

INFORMATION AND COMMUNICATION ACCESSIBILITY FOR SENIORS IN POLISH HEALTH CARE

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Abstract The study focuses on information and communication accessibility in Polish health care, with particular emphasis on geriatric patients. We aimed to identify and analyze legal barriers and institutional mechanisms that determine interaction effectiveness between older adults and public administration. The core of the research problem lies within the paradigm of demographic population aging, which creates the need to implement systemic communication solutions. Communication accessibility constitutes both a formal legal requirement and a key determinant behind the quality of the therapeutic process and the health safety of older patients. We employed two research methods: doctrinal and empirical.

1 Introduction

Population aging constitutes a significant challenge for states in many fields of social life. Although most prominent in Western Europe, this issue also encompasses Poland. According to 2024 Eurostat data, the share of older adults – namely persons aged at least 65 years – in the EU population reached 21.6% (Eurostat, n.d.). This figure indicates a continuous increase: by 0.3 percentage points (pp) compared with 2023 and by 2.9 pp compared with 2014. Demographic projections suggest a substantial rise in the proportion of the oldest age group, namely 80 years and over. Researchers expect that the share of this group in the EU population will increase 2.5-fold between 2024 and 2100, from the current 6.1% to 15.3%. Simultaneously, the rate of population aging varies across Central and Eastern European countries: Bulgaria, Latvia, and Croatia are among the most demographically advanced, Poland is aging rapidly, and Slovakia remains one of the youngest societies in the region. Meanwhile, in Poland, population aging displays a particularly rapid increase in the number of people in the oldest age groups. Population aging varies in intensity across regions of Poland. Most individuals aged 60 and older live in urban areas (63.7%). Data from Statistics Poland (2024) show that the Świętokrzyskie Voivodeship had the highest share of older adults (29.8%), whereas the Małopolskie Voivodeship had the lowest (24.5%). By the end of 2024, 576.9 thousand retirees aged 60 and over remained employed, which represents a 1.4% increase compared with the previous year. At the same time, 84.8% of older adults remained economically inactive (Wyszkowska, Gabińska & Romańska, 2025, pp. 15–18). Polish seniors do not constitute a homogeneous group in terms of their activities and lifestyles. Researchers distinguish three categories: broadly active seniors (average age 69), seniors active mainly in the private sphere (average age 71), and withdrawn seniors (average age 76). Age and health status largely shape their behaviors. The youngest cohort (ages 60–64) shows the highest level of activity; they also have the highest levels of education and material well-being and predominantly live in urban areas. In contrast, withdrawn seniors tend to have lower levels of education, poorer financial conditions, and more significant health problems. Seniors active in the private sphere most often live in rural areas, and their levels of education, health, and material status fall between those of the first and second groups (Omyła-Rudzka, 2025, pp. 12–14). According to the PolSenior2 study and other data, a substantial majority of older adults report long-term health problems or chronic diseases. For example, in 2023, 63.2% of people aged 60 and over reported such issues. Moreover,

multimorbidity (polypathology) occurs frequently among this group. The increasing pace of population growth for 75+ and 80+ groups, referred to as ‘double aging,’ requires the Polish State to undertake appropriate measures – including, and perhaps above all, in the health care sector. However, some of these initiatives demand systemic solutions, such as the need to integrate the activities of all institutions responsible for senior policy, creating a coordinated senior policy that aligns social and health policies for older adults, legally defining long-term care, and the need to introduce social facilitation measures and innovations in health care. Other initiatives include the need to provide information and the use of existing accessibility instruments, such as communicating relevant preventive programs and promoting healthy aging, physical activity, and wholesome lifestyles to extend healthy life expectancy.

2 Communication in Health Care

As a patient, an older adult interacts with multiple entities within the health care system, including those that provide health services operating within primary care (PC), outpatient specialist care (OSC), emergency departments (ER), hospitals, and, in the final stage of life, long-term care facilities and hospices. From primary care, through specialist care, to long-term or terminal care, it is essential for there to be effective communication between medical staff and the patient, or a person authorized by the patient. However, in practice, such communication often proves inadequate due to various limitations in the health care system and barriers arising in the day-to-day functioning of health care institutions. Irrespective of these challenges, communication plays a fundamental role in realizing patients’ rights, particularly those of older adults, in safeguarding patient dignity and autonomy (Bernatek-Zagula, 2008, p. 95), and in ensuring treatment safety. In order to ensure that patients are able to provide informed consent for the treatment they receive, staff must convey information in a manner adapted to the patient’s age, health status, and cognitive abilities, using plain language and avoiding medical jargon. Furthermore, proper communication with older patients fosters trust and reduces anxiety among older adults, who often feel isolated or overlooked. Such an approach helps to prevent ageism and the perception of the older person as a ‘difficult’ patient (Bujny, 2007, p. 138). Achieving an appropriate communication standard requires a shift from a service-oriented model of doctor–patient interaction to a relational model. In a theoretical framework, one can develop this model by applying Jürgen

