

Chapter 5

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HEALTH CARE QUALITY ANALYSIS IN POLAND IN CHOSEN YEARS

Abstract: Health care is one of the most basic segments of human's life and also one of the most crucial problems of every country. The aim of this chapter is to analyze and compare the information about health care quality in Poland in chosen years based on statistic data and EHCI ranking.

Key words: quality, medical services, EHCI ranking.

5.1. Introduction

In the era of ageing societies the quality of health care acquired a new dimension of significance. For every human being health is a superior value that needs to be protected in order to lead a decent life. A constant progress in technology, medicine and chemistry allows making decisions about one's health consciously. For this reason people not only maintain a healthy lifestyle but also choose the best options from a wide range of public and private health care institutions. Such a competition in this field requires the implementation of the best "marketing techniques" in order to encourage potential patients to pay a visit as nowadays they not only assess the competences of the staff but also take into consideration the waiting time (for a visit, examination, laboratory results, admission), organization of work, equipment and appearance of the institution (BORKOWSKI S., ROSAK-SZYROCKA J.

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2010a, BORKOWSKI S., ROSAK-SZYROCKA J. 2010b, BORKOWSKI S., ROSAK-SZYROCKA J. 2013, BRUCHACOVA Z. 2001).

5.2. Health care situation in Poland

Considering hospitals, according to the Directive of the Ministry of Health and Social Care of December 22, 1998,, there is also an additional division of them, depending on the number of wards (BORKOWSKI S., ROSAK-SZYROCKA J. 2010, BORKOWSKI S., ROSAK-SZYROCKA J. 2013): **Hospitals of the first reference level, Hospitals of the second reference level, and Hospitals of the third reference level.** In the table 11.1 was showed number of hospitals in Poland in 2011. It can be seen that the overall number of hospitals in Poland in 2011, including public and private, was 1119. In case of public hospitals their number is highest with bed numbers from 251 till 500 and number of public hospitals is 195. In case of private one their number is highest with bed numbers smaller than 50 and their number is posing 311. Altogether highest number of hospital is in case of smaller than 50 beds and then number of hospitals in posing 338 (www.who.int).

Table 5.1. Number of hospitals in Poland in 2011

Number of beds	Public hospitals	Private hospitals	Total
<50	27	311	338
50 – 150	133	92	225
151 – 250	138	43	181
251 – 500	195	40	235
>500	120	9	129
Hospitals with only day-care beds	2	9	11
Total	615	504	1119

Source: *www.who.int*

In Poland there is a system of national insurance, which is partially financed by the government and partially from the National Health Fund

(NFZ). Only a small share of funds come from private sources. The total expenditure on health in selected years can be seen in the Table 2.

Table 5.2. Total health care expenditure in Poland (%)

General government expenditure	13,6%	11,4%	12,3%	11,9%
Social security funds from sickness funds (1999) and NFZ	57,6%	57,9%	58,6%	60,3%
Out-of-pocket money	26,6%	26,1%	24,3%	22,4%
Voluntary Health Insurance	0,4%	0,6%	0,5%	0,6%

Source: Own study on the basis of *Poland: Health system review. Health Systems in Transition*.

It can be seen, that the general government expenditure has slightly decreased, while the share of NHF increased. However, Poles still do not value the importance of Voluntary Health Insurances, which are more common in other foreign countries (ROSAK-SZYROCKA J., KLIMECKA-TATAR D. 2012).

Since 2003, when the Sickness Funds were replaced by the NFZ, responsibilities of the government in financing health care were taken over by self-governments in individual provinces and regional branches of the National Health Fund. The money for the health care come from the contributions paid by the employers and employees. These contributions are then allocated to the accounts of:

- Social Insurance Institution (ZUS),
- Agricultural Social Insurance Institution (KRUS),
- Private and voluntary health insurers.

The first two institutions commit funds to the National Health Fund and its regional branches, while private companies pay the money directly to the Health Care Providers.

5.3. Euro Health Consumer Index (EHCI International health care) ranking 2009 and 2012

The quality (ROSAK-SZYROCKA J., KLIMECKA-TATAR D. 2012) of medical services determines further life of a client/patient and the quality of its living. Managing the process of service providing, i.e. the process of its proceeding enables to acquire confirmation that the declared standard of the service shall be delivered, i.e. consumed. According to the document of the World Health Organization (WHO), quality in health care is one of the top priorities. In the document called „Health 21”, comprising 21 purposes of the health care, states in the goal no. 16 that: “till the year 2010, we need to secure management in health care towards transferring to programs oriented to population and medical care directed towards the health result”.

Patient as a direct and external client wishes to get a high-quality service provided by the qualified personnel without any complications, in adequate and appropriate conditions. Health care workers being the internal, indirect clients want to provide medical services in accordance with the current, professional knowledge, by using proper apparatus, leading to the improvement of a client’s (patient’s) health condition (BORKOWSKI S., ROSAK-SZYROCKA J. 2013). It is very difficult to explicitly define the concept of quality in medical services. It may be stated that the quality of medical services is:

- the level of meeting and satisfying patients’ needs,
- the level of a service’s class in reference to its potential to provide patients’ satisfaction,

- the kind of care where the patient's measurable interest is maximized, taking into account the balance between anticipated benefits and losses accompanying the process of care at all its stages.

