D5.1 Readiness of European Regions for Integrated Care

Annex F: Self-assessment process in Poland

WP5 Maturity Assessment for Integrated Care

Co-funded by the Health Programme of the European Union

The SCIROCCO Exchange project is co-funded by the Health Programme of the European Union under Grant Agreement No.: 826676 (Chafea)

Document information

Organisation responsible for conducting the self-assessment process in Poland:

- National Health Fund, Poland

Authors:

Katarzyna Wiktorzak

Agata Szymczak

Milena Sześciórka-Rybak

Anna Ślusarska -Jasińska

Delivery date: 29 January 2020

Dissemination level

I	Public

Statement of originality

This Report contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.

Disclaimer

The content of this Report represents the views of the author only and is his/her sole responsibility; it cannot be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains.

1 Introduction

National Health Fund (NFZ), Poland is a state institution that finances healthcare benefits from contributions paid by people insured in the NFZ. Scope of the NFZ activity comprises of the management of: financial resources; determination of quality and accessibility; analysing health care costs; contracting and financing health care services; implementation of commissioned tasks, in particular those financed by the Minister of Health; monitoring of drug prescription; health promotion; and maintaining the Central Register of the Insured.

The payer function remains centralised within the NFZ, however contracting of services has been devolved to the voivodeship level – the 16 voivodeship branches of the NFZ are charged with purchasing services in their respective territories within the internal market open to public and private health care providers. Financing comes mainly from mandatory healthcare insurance contributions which are, in fact, a dedicated tax. Health care services for populations exempt from paying insurance contributions (such as children), as well as emergency medical services and certain highly specialized services, are financed from the state budget (i.e. from general tax revenues).

1.1 Characteristics of healthcare system

Table 1 – Characteristics of the Polish Healthcare System

Item	Description
Country	Poland
Geographical scale of the country	Country
Geographical size and dispersion of the country	312 679 km2
Population size of the country	38 million
Population density of country	124,2/km2
Life expectancy of the country	78
Fertility rate of the country (births/woman)	1,45
Mortality rate of the country (deaths/1,000 people)	1035,96
Top three causes of death of the country	Cardiovascular diseases, cancer and injuries

Item	Description
Organisation and governance of healthcare services	Governance of the healthcare system is divided between the Minister of Health (and supporting institutions) and three levels of territorial self-government. The diversity of competencies, and the insufficient coordination among these levels, obstructs coordination of activities in the healthcare system. The National Health Fund (NFZ) remains the sole purchaser in the statutory health care insurance system, although there have been calls to abolish it and transfer the payer function to the Ministry of Health. The NFZ's influence over contracting has been weakened by the introduction, in late 2017, of the hospital network. Qualifying hospitals are automatically granted contracts for a period of 4 years without the need to participate in tenders. Purchasing and provision are strictly separated. The majority of hospitals are public and operate as "independent public health care units" (SPZOZs) and certain shortcomings of their legal form resulted in poor financial management. This led to attempts to transform them into companies under the Commercial Companies Code, but these efforts have recently been halted. Annually updated health needs maps were introduced in 2015 as medium- and long-term planning tools and are intended to improve contracting of services, planning of investments and health policy planning. The Polish state health technology assessment agency (AOTMiT) has an important role in determining the basket of benefits and since 2015 also has a role in setting tariffs for these services. However, NFZ continues to play an important role in setting tariffs, where tariffs have not yet been set by the AOTMiT. AOTMiT is also responsible for the appraisal of public health policy programmes. Overall, the role of HTA is strong in Poland compared with other countries in Europe. The pharmaceutical sector is extensively regulated. Recent regulations introduced, among others, are changes to pricing (to stimulate consumption of generics) and a claw-back on excessive reimbursement expenditures (to control NFZ's spending) (both introduced in 2012). The position of patients has been strengthened over the years. This includes better availability of patient information and improved protection of patient rights (e.g. the introduction, in 2012, of no-fault compensation for medical events in hospitals and special commissions to adjudicate them). In late 2014, Poland implemented the EU Directive on Patient Rights in Cross-border Health Care, but in practice access to care abroad under this Directive has been limited for Polish patients.
Healthcare spending of the country (% of GDP)	6,7 %
Healthcare expenditure of the country	92,56 Billion PLN
Distribution of spending in the country/region (Please explain, if possible, what %	In 2018 public spending for healthcare (excluding private healthcare and community services) were 95 million PLN, where 49,58% were

