Quality Management—A Challenge for the Health Care System in Poland

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The aim of this paper is to describe the origins, initial steps and strategy, current progress and main accomplishments of introducing a quality management culture within the healthcare system in Poland. The following main points will be discussed:
— A general overview of the national healthcare context with specific emphasis on major structural and functional problems of the system and on the main factors and forces influencing current changes in healthcare in Poland.
— Suggestion and explanation of why quality management philosophy, methods and tools introduced into the healthcare system may constitute part of a solution for the problem of how to improve healthcare in Poland.
— A summary of national activities, illustrating how an implementation strategy was put into action, what has happened so far, and the results and perspectives for the future.
— A conclusion that foreign aid and international collaboration, used in an appropriate and effective way, may constitute a crucial factor in promoting beneficial changes in countries which, like Poland, are currently undergoing dramatic social and economic transition that began in Europe in 1989, the Polish health care system has been in very rapid, sometimes spontaneous reorganization that to some extent has not been planned or controlled. The old structure, which was imperfect anyway, has now been subjected to destabilization, and is suffering from severe systematic problems.

The Polish health care system is undergoing revolutionary changes: liberalization of the market, diminishing influence of the Ministry of Health on the growing private health sector, increasing expectations of customers together with a great demand for high quality care and ways to ensure it.

OVERVIEW OF THE NATIONAL HEALTHCARE CONTEXT. MAIN CHALLENGES

Management

Currently, the authorities responsible for the health care system in Poland are the Ministry of Health and the Council of Ministers, together with the Offices of the Governors for each of the 49 provinces. Also, health care is provided independently by three Ministries (Defense, Internal Affairs and Railway Transport) and by big branches of industry (mines, steel) for their employees and families. It is also possible to obtain health care through the private sector—medical cooperatives, group and individual private practices. Although more than 99% of the citizens of Poland are entitled to free health care provided by the public sector—a tradition dating back to the precommunist 1921 constitution (art. #79 of 1933)—the private outpatient sector has recently been growing rapidly, despite the fact that patients must pay out of their own pocket, and there is no reimbursement system. When using public sector services, patients often have to pay some form of informal fee, or make an official voluntary contribution to the hospital's or health center's budget. The Ministry of Health is formally responsible for the national health care policy and budget, for public health, and for some highly specialized health services. The governors of the provinces are responsible for health care at the provincial and local levels. The Ministry is...
responsible only for coordinating the activities of hospitals and clinics overseen by the local authorities. Health policy is coordinated in a rather fragmented way. So far there is no formal system of accreditation of health care organizations at any level.

**Health professionals**

The number of health care system employees exceeds 700 000 (300 000 medical staff; 400 000 administration and auxiliary staff). The number of physicians exceeds 90 000 (more than 23 per 10 000 population), and the number of dentists is about 17 000 (4.3 per 10 000). After receiving a diploma and completing a one-year general internship program, the majority of physicians continue their professional training leading to the first- and then second-level certificates in chosen specialties.

Despite the large number of specialists, access to care in the public sector is often difficult and ineffective. In 1991, a postgraduate program for family practitioners was successfully launched by the Ministry of Health in an attempt to improve primary care accessibility and effectiveness.

There are over 204 000 (53.3 per 10 000) nurses and midwives professionally active in Poland. Of these, fewer than 0.1% have a university degree. Nurses play an auxiliary role in the system; the extent of their responsibility for the overall process of care is limited.

**Medical scientific societies**

Medical professionals in Poland have a strong tradition of self-government, that goes back to the 19th century, when a considerable number of scientific societies were established. Currently there are over 70 medical societies and associations in Poland. However, only some of them are genuinely active in stimulating scientific activities and are engaged in present changes in the health care system.

**Chambers of doctors and pharmacists**

These professional self-governing bodies, which existed before World War II, have been recently re-established in Poland in an attempt to rebuild professional democracy in the medical community and to promote grassroots activities. Membership in the Chamber is compulsory for the representatives of a given profession. It should be noted that some important initiatives concerning changes in health care in Poland originated within these organizations.