Habermas's theory of communicative action. In the context of healthcare, the Habermasian ideal speech situation refers to a relationship in which the patient and the clinician jointly develop a treatment plan based on well-founded arguments and mutual understanding, while excluding coercion and paternalism. This approach enables patients to fully articulate their needs and provides an ethical justification for therapeutic decisions, framing the healing process as the outcome of a collaborative dialogue rather than by imposing decisions unilaterally (Wonicki, 2012). Within this framework, the asymmetry of knowledge between the professional and the patient remains a fact. However, clinicians bracket it as a source of authority so that therapeutic actions emerge from ethical consensus, mutual understanding, and shared responsibility for the course of treatment (Maślanka, 2011).

3 Legal Framework in Communication and Information Accessibility

The obligation to inform patients about their health status stems from two spheres: first, from law, including both national and international acts, such as Article 8 of the European Convention on Human Rights and Fundamental Freedoms; and second, from ethics, in particular Article 16 of the Polish Code of Medical Ethics, annexed to Resolution No. 5 of the Extraordinary 16th National Medical Congress of May 18, 2024. Legal acts defining the right to medical information, specifically access to information about one's health, include: the Act on Patient Rights and the Patient Ombudsman of November 6, 2008 (Ustawa o prawach pacjenta i Rzeczniku Praw Pacjenta), Articles 9–12; the Act on the Collection, Storage, and Transplantation of Cells, Tissues, and Organs of July 1, 2005 (Ustawa o pobieraniu, przechowywaniu i przeszczepianiu komórek, tkanek i narządów), Article 5; the Act on Laboratory Medicine of September 15, 2022 (Ustawa o medycynie laboratoryjnej), Article 24; the Act on Mental Health Protection of August 19, 1994 (Ustawa o ochronie zdrowia psychicznego), Articles 23(3) and 33(2); the Act on the Prevention and Control of Infections and Infectious Diseases in Humans of December 5, 2008 (Ustawa o zapobieganiu oraz zwalczaniu zakażeń i chorób zakaźnych u ludzi), Articles 17(9), 26, and 28; and the Act on Medical Activity of April 15, 2011 (Ustawa o działalności leczniczej), Article 29(4).

In certain situations, the law allows these legal obligations to provide information to patients to be fulfilled by imparting the requisite information to persons other than the patient, such as close relatives. Article 31(4) of the Act on the Professions of

Physician and Dentist of December 5, 1996 (Ustawa o zawodach lekarza i lekarza dentystry), sets regulations in this regard. These provisions concern specific patient groups, which may include older adults, such as persons who remain legally incapacitated, unconscious, or unable to comprehend the significance of the information. Either the law itself or the patient's consent can serve as the legal basis for providing information to a person other than the patient (Ziółkowska, 2015, p. 154).

Satisfying the obligation to inform patients requires adherence to the principles of accessibility as defined in: the Act on Sign Language and Other Means of Communication of August 19, 2011 (Ustawa o języku migowym i innych środkach komunikowania się); the Act on Ensuring Accessibility for Persons with Special Needs of July 19, 2019 (Ustawa o zapewnianiu dostępności osobom ze szczególnymi potrzebami); and, indirectly, the Act on Digital Accessibility of Public Entity Websites and Mobile Applications of April 4, 2019 (Ustawa o dostępności cyfrowej stron internetowych i aplikacji mobilnych podmiotów publicznych). These obligations are particularly important for older adults, who typically have special needs, including specific communication needs. With age, the natural decline in vision and hearing poses serious barriers to standard medical communication. Geriatric challenges, both sensory and cognitive, oblige health care professionals to actively adapt communication to the patient's individual needs, which directly affects fulfilling patient rights, ensuring that treatment is effective, and protecting seniors' safety.