Item	Description
of budget is allocated for hospital, family health (primary), community services and/or other services.)	allocated for hospital, 11,77% for primary healthcare and 4,92% for specialised outpatient care.
Size of the workforce (thousands)	567 000 health professionals - 146 000 physicians, 292 000 nurses, 41 300 dentists, 37 700 midwives, 34 800 pharmacists
Healthcare policies in the country/region	Planning in the healthcare system is the responsibility of the central government administration, particularly of the Ministry of Health and the voivodes. The Ministry of Health and the voivodes are supported in this function by a variety of institutions, many of them created fairly recently. Key planning documents include: The Long-term National Development Strategy: Poland 2030. Third wave of modernity complemented by the Strategy for Responsible Development until 2020 (with perspective until 2030). These documents, developed by the Ministry of Regional Development, define the vision for the country's development in the medium and long-term. The National Strategic Framework: Policy paper for health protection for 2014-2020 (http://www.zdrowie.gov.pl/aktualnosc-2357-Krajowe_ramy_strategiczne_Policy_paper_dla_ochrony_zdrowia_na_lata_2014_2020.html), which sets out priorities for the healthcare system in connection with the planned measures that are to be financed with the support from EU structural funds allocated for the years 2014-2020. The National Health Programmes (NPZs - https://www.gov.pl/web/zdrowie/narodowy-program-zdrowia-ogloszenia) are the key medium term national health strategy documents in the area of public health. The current Programme was formulated for the 2016-2020 period. Annual Health needs maps, introduced in 2015, are the key medium to long-term health policy planning document.

1.2 Integrated care in Poland in primary healthcare units

Coordinated care is planned to be implemented in Poland based on solutions developed in the pilot project "Preparation, testing and implementation of coordinated care in the healthcare system, Stage II. Pilot phase – Primary Care PLUS model" co-financed from the European Social Fund under the Operational Programme Knowledge Education Development under the European Commission Priority Axis 4 and 5 (https://akademia.nfz.gov.pl/poz-plus/). Project Primary Care PLUS is primary healthcare model which covers the scope of primary care (POZ), selected outpatient specialised care (AOS) and ambulatory physiotherapy (FIZ). In addition, it offers broader competences to the team of family doctors, nurses, midwives and physiotherapists (optional).

The main objective of this project is to expand and strengthen the implementation of health needs of the care population through high quality benefits, actively providing health care to citizens regardless of their health status in a comprehensive way integrating preventive actions and corrective medicine. It is based on a targeted cooperation between the family doctor and the basic health care team (POZ), including physiotherapists and professionals. The tools to support implementation include the devolution of competences to the lowest effective level and the creation of an open communication between the entire medical staff and the patient and his/her family. Communication can improve the IT systems designed to facilitate the exchange of information on past and planned medical events and the electronic archiving of medical records between healthcare providers involved in the treatment process and the patient themselves.

The model of Primary Care PLUS covers all patients aged 18+ registered in selected 41 PHC clinic with population: ca. 300 000 patients. All patients are subjects to health check-ups and disease prevention programmes. Patients with 11 selected chronic diseases are assigned to the disease management programmes (DMP).

2 Self-assessment process in Poland

2.1 Identification process of the local stakeholders

The local stakeholders were identified from the group of Primary Healthcare Centres (PHC) in Poland that take part in Primary Care PLUS pilot project. To assess the maturity of Primary Healthcare Centres in Poland, a multilevel group of experts among the employees of the Centres was selected. There were 39 Centres which took part in the survey and 93 interviews were conducted with 2 or 3 respondents from each Centre.