**Infrastructure**

Health care in Poland is delivered at three levels:

- Local—by district health centers (a hospital plus a number of primary care clinics);
- Provincial—by provincial hospitals (hospitals with a full range of specialty departments and a number of specialty clinics);
- Regional—by medical schools’ teaching hospitals and research institutes.

In-patient care is provided by 734 hospitals (210 463 beds, 54.1 per 10 000). A total of almost 5 million patients are hospitalized each year. The 9617 public-sector clinics (6306 in urban areas and 3311 in rural areas) receive more than 200 million patient visits each year. Apart from some newly-built or renovated facilities, most of the infrastructure is not modern.

Utilization review is not performed in a systematic way. In some hospitals beds are over-used, while in other hospitals they are under-used. Additionally, sometimes hospital facilities are used by heads of departments as their private domains, without any external or internal control, utilization review, or evaluation of length of stay or cost-effectiveness. In general, economic awareness is not an everyday concern of Polish health care providers.

**Financing**

Because of the alarming scarcity of resources, the financial condition of Polish health care is critical at present. The percentage of gross national product (GNP) spent on health care is low in comparison with the majority of countries in the European Community (EC). Despite the fact that 16.2% of the national budget in Poland is allocated for health care, health expenditure per capita is extremely low in comparison with Western European countries: in 1989 it was $110, and in 1993 only $73. In the U.K. in 1993 it was $972, and in Germany $1486. The amount of money allocated for health care is proposed by the Government (the Council of Ministers) and then determined by the Parliament, which also decides on the distribution of this sum between the central budget (Ministry of Health) and local budgets (Provinces). Control of the health care budget is not formally institutionalized at any level. The Ministry lacks detailed information about how the health care budget is actually spent. Systematic evaluation of the effectiveness of the performance and budget expenditures of health care organizations does not take place.

The rapidly growing private sector often overlaps with public-sector facilities and resources. Almost all physicians with private practices are simultaneously employed by public-sector hospitals and clinics. Because of this complex phenomenon it is impossible in practical terms to estimate how much money is actually flowing through each sector and the health care delivery system as a whole [2].

**Quality control**

Polish health care organizations have no previous experience in the practice and theory of quality manage-
ment. Control of the quality of health care is performed to a very limited extent. The basic forms of quality control include:

- formal supervision performed by groups of consultants within specific specialties at the national, regional and provincial levels, characterized by a reactive ("bad apples") approach where action is taken when an adverse event happens and is reported;
- direct supervision of the performance of the staff by the head of a department;
- quality-control-related activities performed within hospitals (infection control, monitoring of drugs, etc.).

There is no tradition of accreditation of health care organizations in Poland. Only recently have several initiatives been undertaken to work out proposals for a health care accreditation system.

Formal regulations pertaining to quality of care.

In the by-laws of a number of medical scientific societies and newly reestablished professional chambers, concern about the quality of care has been expressed, but these statements do not have the character of institutional or executive policy.

The issue of quality constitutes the focus of the founding documents of the Polish National Society for Quality Improvement in Health Care, established in 1993, and the National Center for Quality Assessment in Health Care, founded in March 1994. Concern for the quality of care is mentioned in the form of recommendations included in a number of regulations recently issued by the Ministry of Health [3].

THE BURDEN OF ILLNESS IN THE POLISH POPULATION

In comparison with that of other European countries, the current health condition of the population of Poland is not good. During the last few years life expectancy has decreased and is now one of the lowest in Europe (66.1 years for males; 75.3 years for females). The infant mortality rate (14.98) also places Poland low on the European scale. The number of open-heart procedures is one of the lowest in Europe. Thirty percent of the population (13 million people) lives in ecologically endangered areas [2]. Almost 80% of all deaths in Poland are the result of cardiovascular diseases, neoplasms and accidents. High mortality of trauma victims is the result of ineffective emergency and intensive care. It is becoming increasingly difficult to maintain good vaccination rates. Over 16,000 new cases of tuberculosis are reported every year, and this incidence rate is twice as high as in other European countries.