Consequently, one effectively realizes a patient's right to information only when one adapts that information to the patient's sensory and cognitive abilities (see Lewaszkiewicz-Petrykowska, 1994, p. 49). Moreover, only then can the information serve as the basis for informed consent to medical procedures (Safjan, 2005, p. 19; Drozdowska & Wojtal, 2010, pp. 44–45). Broadly speaking, the Polish health care system has a long-standing tradition of noncompliance with patients' information rights, which can lead to extreme situations. On the one hand, health information provided by the Ministry of Health or the National Health Fund (NFZ) often appears unclear (Charzyńska, 2017, p. 247), while information on patients' rights, such as prehabilitation, frequently remains missing (Hnat, 2025). On the other hand, medical communication sometimes becomes oversimplified and reduced solely to forms – seldom individualized and frequently replacing or diminishing doctor-

patient contact (Szudejko, 2023, pp. 40–41). In this context, fulfilling the information obligation toward seniors, particularly those with special needs requiring additional communication support, proves highly challenging.

4 Communications and Accessibility Barriers in Health Care

4.1 The Barrier of Specialized Language: Medical Jargon

The problem of effective communication with seniors becomes particularly important for the doctor-patient interaction. The risk involves communication disruptions, such as difficulties in asking and answering questions accurately, lapses in concentration during conversations, and problems with summarizing information (Ostrowska, 2018, pp. 9–12). Seniors might repeat information several times to ensure that they both heard and understood the message correctly. Key disruptive factors on the part of physicians include reliance on stereotypes in perceiving seniors, expressing reluctance toward this age group, providing limited or overly concise responses, and excessive use of specialized language, or medical jargon (Park & Song, 2005, pp. 155–160). Other barriers include the inability to convey information clearly, speaking too quickly, failing to respond when patients show difficulty understanding information, inappropriate volume – speaking either too loudly or too softly, neglecting patients' sensory impairments (Sulkowska, et al., 2018, p. 40), the use of baby talk, infrahumanization (Barański, 2021, pp. 60–62), as well as heightened authoritarianism, reduced patience, and lower engagement (Stefaniak, 2011, p. 209).

The use of specialized terminology constitutes a significant communication barrier, particularly for seniors. Notably, the outcomes of medical education include the ability to communicate with patients and their families in a trusting atmosphere, considering the patient's needs, delivering unfavorable information according to professional communication principles, and conducting medical interviews with adults, including seniors, using skills related to the communication content, process, and perception, while considering both biomedical and patient perspectives. Therefore, communication forms part of the curriculum for at least one semester (Wrocław Medical University, 2025), for several semesters (Warsaw Medical University, 2025), or even from the first to the fifth year of study (Łódź Medical University, 2025). Moreover, descriptions of a medical graduate emphasize the need

to adapt verbal communication to the patient's needs, express oneself clearly, and avoid medical jargon. Similarly, the nursing education standards include the ability to identify errors and barriers in the communication process and to use verbal and nonverbal communication techniques in nursing care, adapting verbal communication to the patient's needs, expressing oneself clearly, and avoiding medical jargon. Paramedics must additionally know the principles of communicating with visually impaired, blind, hard-of-hearing, and deaf patients, as stated in the Regulation of the Minister for Science and Higher Education on the Standards of Education Preparing for the Professions of Physician, Dentist, Pharmacist, Nurse, Midwife, Laboratory Diagnostician, Physiotherapist, and Paramedic of July 26, 2019 (Rozporządzenie Ministra Nauki i Szkolnictwa Wyższego w sprawie standardów kształcenia przygotowującego do wykonywania zawodu lekarza, lekarza dentystry, farmaceuty, pielęgniarki, położnej, diagnosty laboratoryjnego, fizjoterapeuty i ratownika medycznego).

Unfortunately, the functioning of health care institutions shows that the knowledge and skills acquired in communication courses fail to translate into actual practice, or do so only to a limited extent. Physicians and other health care professionals themselves recognize that they lack solid communication knowledge, even though the latter remains essential for efficient work and for effectively obtaining informed consent from patients. For this reason, Polish universities, led by Jagiellonian University, have introduced mandatory courses on patient communication for future physicians and nurses (Polityka Zdrowotna, 2023).