2.2 Self-assessment survey

Prior to the interviews, the official invitations to participate in the maturity assessment process were sent to 41 Primary Healthcare Centres (PHC) in 16 voivodeships in Poland, 39 of which accepted the invitation.

The management of the Centres was asked to identify the key stakeholders to participate in the process. As a result, 2 or 3 stakeholders from each PHC were identified to respond the questionnaire and provide their perceptions on the maturity of the PHC for integrated care. These stakeholders included medical personnel, executives of the PHC and employee of IT department.

The local stakeholders were given the following supporting documents:

- Formal invitation to participate in the survey;
- PowerPoint presentation introducing the SCIROCCO Exchange project, including the objectives and rationale of the maturity assessment process;
- User manual how to prepare for the interview.

Phone interviews were carried out between January and April 2019. The surveys were then uploaded on the SCIROCCO Exchange Tool between April and September 2019. Outcomes of the assessment were shared with each respondent.

- PHC small-size: < 5 000 patients
- PHC medium-size: 5 000 - 10 000 patients
- PHC large-size: > 10 000 patients

Table 1 List of participants

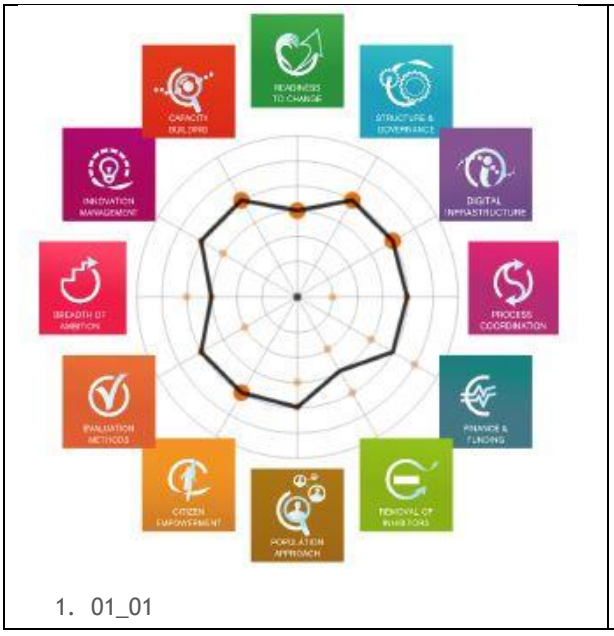
Code	Name	Size of medical centre[1]
01_01	NZOZ "PRZYCHODNIA RODZINNA" w Sobótce	medium
01_03	POWIATOWE CENTRUM ZDROWIA SP. Z O.O. w Lwówku Śląskim	medium
02_01	NZOZ CENTRUM MEDYCZNE "FARMA-MED" w Inowrocławiu	medium
03_01	NZOZ "ZDROWIE" S.C. w Batorzu	small
03_02	NZOZ "CENTRUM" ALEKSANDRÓW w Aleksandrowie	small
04_01	WSPL SPZOZ w Gorzowie Wielkopolskim	medium
05_01	"NEUCA MED." SP. Z O.O. w Zgierzu	medium
05_02	CM "MEDYCYNA GRABIENIEC" w Łodzi-Bałuty	medium
05_03	CM "SZPITAL ŚW. RODZINY" w Łodzi-Śródmieście	medium
06_01	"SCANMED" S.A. KROWODRZA w Krakowie-Krowodrza	large
06_02	"SCANMED" S.A. ŚRÓDMIEŚCIE w Krakowie-Śródmieście	medium
06_03	NZOZ KRAKÓW-POŁUDNIE SP. Z O.O. w Krakowie-Podgórze	large
06_04	NZOZ "KROMED" S.C. w Grybowie	medium
07_01	SPZZLO WARSZAWA-ŻOLIBORZ	large
07_02	SPZZLO WARSZAWA-WAWER	large
07_03	NZOZ "MEDIQ" w Legionowie	large
07_04	NZOZ "CENTRUM" MIŃSK w Mińsku Mazowieckim	medium
07_05	NZOZ "CENTRUM" SIEDLCE	medium
07_06	"ZDROWIE" S.C. PORADNIA RODZINNA w Płońsku	large
08_01	"OPTIMA MEDYCYNA" S.A. DYTMARÓW	small
08_02	"OPTIMA MEDYCYNA" S.A. RACŁAWICE ŚLĄSKIE	small
09_01	ZOZ NR 2 ŁĄKA	small
09_02	ZOZ NR 2 WYSOKA GŁOGOWSKA	small
10_01	SPZOZ MOŃKI w Krypno Kościelne	small
10_02	ŁOMŻYŃSKIE CENTRUM MEDYCZNE	medium
11_01	"COPERNICUS" SP. Z O.O. w Gdańsku	medium
11_02	"BALTIMED" w Gdańsku	medium
11_03	NADMORSKIE CENTRUM MEDYCZNE w Gdańsku	medium
12_01	"EPIONE" SP. Z O.O. PIOTROWICKA w Katowicach	medium