WHY QUALITY? ORIGINS OF THE MOVEMENT TO CONDUCT QUALITY OF CARE RESEARCH AND ESTABLISH QA/QI SYSTEMS

Following dramatic political changes in Europe that started in Poland in 1989, the conditions emerged for promotion of the new intellectual attitudes and structures allowing the introduction of gradual changes in almost all aspects of life. Options became available for new kinds of purely citizen-based grass-roots activities, for new ways of functioning in the political structures at the highest governmental levels, and for development of new rules of functioning in a democratic society. However, the political situation in Poland is very dynamic: the political scene changes, new trends compete with old structures. Some new people appear to use old ways of thinking and vice versa. It is difficult to follow and differentiate between overlapping political trends and the interests of fluctuating groups and changing political winds.

On one hand, it is not easy to construct and implement new policies in such an environment; on the other hand, opportunities for major reform frequently come in times of crisis. Historically, this point in time offers a unique opportunity to introduce changes that would have the potential to influence future development of health care policy and management, and basic, clinical and health services research as well as medical education in Poland. According to the views expressed by political scientist Michael R. Reich in an interview published in the Harvard Public Health Review, in a changing and challenging political environment 'there are windows of opportunity for enacting major reform in health care systems, and you need to construct policies and strategies that will squeeze through those windows before they shut' [4].

It seems plausible that, in the case of the Polish health care system, it may be the quality improvement philosophy, methods and tools that could possibly squeeze through those windows of opportunity. Hence, the idea behind the initiative of developing the concept of quality within the Polish health care system was to introduce something (concepts, thoughts, new philosophy, new culture) that, once in the system, would function independently of the situation whether these metaphoric windows are open or shut. This new culture might even help to keep the windows open no matter what kind of political winds blow, according to the 19th century American obstetrician and writer Oliver Wendell Holmes [5]: 'the human mind, stretched to a new idea, never goes back to its original dimension.'

The first steps toward implementation of a quality culture in the Polish health care system were undertaken with the full awareness that the concept of quality cannot remedy all the problems overnight, but also, with some hope that introduction of this element may create an environment in which change for the better will be more feasible, easier and faster.
In 1992, the initial idea was thrown into a new and fresh socio-political environment. The inspiration, which came from the West, was well-received at the ministerial level, forwarded to the medical community level, and undertaken by a group of enthusiasts. This multiprofessional group of health care providers represents a part of the medical community which realizes that health care professionals in Poland have two types of patients in front of them: an individual patient that needs to be taken care of, and the system in which all health care providers function. In the case of Polish health care, it is the system that needs to be improved before anybody can be effective in providing care to patients.

Another very tangible aspect is the desire to keep up with developments abroad—especially in the U.S. and Western Europe, where the concept of quality has been present and active within the health care system for many years, both in everyday practice and in basic, clinical and health services research.

IMPLEMENTATION STRATEGY. SUMMARY OF NATIONAL ACTIVITIES

The first attempt to make Polish health professionals aware of the concept of quality management was undertaken in January 1992 when a selected group of the largest Polish hospitals was asked to answer a 100-item questionnaire with general questions about quality-related activities, and, more specifically, about the baseline situation concerning practice guidelines in four areas: prophylactic use of antibiotics, preoperative assessment, bedsores management, and record keeping. This pioneer endeavor in Poland was a part of a larger European research effort known as the COMAC Project—formerly COMAC (Comité Médicale d’Action Concrète) of the European Union (EU), now the BIOMED Programme—a program of the EU for biomedical research which includes public health and health services research. The COMAC Project consisted of a multicenter comparative study of different quality assurance strategies and their effect on the improvement of care in hospitals of the European Community countries. The COMAC Project was carried out in Europe between January 1990 and July 1993 as a part of the fourth Medical and Health Research Coordination Program of the European Community and run by COMAC/HSR from Brussels, the division of the EC in charge of concerted action programs in the field of health services research. The project was coordinated from the National Center for Quality Assurance in Hospitals (CBO) in Utrecht, The Netherlands [6-8].

