86%) or by their family members (57%). A relatively small group of respondents accepted the idea that a decision in these matters should be left to specialists, i.e. doctors.

According to the Central Statistical Office, despite the process of secularization that started in Poland in 1989 together with the change in the political system, in the first half of 2018 almost 70% of the Polish residents aged 16 and more declared themselves as religious, and ca. 11% as deeply religious. 11% of the population declared themselves in the matter of religion as undecided or searching, but attached to the religious tradition. Persons indifferent to faith were less than 6%, and the non-believers – 3% of the analyzed population. A study on social coherence demonstrated that between 2015 and 2018 there were no statistically significant changes in these views [33]. There are clear differences between genders in terms of declared religiosity. It should be noted that the function of religiosity as a regulatory mechanism in discovering the meaning of life – a mechanism that helps facing the suffering of one's own or others – plays an important role in actualizing religiosity in a subject's everyday life, thus it must be considered as a "living relation" that involves the subject [34]. In Poland almost twice as many women as men describe themselves as "deeply religious (25.6%–13.9%) and much less frequently as "non-believers" or "indifferent to religion" (5.2% –11.8%); they also much more frequently declare their belief in God (93–90%) [36]. The obtained results clearly place Polish women among nations where religion has a strong impact on shaping the views regarding the value of life and attitudes to taking care of a terminally ill family member. What is very interesting, in questions aiming at the verification of views on the functional aspect of care for terminally ill persons religiosity (tab.2, tab.3) as well as age (tab.2) appeared – except for the question regarding leaving one's job to provide care for an ill person. Due to the changes in family model that have taken place in Poland after 1989, predominantly lower birth rate and a marked tendency among people of working age to go on long-term international migrations, the caregiving potential of families has decreased.

Residents of smaller settlements, mainly those from rural areas, are more willing to take the full responsibility for caregiving as in these places the traditional family model has been more often preserved (Tab. II, Tab.IV). An important aspect is also lower accessibility to health services and social benefits in poorly urbanized areas [25]. Care of a dependent person involves costs such as expenses on sanitary products, medicines and accessories as well as care, medical and physiotherapy services. A vast majority of the respondents (81%) disagreed with the statement that the financial burden of taking care of a dependent person should be borne by a family (Tab. I).

A particularly strong vector of answers was found in the group of respondents with previous experience in caregiving (60% strongly disagreed, 25% disagreed). In Poland, if a caregiver leaves their work to look after a dependent adult family member, they can receive a special carer's allowance of 620 Polish zlotys (ca. $160) – but only if the family income per person is below the threshold of 764 zlotys ($200), while in 2019 the minimum monthly pay for full-time work was 2250 zlotys ($585) [37]. Despite low financial support for the caregivers of dependent persons, 46% respondents considered resigning from their jobs if there was a need to look after a severely ill family member. This answer was selected slightly more often by persons with prior experience in caregiving (51%) and those describing themselves as religious (53%).

It should be taken into consideration that the study had a declarative character; the data collected by the team of Gerber, Hayes and Bryant [38], who did a qualitative research on the terminally ill patients and their family caregivers (i.e. persons with current experience in providing such care) regarding their preferences as to the place of care and place of death, demonstrated that the respondents mostly answered that such preferences are dependent on the current situation and related uncertainty. What was also important for them was the information on systemic alternate care solutions, which in Poland are clearly lacking. The sense of security related to the access to extra familial forms of care, and sometimes a fear of the need to adjust to institutionalized expectations, have an influence on the stability of family boundaries. The lack of clarity over manners and quality of transaction between families and external social support systems may weaken the family's safety boundaries. It also affects its integrity and sense of identity, and results in redirection of strength towards adjusting to the demands of health, educational and social services suppliers, who attempt to help satisfy the special needs of the family [21], including the care needs.

In Poland, the incomplete systemic solutions overlook another important issue, i.e. the condition of informal caregivers, for whom providing long-term care of elderly persons has a number of consequences – psychological, social, health-related and economic. Those who play the role of caregivers are at higher risk of experiencing depressive states, social isolation and exclusion from the job market [39, 40, 41]. Also in systemic perspective it is emphasized that a severe illness is a family matter, and everyone treating severely ill patients should pay special attention to its meaning in the functioning of the whole [20]. The deterioration of psycho-physical condition of particular family members deteriorates a systemic care potential of the family as a cohesive organism.

A frequent practice is that the main care providers and their nearest circle ignore stress and caregiver's burnout, which has an impact on future functioning of the main carer [42]. Consequently, this may generate a family spiral of care, where the exhaustion of the main caregiver (a connection between the poor state of carers' health and high burden of care was demonstrated by e.g. the team of Brazil, Bédard, Willison and Hode [43] and which requires involving yet another person in this family system – usually a younger woman. Limited accessibility of help assets – human (workers directly providing care services), material (the waiting time for a place in a nursing home can be even two years) and financial (local authorities refuse to pay benefits when they lack funds) – does not create other possibilities. This strengthens the systemic conviction of the respondents regarding the assumed role of the family.

Conclusion

The family structure of dividing duties connected with family taking care of persons in the end-of-life situation clearly reveals a preserved patriarchal pattern. This situation is exacerbated by the non-functioning social security system and – as revealed by the research – the fact that socio-culturally, Poland belongs to the countries where religion has high influence on the presented attitudes. The process of society aging, together with doubling of care areas (delayed maternity, longer lifetime of seniors) will result in higher burden of care placed on families. This necessitates a search for new solutions supporting the functioning of women-carers, including the transformation of the family system, which should adopt the participation model of dividing caregiving-related tasks. What seems to be an important direction is also some involved social education redefining knowledge on informal caregiving in families.

Conflict of interest
None

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