[1] Each PHC is categorised based on the size of population covered: small-size: < 5 000 patients; medium-size: 5 000 - 10 000 patients; large-size: > 10 000 patients

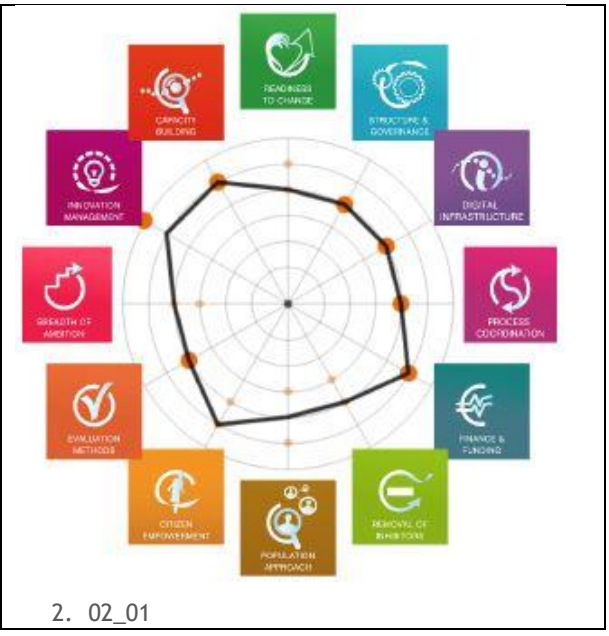
Code	Name	Size of medical centre[1]
12_02	"EPIONE" SP. Z O.O. SZOPIENICKA w Katowicach	medium
12_03	NZOZ CENTRUM MEDYCZNE SP. Z O.O. w Katowicach	medium
12_04	CENTERMED SP. Z O.O. w Katowicach	medium
13_01	CENTERMED KIELCE	small
14_01	"ELMED"SP. Z O.O. w Orzynach	small
15_01	ZPiSOZ "MEDIX" w Kaliszu	medium
15_02	"PRO-FAMILIA" w Czerwonak	small
15_03	"VITA" PRZYCHODNIA MEDYCYNY RODZINNEJ w Osiek nad Notecią	small
15_04	NZOZ "MULTIMEDIS" w Poznaniu- Wilda	medium
16_02	"SZAFERA" PRZYCHODNIA MEDYCYNY RODZINNEJ w Bezrzeczu	Małe

2.2.1 Outcomes of self-assessment survey

The following spider diagrams reflect the perceptions of stakeholders from Primary Healthcare Centres on maturity of their organisations for integrated care across the Poland. Each spider diagram is linked to the codes provided in the Table 1.



