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## Volume 13, Issue 5/2011 - Interview

### Overview of the Polish Healthcare System

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#### Capital Stock and Investments

In 2009 there were 754 general hospitals in Poland. The vast majority (526 or 70%) were public, and the rest (228) were private, representing 90.2% and 9.8% of general hospital beds. In the same year, there were 52 psychiatric hospitals.

There are substantial differences in the proportion of public and private hospitals between regions. Voivodeships with the highest proportions of private hospitals (such as Kujawsko-pomorskie, Małopolskie and Pomorskie) are those that are economically well developed or are located close to national borders.

According to the CSIOZ's register of healthcare units (RZOZ) about 50% of all hospitals in Poland have less than 150 beds, with the proportion of small hospitals being higher for private institutions. On the other hand, most medium-sized hospitals (between 151 and 500 beds) are public.

The latest RZOZ data (2011) shows the average age of hospitals in Poland as 15.1 years. Most hospitals (58%) are between 10 and 20 years old. However, this assessment may be skewed due to the inclusion of very small or not functioning units in the registry. Most private hospitals have been established after 1999 and are therefore in relatively good conditions. On the other hand, some public were built in the 1970s and 1980s, and many are still housed in buildings constructed before World War II. As a result, their general condition is poor, and maintenance is very costly.

According to the 2008 Green Book II on Healthcare Financing in Poland (Ministry of Health, 2008), the average level of depreciation of fixed assets in the healthcare sector was approximately 62% at the end of 2006, whereas (according to construction industry standards) 40% is the level of depreciation that would qualify a building for an extensive overhaul (Ministry of Health, 2008). The situation is further aggravated by the widespread, long-standing practice of using amortization write-offs to cover financial losses. This practice stems from the financial limitations faced by the SPZOZs (independent public healthcare facility) and results in reduced spending on modernisation and renovation of facilities. According to the Green Book, over 60% of hospitals' fixed assets require major repairs or replacement and 40% of the buildings must be modernised.

The amount earmarked by the state for investment in healthcare is determined yearly in the budget. In the budget planned for 2011, over PLN 807 million was allocated to investment funding in healthcare, out of which PLN 265 million was allocated to healthcare programmes (some of these programmes also cover investments in equipment and clinics). The majority of budgetary funding (80-90%) was allocated to implementation of projects co-financed by the EU (see below). In theory, contracts with the NFZ (National Health Fund) should also provide hospitals with money for renovations, expansion and replacement of equipment. However, after paying for human resources, medicines and other expenses, the amount left for capital investments is negligible. Other sources, such as non-governmental organisations are used to finance smaller investments.

#### Infrastructure

In Poland, there was very little change in the number of beds until the late 1990s, but the restructuring that followed the 1999 reform resulted in a decrease of 11,547 beds between 1999 and 2002. Since then, the number of beds has been slowly declining. An increase in the number of general hospital beds between 2007 and 2008 visible in public statistics was mainly caused by the change in the methodology of counting beds (beds and incubators for the newborns were included in the number of general beds).

The average length of stay (ALOS) in hospital has been falling continuously in Europe in the past few decades. At 5.7 days in 2008, the ALOS in Poland compares relatively well with other European countries. The hospital occupancy rate in Poland has increased since the 1990s. In 2009, the highest occupancy rates were observed in haematology, psychiatric and addiction wards and the lowest in ophthalmic, neonatology, and paediatric wards.

The deficit of long-term care beds has long been on the health policy agenda. Plans to reduce the number of acute hospital beds in favour of long-term and psychiatric beds have been in place since the early 1990s. For example, conversion of acute care beds into long-term care beds was one of the components of the 2006 draft law on "hospital networks" but, as already mentioned, this law was eventually not implemented.