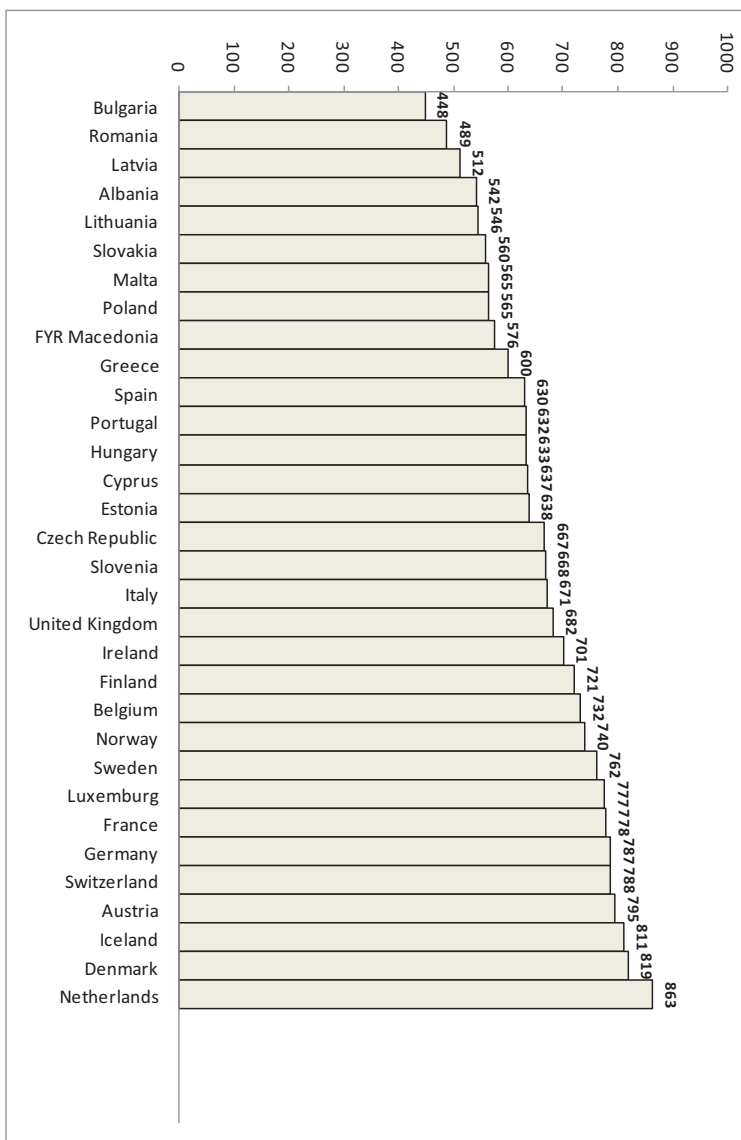
Euro Health Consumer Index is the standard already ranking, comparing health care systems in Europe. In 2012, based on 42 indicators assessed 34 public health care systems in Europe. EHCI ranking was made in 2012 year. Accordance to this ranking following areas were taking into consideration (WWW.WHO.INT, ROSAK-SZYROCKA J., RADOSZ A., WAWRZAK A. 2012):

1. **Patients rights and access do the information.**
2. **Time of waiting for treatment.**
3. **Treatment result.**
4. **Prevention and achieve of offering services.**
5. **Drugs availability.**

EHCI ranking is developed on the basis of public statistics, questionnaires completed by patients and an independent study, conducted by the authors of the ranking - the research institute Health Consumer Powerhouse (HCP), based in Sweden. Following countries were taken into consideration during researches: Albania (AL), Austria (AT), Belgium (BE), Bulgaria (BG), Croatia (HR), Cyprus (CY), Czech Republic (CZ), Denmark (DK), Estonia (EE), Finland (FI), France (FR), Macedonia (MK), Germany (DE), Greece (GR), Hungary (HU), Iceland (IS), Ireland (IE), Italy (IT), Latvia (LV), Lithuania (LT), Luxembourg (LV), Malta (MT), Netherlands (NL), Norway (NO), Poland (PL), Portugal (PT), Romania (RO), Serbia (XS), Slovakia (SK), Slovenia (SI), Spain (ES), Sweden (SE), Switzerland (CH), United Kingdom (UK). In the figure 5.1 it was showed number of points obtained by countries in the EHCI ranking in 2009. In the Figure 5.2 it was showed number of points obtained by countries in the EHCI ranking in 2012.