Importantly, the use of specialized jargon runs counter to the plain language approach promoted within the accessibility framework, as outlined in Resolution of the Council of Ministers No. 102/2018 of July 17, 2018: Accessibility Plus Government Program 2018–2025 (Uchwała Rady Ministrów nr 102/2018: Program Rządowy Dostępność Plus 2018–2025). Moreover, the use of medical jargon reinforces paternalism in doctor-patient communication, as it deepens communicative asymmetry and prevents patients from consciously and actively participating in the discourse (Rutkowski, 2016, pp. 93–94). Therefore, training for medical profession candidates should include plain language communication, enabling those persons to perform intralingual translation in doctor-patient interactions. In other words, medical staff should be able to translate from specialized terminology into plain language, since this proves both possible and

desirable (for more see Łomzik, 2021, pp. 264–273). Moreover, candidates should receive training in the functioning of individuals with complex communication needs, who require special consideration in the context of information delivery.

4.2 Accessibility and Information Barriers

Accessibility and information barriers relate to the way institutions convey required information about patient rights, particularly to seniors with special needs. We may refer to the method of providing information to individuals with special needs as a special type of informing, or ‘informing plus,’ because, in addition to the standard obligation to communicate patient rights, it also includes the delivery form. This may involve making information available through Polish Sign Language (PSL), signed language systems (SLS), or the communication system for blind individuals (CSBI), as well as through other communication-supporting measures under the Act on Sign Language and Other Means of Communication (Article 6(3)), the Act on Ensuring Accessibility for Persons with Special Needs (Articles 4 and 6(3)), and the Act on Patient Rights and the Patient Ombudsman (Article 12(2)). Among the main problems in the area of accessibility and information barriers, we may identify the following:

1. lack of procedures for serving individuals with special needs in various health care facilities: PC units, OSC units, and hospitals, including ERs;
2. insufficient knowledge of patient rights, including information rights, among patients with special needs (Chmielowiec et al., 2025, pp. 551–552, 556–557);
3. the absence of sign language interpreters, including online interpreters, required in health care facilities (Radio Kraków, 2022; see also Sobańska-Laskowska, 2023, p. 108);
4. failure to use appropriate tools and organize work effectively so as to enable service delivery, including providing information to older adults with special needs (for more on such tools see Sahaj, 2021, pp. 33–35).

These problems stem from years of inadequate management within the broadly understood healthcare system and from the lack of knowledge and soft skills among both administrative and medical staff. The absence of procedures for serving individuals with special needs means that health care facilities have failed to adopt standards for serving such patients. The standards in question should specify how a

facility should interact with older adults who are deaf or blind, have communication difficulties, or display cognitive impairments. Under the adopted standards, all facility staff should receive training in the functioning of individuals with special needs and on relevant communication methods. Furthermore, each facility should designate a person to coordinate the needs of such patients and to organize communication-supporting equipment, either through internal funding or using European funds. For example, the project *Accessibility Plus for OSC* currently conducts recruitment (Gov.pl, n.d. (a)).

The lack of PSL interpreters and appropriate equipment in health care facilities largely results from missing NFZ funding. The Act on Health Care Services Financed from Public Funds of August 27, 2004 (Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych), does not oblige the NFZ to finance health care providers' tasks arising from the Act on Ensuring Accessibility. However, support may come from the Accessibility Fund. Facilities can use real-time video interpreter services provided by certain organizations for deaf persons, or the support of a designated assistant, who has the right to participate in communication under Article 7 of the Act on Sign Language and Other Means of Communication.

Regarding equipment in facilities, the limitations concern both finances and, perhaps primarily, awareness. Consequently, patients encounter a lack of procedures and knowledge regarding interaction with individuals with special needs. The latter require appropriate support through the use of text readers, tactile maps, communication cards for deaf individuals, tablets equipped with real-time communication software with PSL or SLS interpreters, signature frames, written communication tools, and personal alternative communication devices such as GoTalk or Mówik.

Communication with individuals with sensory impairments can sometimes approximate standard communication owing to tools such as audio induction loops, FM systems, infrared (IR) devices, or Bluetooth. Unfortunately, their implementation in healthcare facilities has not become widespread yet. Although health care institutions have made progress in recent years, they mostly remain insufficiently prepared to provide information and communication services to individuals with special needs, as evidenced by patient complaints filled with both

the Patient Ombudsman and the Citizen Ombudsman (Imiolczyk, 2020, pp. 20–22). The Citizen Ombudsman highlights these issues in the address to the President of the State Fund for the Rehabilitation of Persons with Disabilities (PFRON) (Biuro Rzecznika Praw Obywatelskich, 2024a) and to the Patient Ombudsman (Biuro Rzecznika Praw Obywatelskich, 2024b). More recently, patients direct their complaints also to the President of the PFRON (PFRON, 2025). In summary, health care institutions continue to fail to treat patients with special communication needs as full participants.