1. 01_01



2. 02_01

3. 03_01

4. 03_02

5. 05_02

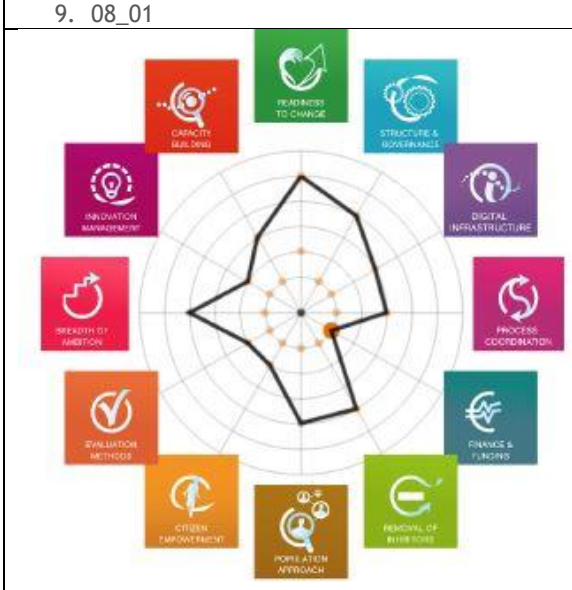
6. 06_04

7. 07_04

8. 07_05

9. 08_01

10. 08_02



11. 09_01

12. 09_02

13.10_02[2]

14. 11_01

15. 11_03

16. 12_03

[2] Only 1 respondent responded to the maturity assessment survey, hence there is different format of the spider diagram.

17. 12_04

18. 13_01

19. 14_01

20. 15_03

21. 16_02	22. 01_03
	
23. 04_01	24. 05_01
	
25. 05_03	26. 06_01

27. 06_03

28. 07_01

29. 07_02

30. 07_03

31. 07_06

32. 10_01

33. 11_02

34. 12_01

35. 12_02

36. 15_01

37. 15_02

38. 15_04

39. 06_02

2.3 Stakeholder workshop

The consensus workshop was organised by NHF on 10 September 2019. The objective of the workshop was to discuss the preliminary findings of the survey of maturity assessment among primary healthcare centers. The outcomes of the surveys served as the basis for discussion, negotiation and consensus-building.

2.3.1 Negotiation and consensus building

All stakeholders were grouped into 3 teams to ensure discussions and sharing of opinions among all participants. The objective was to reach consensus across all 12 dimensions of the SCIROCCO Exchange Maturity Model and agree a final spider diagram in each of the groups. The stakeholders were grouped according to the size of their medical centers:

- PHC small-size: < 5 000 patients
- PHC medium-size: 5 000 - 10 000 patients
- PHC large-size: > 10 000 patients

Each group had its own moderator who presented the agreed group diagram.

Figure 1: Group consensus-diagram for small-size Primary Healthcare Centres

Figure 2: Group consensus-diagram for medium-size Primary Healthcare Centres

Figure 3: Group consensus-diagram for large-size Primary Healthcare Centres

2.3.2 Final consensus

The following table details the outcomes of the consensus-building process for the small-size Primary Healthcare Centres (PHC) (Table 2).

Table 2: Scores, Justifications and reflections assigned to each of the dimensions

Dimension	Scoring	Justifications & Reflections
Readiness to Change	3	The PHC usually have a strategic plan for their development, therefore they do not see any difficulties. However, it is not always known to the whole team.
Structure & Governance	3	The organisational structure is maintained in all locations. The Executive of PHC is open to the ideas of the workers. Meetings of staff with the Management Board are organised.
Digital Infrastructure	3	Infrastructure standards have been adapted to the national level. The majority of the facilities benefit from the possibility to issue electronic sick-leaves and prescriptions. There is an IT system in place, which allows an internal exchange of information.
Process Coordination	3	Having an advanced IT system facilitates effective coordination implementation. An IT system that operates within the facility allows for an internal exchange of information.
Funding	4	The assessment of the financial situation of the PHC is good, with additional external funding, e.g. additional funding for each PHC is being granted if they join POZ PLUS project of coordinated care.
Removal of Inhibitors	3	There are a number of factors, such as the uncertainty of contracts, the age of the workers, the reluctance of people