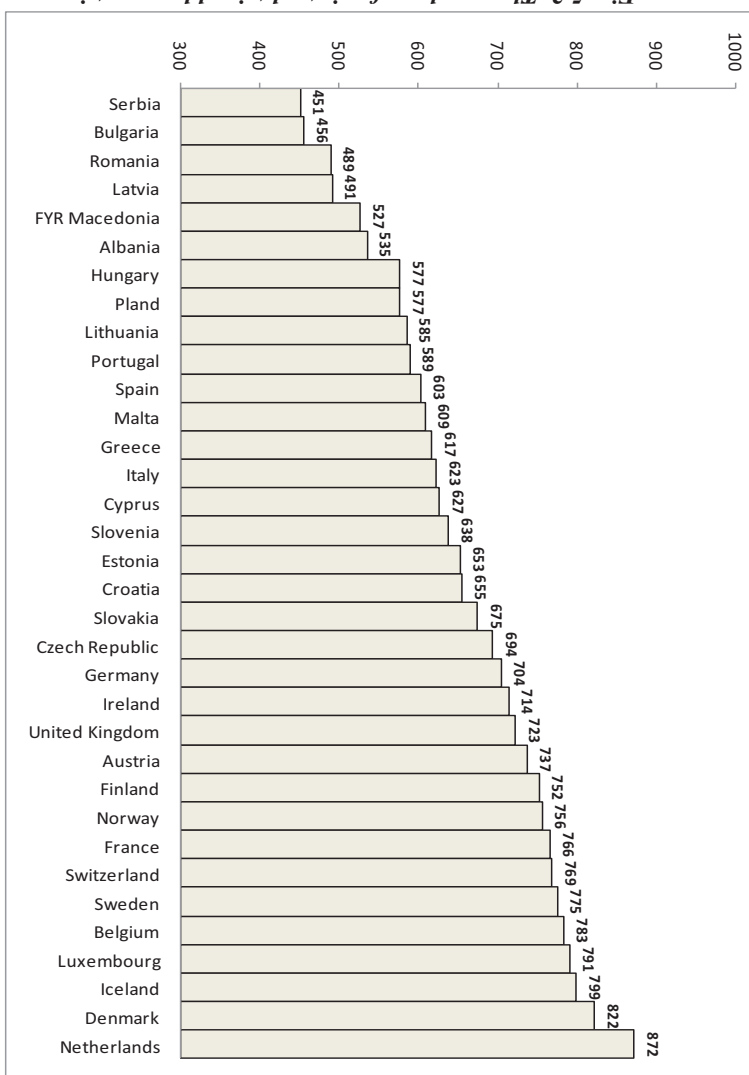
Source: www.healthpowerhouse.com

Fig. 5.1. The number of points obtained by countries in the EHCI ranking in 2009.



Source: www.healthpowerhouse.com

Fig. 5.2. The number of points obtained by countries in the EHCI ranking in 2012.



According to the European Health Consumer Index (EHCI - Euro Health Consumer Index) Poland received 565 points in 2009 while 577 points in 2012. It means that within 3 years health care quality increase about 12 points.

Table 5.3. Number of EHCI points gained in Poland in particular fields in 2009 and 2012 – comparison

	1999	2012
Patient rights and information	117	126
Waiting times for treatment	107	117
Outcomes	131	188
Prevention/range and reach of services provided	86	99
Pharmaceuticals	26	48

Source: own study on the basis of Euro www.healthpowerhouse.com

5.4. Summary

In case of Poland among 42 analyzed indicators in case of Poland in 2012 only 6 were estimated on high level. Indicators estimated on high level are connected with three sub-disciplines like: patient rights and information, outcomes and prevention. Fifteen indicators were estimated on low level. There are following:

- EPR penetration,
- major elective surgery < 90 days,
- cancer therapy < 21 days,
- CT scan < 7 days.
- cancer deaths relative to incidence,
- preventable years of life lost,
- undiagnosed diabetes,
- kidney transplants per million population,
- rate of mammography,
- long term care for the elderly,

- % of dialysis done outside of clinic.
- Rx subsidy,
- novel cancer drugs deployment rate,
- schizophrenia drugs,
- awareness of the efficiency of antibiotics against viruses.

Indicators estimated on low level exists on each kind of sub-discipline. 21 among 42 indicator were estimated on intermediate level. There are following: patient organization involved in decision making, no-fault malpractice insurance, right to second opinion, Web or 24/7 telephone HC info with interactivity, cross-border care seeking financed from home, provider catalogue with quality ranking, patients' access to on-line booking of appointments, e-prescriptions, family doctor same day access, direct access to specialist, infant deaths, MRSA infections, depression, equity of healthcare systems, cataract operations, dental care included in the public healthcare offering, informal payments to doctors, smoking prevention, layman-adapted pharmacopoeia, access to new drugs (time to subsidy), alzheimer drugs. Compare quality indicator there is a possibility to notice 6 factors that were evaluated positive in both countries. These factors are following:

- major elective surgery < 90 days,
- cancer deaths relative to incidence,
- preventable years of life lost,
- rate of mammography,
- % of dialysis done outside of clinic.
- schizophrenia drugs.

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