4.3 Digital Barriers

In recent years, Poland has experienced intensified digitization of public administration (Ziółkowska, 2022, p. 2023), including a significant growth in telemedicine and the range of related services (for more on telemedicine see Wrzesińska-Wal & Hajdukiewicz, 2020, pp. 509–524). Although this development represents a positive solution, it can also pose a barrier, particularly for digitally excluded older adults or seniors with disabilities, when the information provided through these channels proves insufficiently accessible.

Key solutions in this area include:

- electronic medical records (EMRs) – Article 13a of the Act on the Health Information System of April 28, 2011 (Ustawa o systemie informacji w ochronie zdrowia), and the Regulation of the Minister for Health of May 8, 2018, on the types of electronic medical records (Rozporządzenie Ministra Zdrowia w sprawie rodzajów elektronicznej dokumentacji medycznej), according to which EMRs include information on the diagnosis of a disease, health problem, or injury, examination results, reasons for refusal of hospital admission, provided health services including recommendations, hospital discharge summaries, laboratory test results with descriptions, diagnostic test reports, and Individual Medical Care Plans (Szewczyk, 2024, pp. 63–73; Maj, 2022, pp. 165–174);
- e-prescriptions – Article 56 of the Act on the Health Information System. They require a PIN code and the ability to read SMS messages (see more in Owczarczyk, 2023, pp. 13–30);
- Internet Patient Account (IKP) – Article 7a of the Act on the Health Information System.

The IKP allows patients to:

- submit statements authorizing individuals to access medical records, as referred to in Article 26(1) of the Act on Patient Rights and the Patient Ombudsman of November 6, 2008 (Journal of Laws 2024, item 581);
- provide consent for data sharing, as referred to in Article 35(1a) of the Act, and to withdraw such consent;
- submit statements of consent for the provision of information, as referred to in Article 9(3), and to withdraw such consent;
- submit statements of consent for the provision of specific health services, as referred to in Articles 16–18;
- access information on disease prevention and healthy lifestyles based on individual patient data;
- respond to surveys on health care quality;
- access information on issued prescriptions, as referred to in Article 38(4a) of the Act on the Reimbursement of Medicines, Foodstuffs for Particular Nutritional Uses, and Medical Products of May 12, 2011 (Ustawa o refundacji leków, środków spożywczych specjalnego przeznaczenia żywieniowego oraz wyrobów medycznych) (see Kowalska et al., 2023, pp. 35–46).

Among other ways, medical records can be available through on-site review at the health care facility, the preparation of copies, printouts, transcripts, or extracts, issue on an electronic data carrier, and transmission via electronic communication channels (see Klimas, 2018, pp. 91–105; Klich, 2017, pp. 351–360).

The digitalization of medical services and medical records makes it relevant to ask how authorities implement the right to information under Article 23(1) of the Act on Patient Rights and the Patient Ombudsman, particularly with regard to older adults. The Patient Ombudsman has repeatedly emphasized the obligation of health care providers to make medical documentation available in digital form and in a machine-readable format, such as a PDF-accessible file. This obligation stems directly from digital accessibility requirements and conditions the comprehensibility of information for this group of patients. Accordingly, activities undertaken within telemedicine can and should complement direct doctor-patient interactions. Telemedicine tools remain useful for information purposes insofar as both

physicians and patients, including older patients, use them appropriately, which is not always obvious or feasible. Physicians also highlight this concern, emphasizing that health care facilities should integrate telemedicine into a hybrid model of health service provision (Paprocka-Lipińska, 2022, p. 148).

A separate yet equally important issue concerns the digital exclusion of seniors: limited access to smartphones and other internet-enabled devices, as well as cognitive barriers, such as the need to remember passwords imposed by digital interfaces. In conjunction with the digitalization of medical services, this situation poses a risk to ensuring equal access to health care (Ziółkowska & Gronkiewicz, 2023, pp. 537–548). For this reason, digitalization cannot eliminate traditional forms of access, such as in-person registration at health care facilities or direct doctor-patient contact.