Dimension	Scoring	Justifications & Reflections
		to change. The PHC take actions to minimise or remove the inhibitory factors (e.g. internal, external training).
Population Approach	3	The patient population is known to the institution, so decisions are taken on the basis of demographic change. PHC encourage patients to use preventive research during their visits, when calling or using the information point for patients.
Citizen Empowerment	3	Attempts are made to improve the role of patient education. Key actions such as flyers with patients' rights, recommendations from doctors in the course of a visit, a survey and the possibility of lodging a complaint in various forms (oral, written).
Evaluation Methods	3	An assessment is made of selected initiatives and services. Assessment is being made as a part of POZ PLUS pilot project.
Breadth of Ambition	3	The pilot project has established cooperation between primary and specialised care. Previously, this cooperation was not formalised.
Innovation Management	3	Most of the institutions are open to innovation, development, innovation and modernisation. They take part in a number of regional programmes. The strategic direction of development is being developed. Workers in informal form are able to report ideas.
Capacity Building	3	The medical centres seek to improve quality, reduce costs and improve accessibility. They constantly increase the level of knowledge and most of them work with higher education institutions.

The following table details the outcomes of the consensus-building process for the middle-size Primary Healthcare Centres (PHC) (Table 3).

Table 3: Scores, Justifications and reflections assigned to each of the dimensions

Dimension	Scoring	Justifications & Reflections
Readiness to Change	3	The vision or plan is embedded in the internal policies of the PHCs. Most workers are positively affected by possible changes. In some, there is a company's development strategy and organisational rules in place.
Structure & Governance	3	Plan of developing integrated care had been embedded in policy.
Digital Infrastructure	3	Digital infrastructure to support integrated care are piloted. Poland has introduced lately e-prescription, e-referral, e-sick-leave. The need for changes to the infrastructure of certain facilities is recognised. The digital infrastructure enables information on the patient to be exchanged. The IT system is used by all employees. In most places it is possible to exchange information internally.
Process Coordination	3	Adapting the new systems to the national level. An IT system operates within the facility which allows for an internal exchange of information.
Funding	4	The assessment of the financial situation of the centres is good, with external funding, such as the pilot programme and different external funded programmes. Middle-size PHCs are usually more keen than small-sized PHCs to cooperate with local government and apply for external funding for preventive programmes.

Dimension	Scoring	Justifications & Reflections
Removal of Inhibitors	3	The main inhibitor is the human barrier (lack of human resources, long implementation period). Pathways are developed to eliminate inhibitory factors.
Population Approach	3	Both middle-sized PHCs and small-sized PHCs demonstrate unfailing commitment to the health of their population. The patient population is known to the institution, so decisions are taken on the basis of demographic change. Medical centres encourage patients to use preventive research during their visits, when calling or using the information point for patients.
Citizen Empowerment	3	Patients are generally informed about the rights in leaflets, posters. Patients have access to partial information however the range of available data is not comprehensive (history of visits).
Evaluation Methods	3	An assessment is made of selected initiatives and services. Assessment is being made as a part of POZ PLUS pilot project.
Breadth of Ambition	3	The pilot project has established cooperation between primary and specialised care. Previously, this cooperation was not formalised.
Innovation Management	3	Most of the institutions are open to innovation, development, innovation and modernisation. They take part in a number of regional programmes. The strategic direction of development is being developed. Workers are able to report ideas, on an informal basis.
Capacity Building	3	The medical centres seek to improve quality, reduce costs and improve accessibility. They constantly increase the level of knowledge and most of them work with higher education institutions.

The following table details the outcomes of the consensus-building process for the large-size Primary Healthcare Centres (PHC) (Table 4).