In Poland, the techniques used for data collection, apart from the COMAC questionnaire translated into Polish, were observations, interviews, and discussions with representatives of participating hospitals during meetings organized by the Department of Science and Education at the Ministry of Health aimed at promoting a quality-oriented culture within the Polish medical community.

Out of the total number of 90 hospitals that were chosen for the project, 44 hospitals (23 teaching and 21 provincial hospitals) responded to the questionnaire. All of them reported that they conducted some quality-related activities on a regular basis. However, it is necessary to stress that these basic quality control activities could not be regarded as any kind of formally-adopted quality assurance system.

All participating hospitals reported collecting basic data on the care they provided. However, a very low percentage of this data was organized in computer databases, and there was no system for evaluation of data quality. Some hospitals reported having specific guidelines for chosen clinical procedures, but these guidelines were not used in order to compare results of different approaches or to improve the quality of care.

The results of the Polish part of the COMAC Project Assessment Phase were presented in June 1993 at the national-level seminar organized by the Jagiellonian University School of Public Health in Cracow. They were also presented at three international forums—at the First Central—Eastern European Seminar on Quality Assurance in Hospitals, in Eger, Hungary; at the 10th Annual Meeting of the International Society for Quality Assurance in Maastricht, The Netherlands; and at the Satellite Symposium in Brussels, Belgium.

Polish hospitals had had no previous experience in quality management theory and practice. The COMAC Project, apart from being an incentive to gather some basic information about quality control structures and activities, introduced the concept of quality into the health care system in Poland. However, the Project conducted in Poland also gave rise to some frustration caused by the awareness that it may be very difficult to catch up with the developments in the field of Quality Improvement in other countries. On the other hand, it brought about some understanding that quality-related activities do not have to be interpreted as repressive or punitive, that they may in fact constitute a stimulus for collaborative endeavor aimed at improving care provided to patients, improving the work environment for providers, as well as making the system as a whole function better.

As a result of the COMAC Project, the concept of quality has been launched within the medical community in Poland, stimulating the establishment of the National Society for Quality Improvement in Health Care (July 1993), and the National Center for Quality Assessment in Health Care (March 1994).

In mid-1994, quality improvement programs were initiated in three Polish hospitals (Warsaw, Cracow, Radom) in close collaboration with the Vlams Institute for Quality in Belgium.

The next important step was undertaken during August and September 1994, when a group of 12 Polish health professionals underwent a summer-long quality-oriented training at top medical centers in the U.S. The program—the "Polish—American Health Quality Net-
work"—was sponsored by the U.S. Agency for International Development and coordinated by representatives of the Western Consortium for Public Health (Santa Cruz, CA) and the Harvard School of Public Health (Boston, MA).

A carefully selected group of health professionals had a chance to get acquainted with the best examples of the quality culture in action. The Program began in Boston with a three-day comprehensive introductory course organized by the Institute for Healthcare Improvement. This was followed by seminars, workshops and informal meetings with top specialists in the theory and practice of quality management from Harvard School of Public Health, Harvard Medical School, Brigham and Women's Hospital, Children's Hospital, Massachusetts General Hospital and New England Medical Center. Then, after a short rewarding visit to the Joint Commission on Accreditation of Healthcare Organizations in Chicago, the Polish group had a chance to get acquainted with inspiring examples of quality-related activities in California during seminars and meetings with representatives of the Western Consortium for Public Health, Kaiser Permanente Health Plan, Dominican Hospital, Stanford University, and Berkeley University School of Public Health.