4.4 Organizational and Administrative Barriers

Medical services in Poland display a deeply entrenched bureaucratization, which constitutes a significant barrier to change. Medical workforce aging also poses a considerable issue. Projections regarding the number of nurses and midwives prove pessimistic, which generates staffing shortages and organizational challenges, particularly with respect to the length of visits. Apart from clinical examination and diagnosis, a consultation involves completing EMR, and that requires digital competencies. Although the use of medical assistants has become more common among private health care providers, this practice remains less evident in public health care facilities due to organizational constraints and financial limitations. Nevertheless, a widespread introduction of medical coordinators and a broader presence of medical assistants or medical secretaries within the health care system appears justified given the limited number of strictly medical staff and their ongoing aging.

Within the scope of their statutory powers, medical assistants may provide patients with information on test results and administer medications prescribed by a physician. Moreover, when authorized by a physician, they may issue electronic documents such as prescriptions, referrals, and medical leave certificates. As of October 1, 2022, PC physicians can also introduce a new model for the provision of health services in their facilities – coordinated care, as defined in the Notice of the

Minister for Health of February 15, 2021, on Publishing the Consolidated Text of the Regulation of the Minister for Health on Guaranteed Services within Primary Health Care (Obwieszczenie Ministra Zdrowia z dnia 15 lutego 2021 r. w sprawie ogłoszenia jednolitego tekstu Rozporządzenia Ministra Zdrowia w sprawie świadczeń gwarantowanych z zakresu podstawowej opieki zdrowotnej).

A medical coordinator ensures communication and cooperation between the patient and the medical team. The coordinator's key responsibilities include scheduling visits and diagnostic tests, informing the patient about the course of treatment, managing medical documentation, and ensuring effective communication with the patient on therapeutic matters. Although the coordination model remains well-founded, its effectiveness is often impaired due to myriad factors including work overload, lack of systemic integration, and inadequate staffing and financial resources to fully perform such broad and important duties. Therefore, the introduction of medical coordinators appears highly desirable and, in fact, necessary, particularly in large medical institutions such as hospitals, among other facilities. Authorities are already introducing similar measures within the health care system by appointing various coordinators whose tasks involve organizing the patient's treatment pathway, primarily in its informational dimension. In this sense, their role resembles that of accessibility coordinators. Alongside formally established oncology coordinators (Osowiecka et al., 2025, pp. 3–10), we also see stroke coordinators and cardiology coordinators. However, these solutions frequently lack legal regulation and a systemic character, as is the case with oncology coordinators. Moreover, medical coordinators do not currently constitute a separate, formally recognized professional group. At the legislative stage of adopting the Act on Ensuring Accessibility for Persons with Special Needs, the legislator did not consider it necessary to establish accessibility coordinators in medical institutions, unlike in public administration bodies or courts.

Notably, the explanatory memorandum to the draft Act on Ensuring Accessibility for Persons with Special Needs states that the Act will not require the appointment of accessibility coordinators in certain entities: 'therefore, it will not be necessary to designate such a person, for example, in a police unit, a cultural institution, or a hospital, but rather at the level of offices serving the competent ministers, in regional and local self-government bodies, and in the judicial authorities' (Sejm of the Republic of Poland, 2019, p. 18). We should regard this approach as a mistake, given

the generally low level of implementing patient rights, including the right to information. The Supreme Audit Office (NIK) also highlights this deficiency in its post-audit statement – *Information on Audit Results: Compliance with Patient Rights in the Health Care System* (Najwyższa Izba Kontroli, 2024, pp. 13–14, 17, 31–32). The introduction of an accessibility coordinator appears all the more justified in light of the difficulties that seniors and persons with special needs experience within health care institutions.