EU investments in healthcare infrastructure for 2007-2013 are channelled through the Operational Programme on Infrastructure and Environment, which provides European Community support under the convergence objective. The total budget of this programme is 37.56 billion euro (this is the biggest operational programme in Poland and in the EU), out of which nearly 412 million euro was allocated to Priority 12 (health, safety and improvement of health protection system), which provides support for developing an integrated emergency medical services system and healthcare infrastructure. At the end of 2010, the value of contracted funds amounted to 86% of the total funds available for Priority 12. Most contracts (231 out of a total of 283) were in the area of the integrated emergency medical services system.

Highly specialised hospital equipment is funded by the Ministry of Health from the State budget. Funding may also be awarded under the Operational Programme Infrastructure and Environment. Medical equipment used by emergency rescue teams and hospital emergency wards may be financed by the Ministry of Health, other Ministries, voivodes and local self-governments.

### Information Technology

In primary care computers are mainly used for patient registration and administrative purposes but not during medical consultations – neither the physician nor the patient have access to electronic data (such as patient records). Although computers are used in the majority of healthcare units in Poland, usage in single-physician medical practices and middle-sized ambulatories is low and medical documentation is still maintained in paper form. Several voivodeships have well developed IT systems in large clinics and specialist hospitals, in which the administration is connected to the flow of medical data from hospital wards, hospital pharmacies and surgery management systems.

However, the use of IT in secondary care still seems to be much less advanced than in Western Europe. The use of e-health in Poland is very low but some initiatives in this area have been piloted. For example, although virtually all prescriptions are dispensed in printed form, prototype e-prescriptions were implemented in sixteen pharmacies, two medical practices and two outpatient clinics in 2011 in Leszno. A prototype of Internet patient account (with information on medical history) was introduced in 2011 in several diabetic medical centres in Kraków. County-wide rollouts by 2014 are the ultimate goal in both cases.

Some university clinics and specialist hospitals use telemedicine in the areas such as cardiology and orthopedics. Electronic appointment booking is not widespread but there are encouraging examples of such practices (e.g. for online booking of specialist appointments in hospitals). Electronic patient registration is one of the tools foreseen in Project P1 of the Healthcare Computerization Programme, which was launched in 2009 and is in 85% co-financed by the EU under the Innovative Economy Programme 2007-2013. Large hospitals are more likely to use IT infrastructure, for both administrative purposes and for medical records keeping.

Currently, there is redundancy of collected data (the same or similar data can be found in different registers), inconsistency of data between registers (for example, a change of address in one register is not automatically updated in other registers) and no linkages between various databases. Medical ICT systems are usually developed separately by individual healthcare units and compatibility and coordination are low. There have been initiatives (co-funded by the EU) to unify ICT infrastructure and software, but they were small and only on regional level. However, a more comprehensive approach was introduced by the Healthcare Computerization Programme. This included the creation of an electronic platform for gathering, analysing and sharing of digital records with mostly patient-oriented functionalities (for which patients and healthcare employees will be the principal users) and a second platform providing entrepreneurs (healthcare providers) with online access to the services and resources of digital medical registers (Project P2). This initiative is particularly useful since medical records are currently maintained by individual health service providers and a central register is lacking. Implementation of the programme, which is managed by CSIOZ, is due to be finished in 2014.

There are also regional initiatives in the area of e-health. Future strategy in the area of ehealth is outlined in a recent CSIOZ study introducing the "e-Health Poland" strategy. Its key goals include digitalization of medical registers and strengthening of their legal basis (some have outdated or no legal basis); achieving interoperability of information systems, improve accessibility to information systems for the public administration, physicians and patients; reducing the cost of data collection and processing; and implementing EU directive on patient rights in cross-border healthcare (Directive 2011/24/EU). The strategy was backed up by legislation proposed by the Ministry of Health and adopted in April 2011 (Act on the information system in healthcare). The Act sets out the organisation and operation of an information system in healthcare, with the goal of reducing information gaps in the sector. An improved healthcare information system should facilitate optimal policy decisions in the future and lead to improved performance of the Polish healthcare sector.



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