The idea behind the Program was to creatively transfer American know-how into the environment of the Polish health care system. The aim was to create a group of professionals who, after being exposed to the American health care system, would be able to disseminate the concept of quality improvement within the Polish health care community, starting on a local level in their own institutions, and, at the national level, by collaborating with the Center for Quality Assessment in Health Care.

As a result of this program, a group of people, who acquired hands-on experience and became acquainted with some of the best examples to follow—a multi-professional diaspora of pioneers representing various domains of health care—has been created [9]. Members of the group trained in the U.S. collaborated with the Center for Quality Monitoring in Cracow in organizing the First National Conference on Quality in Health Care in Poland, in October 1995.

The Conference, sponsored by the U.S. Agency for International Development, gathered over two hundred participants from throughout Poland who presented the results of their own quality-related projects run in local hospitals and clinics as well as central institutions. Participants also had the opportunity to become acquainted with the latest trends and achievements in the field of quality management, presented by invited speakers representing various institutions from the Netherlands (CBO), and the U.S. (United States Agency for International Development, Department of Veterans Affairs, Center for Health Care Policy and Evaluation, Harvard Medical School and the Joint Commission International).

This first Quality of Care Conference in the history of health care in Poland focused on promoting the idea of quality, and constituted an encouraging and rewarding impetus toward further efforts for all participants. The Conference gathered a very special group of health professionals: people who understand the need for change, who are open and receptive to new ideas, and who appreciate the opportunity for improvement that may be brought about if the quality management culture is present within the Polish health care system. It is encouraging to see that there are increasing numbers of people who decide to become active participants in a changing environment. They can find institutional support for their efforts in the National Center for Quality Assessment in Health Care, which is designed to constitute 'the headquarters for change' and has defined its main objectives in four basic areas:

- support for the formation of quality committees within hospitals;
- monitoring of selected measurable aspects of care;
- encouragement and support for developing and applying clinical guidelines;
- development of an accreditation system for health care organizations.

The crucial goal of the Center is to provide educational and financial support for health professionals who want to develop "quality awareness" attitudes within their organizations. Representatives of several hospitals and clinics that are leaders in the field of quality improvement in Poland met again in April 1996, at the one-day Quality Seminar organized by the Center in Cracow. The meeting offered a rewarding opportunity to discuss current projects, and accomplishments as well as problems encountered: for example, how to overcome passive resistance towards any changes in some medical communities.

The activities of the Center are constantly stimulated and nourished by an ongoing collaboration with USAID and with representatives of the Harvard School of Public Health. The current project involving the above institutions constitutes a part of a larger USAID endeavor, called "Strengthening Local Government in Poland". Some of the goals of the project are to continue the training in quality management for health professionals, to implement the quality monitoring system for hospitals, and to assess the impact on quality due to changes in the way health care is financed. An important quality-related accomplishment of the last two years is the establishment of a Hospital Accreditation Program, a program developed with support from the Joint Commission International, Chicago, USA. In addition a group of Polish organizations interested in developing accreditation standards has formed an Accreditation Council. In March 1997 the Second National Conference on Quality in Health Care was held in Cracow [10].
CONCLUSIONS

In summarizing the lessons learned from the challenging, but simultaneously greatly rewarding process of introducing the quality culture into the Polish health care system, it is worthwhile to stress three main points:

— If there is need for change and improvement it may always be wise to take advantage of any “windows of opportunity” for enacting reforms in the health care system and to construct policies and strategies that will squeeze through those metaphoric windows before they shut, no matter how unstable or unreliable the political situation may seem.

— Introduction of a quality management philosophy and methodologies into a changing system may constitute an effective way of gradually improving the system.

— The introduction of a quality management philosophy and methodologies into the Polish health care system provides a good example of how foreign aid and international collaboration can stimulate positive changes within the health care system of a country that, like Poland, is currently undergoing revolutionary transition in all aspects of social, economic and political life.

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