5 Conclusions and Recommendations

The law formally protects senior patients under the Act on Patient Rights and the Patient Ombudsman, which sets the principle of comprehensibility. Poland has also passed accessibility laws, such as the Act on Sign Language and Other Means of Communication and the Act on Ensuring Accessibility for Persons with Special Needs. Nonetheless, administrative practice still creates barriers. Authorities fail to enforce this law due to financial reasons and because of organizational, administrative, and, above all, mental barriers. In light of the above, one may conclude that the system of structures organizing society, in this case, the healthcare system, effectively colonizes the lifeworld in the Habermasian sense. As a result, power and money displace understanding and dialogue, reducing them to secondary values. This dynamic leads to the erosion of a shared public sphere in the domain of health. Moreover, in the context of a ‘fatigue’ or ‘exhaustion’ society, characterized by egotism and social isolation (Han, 2022, pp. 53–58), high-quality public services increasingly become a luxury rather than the State’s foundation. Over time, the absence of adequate institutional solutions will further undermine social cohesion by weakening generalized social trust. At the same time, this organizational and professional arrangement generates risks from which certain groups, often those that have partially produced them, can benefit by expanding their activities into the private sphere (Beck, 2004, p. 314). This process further accelerates the erosion of community and, in effect, increases dependence on the market across all areas of life (Han, 2024, pp. 21, 91). Because contemporary societies are more interdependent than commonly assumed, the State should pursue structural reform. Restoring a balance between public and market-based services appears necessary, even if doing so requires challenging the interests of specific groups, including those who benefit from the risks produced. At the same time, the medicalization of communication cannot serve as the sole ideological foundation of the doctor–patient relationship.

Following Habermas, one must recognize that not every use of language constitutes communicative action. Neglect of older adults in healthcare, including the failure to comply with existing regulations, leads to the disregard of standards concerning older persons developed by international bodies (Wedel-Domaradzka, 2023, *passim*) and may directly violate the rights of persons with disabilities as enshrined in the Convention on the Rights of Persons with Disabilities (e.g., Articles 9, 25, and 26). Addressing this situation requires a range of measures, including both immediate, practice-oriented initiatives and legal reforms formulated as *de lege ferenda* proposals.

Any effective reform must begin with increased funding for the Polish health care system, which the report '*10 nowych źródeł finansowania NFZ*' (*10 New Sources of NFZ Funding*) indicates as feasible (Owczarek et al., 2025, pp. 3–43). Another way to secure additional funds for health care could involve introducing income thresholds in the '800+' benefit program, which operates under the Act on State Support in Raising Children of February 11, 2016 (Ustawa o pomocy państwa w wychowywaniu dzieci). This program effectively initiated a wave of public service privatization in Poland (see Pawłowski, 2020, *passim*). Due to the deterioration of public service quality, this phenomenon increased the inequalities in Polish society (Bukowski et al., 2024, *passim*), including disparities in healthcare access, which particularly affected senior citizens.

Among the practical actions, authorities should take appropriate organizational and administrative measures both at the level of health care system units and with regard to the medical and paramedical staff. The first proposal should entail launching formally designated units, such as geriatric centers for patients aged 75 and over. Although specified in the Act on Special Geriatric Care of August 17, 2023 (Ustawa o szczególnej opiece geriatrycznej), such centers have not yet opened due to the lack of implementing regulations required by the law. Naturally, the organization of such centers may require reconsideration. Nevertheless, the concept itself, abandoned mainly due to insufficient funding in the health care system, appears important and promising. Around these centers, authorities could aim to integrate medical services with social services, forming a model of organized community geriatrics. Coordinated care represents one attempt to address these issues (Badora-Musiał, 2025, *passim*), although practice shows that it still requires refinement (Stawicka, 2025).

Some health care managers and physicians publicly propose appointing geriatric coordinators or establishing a fast-track geriatric pathway for seniors, modeled after oncology pathways. Furthermore, physicians recognize the need to develop solutions in the field of community geriatrics. Currently, primary care in Poland partially fulfills this role, but in the context of an aging population, this coverage appears insufficient. Notably, Poland lacks hospitals dedicated to patients with cognitive impairments such as dementia or Alzheimer's disease or with sensory limitations. In addition to performing standard medical work, such hospitals would be able to provide appropriate communicative care for these patients. Consequently, the health care system generally redirects seniors to conservative treatment, even though they could undergo certain medical procedures – including operations – and potentially enjoy longer and healthier lives.