Table 4: Scores, Justifications and reflections assigned to each of the dimensions

Dimension	Scoring	Justifications & Reflections
Readiness to Change	3	The new implementation path for part of the action is developed/systematized. Therefore, they do not rise any difficulties. The PHC centres usually has a strategic plan for their development. However, it is not always known to the whole team.
Structure & Governance	4	The management structure is defined. A plan for change is usually developed. It is known to the wider group of staff — the management. Workers are aware of development.
Digital Infrastructure	3	Digital infrastructure supporting integrated care is piloted but not yet wide implemented. A set of technical standards for the joint acquisition of new systems has been agreed; ICT is in the process of being consolidated on a large scale.
Process Coordination	2	Standardised coordinated care processes are being developed; The guidelines are applied some initiatives and paths are formally described.
Funding	4	The assessment of the financial situation of the centres is good, with external funding, such as the pilot programme and different external funded programmes. Participation in the external project POZ PLUS makes all institutions have the same assessment – they have income from other sources than only a contract with a payer.

Dimension	Scoring	Justifications & Reflections
Removal of Inhibitors	3	The inhibitory factors are defined and known including: Frequent changes to legislation, difficulties in IT system, lack of personnel. No methods of elimination have been developed so far.
Population Approach	4	The patients were stratified in order to participate in the pilot project POZ PLUS and for the purposes of the invitation to preventive programmes. Patients visiting the facility shall be invited to the preventive programmes or health programmes.
Citizen Empowerment	2	Patients have access to knowledge, but the PHC facility is not focused on promoting this knowledge and strengthening this area.
Evaluation Methods	3	An assessment is made of selected initiatives and services. Assessment is being made as a part of POZ PLUS pilot project.
Breadth of Ambition	3	The pilot project has established cooperation between primary and specialised care. Previously, this cooperation was not formalised.
Innovation Management	3	Actions are being taken to capture innovation and reward them. However, these actions are not always formal.
Capacity Building	2	There are attempts to build capacity, for example, by sending staff on training, conferences, etc.

3 Analysis of the outcomes

1. The assessment of primary healthcare providers in Poland reflects the actual state in healthcare system, scoring 3 or 4 in all dimensions. The units that have been taking part in the maturity assessment are the selected primary healthcare units that have met all requirements of POZ PLUS programme such as implementation of electronic timetable of visits, electronic patient documentation, participation in preventive programmes. This may be the reason why, despite the differences in the size of the facility itself and the population it covers, the results do not differ significantly.
2. The overall outcomes show that primary care in Poland is making significant progress in all dimensions, but mostly due to the fact that they take part in a pilot project POZ PLUS that generates new pathways, adopts new solutions, and forces cooperation between primary and specialised care.
3. The dimensions where more room for improvement was found are “Process Coordination”, “Digital infrastructure” and “Citizen Empowerment”. However, during 2019, Poland introduced a national e-solution referring to every patient called IKP – Individual Patient Account, where every patient has access to historic data on healthcare services reimbursed by National health Fund, e-prescriptions ordered, e-referrals and planned visits to doctors, which strengthens patient empowerment.
4. There are some specific factors that justify the scores. The transformation towards integrated care has been promoted by the Ministry of Health via the first pilot project of integrated care at the primary level- POZ PLUS. The assessment was made only by those healthcare providers that were willing to make necessary changes, adopt new roles of PHCs and coordinator, adopt new ways of working within a team and face new challenges. Digital infrastructure to support integrated care is being piloted. Poland has introduced e-prescription, e-referral and e-sick-leave. Still missing is the electronic medical records of patients

4 Key messages

The stakeholders valued the maturity assessment process and agreed that the process should be performed once again after implementation of integrated care solutions achieved throughout the pilot project POZ PLUS.

5 Conclusions and next steps

The SCIROCCO Exchange Tool and self-assessment process has allowed to acknowledge the current level maturity of Primary Healthcare Centres in integrated care. The assessment among PHCs, that have joined the pilot of integrated care project in Poland, can become the foundation to the assessment of the progress achieved throughout the pilot project POZ PLUS. We plan to repeat the whole assessment at the end of the project to assess the progress of the individual PHCs, after 2-3 years of integration at the primary level.