A separate issue that requires reform concerns training. The lack of service standards for persons with special needs, including seniors, in many health care facilities appears to reflect low awareness across all levels, from management staff to medical and paramedical personnel. This lack of standards proves unjustified, especially given the availability of numerous publicly accessible materials and brochures (e.g., Zespół Rzecznika Praw Pacjenta, 2022a), including ready-to-use standards freely available for adaptation in various health care units, such as primary care (Gov.pl, n.d. (b)), outpatient care (Ministerstwo Zdrowia, n.d.), and hospital care (Zespół Rzecznika Praw Pacjenta, 2022b). Existing training initiatives on accessibility also demonstrate available frameworks. The project *Patient First: Activities of the Patient Ombudsman to Improve the Quality of Health Services* (Po pierwsze pacjent – działania Rzecznika Praw Pacjenta na rzecz poprawy jakości usług zdrowotnych) took place between 2020 and 2023 (Gov.pl, n.d. (c)). In turn, the ongoing project *Safe Patient: Activities for Patient Rights in the Health Care System* (Bezpieczny pacjent – działania na rzecz praw pacjenta w systemie ochrony zdrowia) is scheduled for 2024–2027 (Gov.pl, n.d. (d)).

The medical professions acts do impose a duty of continuous education and professional development on all medical personnel. These include, for example, the Act on the Professions of Nurses and Midwives of July 15, 2011 (Ustawa o zawodach pielęgniarstwa i położnictwa), the Act on the Professions of Physician and Dentist, and the Act on Certain Medical Professions of August 17, 2023 (Ustawa o niektórych zawodach medycznych). Still, these programs should entail training in

communication with seniors on a much larger and mandatory scale. Such training would adapt language to patients with hearing, vision, or memory impairments, as well as to those with dementia. This adjusted language would ensure accurate and empathetic communication regarding diagnosis, prognosis, and treatment plans, while fully respecting the senior patient's right to make informed decisions.

Given the partial or limited knowledge of patient rights, including information rights, literature suggests that medical education should place greater emphasis on teaching about patient rights. A gap exists between medical personnel's perception that they demonstrate familiarity with patient rights and their actual knowledge of and adherence to these rights (Chmielowiec et al., 2025, p. 556). Furthermore, every newly hired employee, whether medical or non-medical, should undergo mandatory onboarding training on accessibility, including the standards adopted at the specific facility, particularly those relating to information and communication accessibility. Accessibility coordinators or medical coordinators appointed by the unit manager should bear responsibility for the organization of ongoing training after employment in a health care unit. A necessary condition is that these coordinators operate exclusively in this capacity, without additional roles.

Properly conducted training, both during medical studies and throughout employment in health care facilities, should aim at a comprehensive improvement in quality, observable in three spheres: the clinical aspects, such as safety and effectiveness; the organizational aspects, namely efficiency and accessibility; and the consumer aspects – that is, patient experience and satisfaction. Furthermore, formalizing and implementing standards for serving persons with special needs should address certain NIK recommendations stemming from the 2024 post-audit report, directed at health care unit managers. These include ensuring that patients receive all information required by law, providing personalized consent forms for specific procedures that include all relevant details, and enabling electronic patient registration. Such registration should incorporate communication supporting tools, such as SMS, MMS, email, or audiovisual-enabled messaging platforms.

Among the legal proposals, in addition to the need to legally define long-term care, authorities could introduce detailed standards for geriatric communication – for example, in the Act on Patient Rights or its implementing regulations – and include the profession of medical coordinators in the Act on Medical Professions. Such

measures would certainly benefit both senior patients and the remaining patient groups. An alternative option in this regard involves adding hospitals and large outpatient clinics to the group of entities required to appoint accessibility coordinators, in accordance with Article 14 of the Act on Ensuring Accessibility. Finally, we deem it essential to formally strengthen the role of the Patient Ombudsman and the supervisory bodies overseeing medical facilities in intervening when the information right suffers a violation. This need also applies to information aimed specifically for senior patients, as highlighted in NIK's 2024 post-audit report.

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Legal Acts

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Povzetek v slovenskem jeziku

Študija se osredotoča na dostopnost informacij in komunikacije v poljskem zdravstvenem sistemu, s posebnim poudarkom na geriatričnih bolnikih. Cilj avtorjev je identificirati in analizirati pravne ovire ter institucionalne mehanizme, ki določajo učinkovitost interakcije med starejšimi odraslimi in javno administracijo. Srž raziskovalnega problema leži v paradigmi demografskega staranja prebivalstva, ki ustvarja potrebo po uvajanju sistemskih komunikacijskih rešitev. Dostopnost komunikacije predstavlja tako formalno pravno zahtevo kot tudi ključni dejavnik, ki vpliva na kakovost terapevtskega procesa in zdravstveno varnost starejših pacientov. Uporabljeni sta dve raziskovalni metodi: doktrinarna in empirična.