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The Health Assistance in Hospital and at Home

The Polish Situation

Lifelong Learning Programme

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The Health Assistance in Hospital and at Home

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Jacek kabziński, dr. N. Med.
Akademia Humanistyczno-Ekonomiczna w Łodzi
Lodz, Poland
jkabzinski@ahe.lodz.pl

Abstract

The healthcare system in Poland is based on a system of insurance. It makes it widely accessible, but it also poses difficulties in ensuring adequate funding. The report presents the basics of healthcare organization in Poland, the detailed legislation regulating this issue and describes the main entities constituting the system. It describes also the authorities responsible for shaping the healthcare system, both at national and local level.

Particular attention is given to the home health service, and especially its implementation on two areas - primary care and palliative - hospice care. The report presents the organization of these two branches of the healthcare system, an analysis of the medical staff, access to treatment and a system of training specialists in these fields. A comparison was made for access to medical treatment in Poland and the European Union using data on the number of active medical staff.

The report presents data separately for doctors, nurses and midwives involved in home healthcare, which allowed to make individual analysis for each of these groups. It also describes Poland's health policy and its implementation with a view to improving the health situation in Poland and the strategies implemented at the local level. It also identifies examples of good practices as models for the implementation of the system.

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1. Introduction to the National Situation

Polish Constitution and specifically its article 68 provides that every citizen has the right to receive health service [1]. Irrespective of citizens' financial situation, the public authorities shall ensure equal access to health care services financed from public funds. Conditions and scope of benefits are specified by the statute. Polish health care system is based on the insurance model (mandatory universal insurance), and the model consists of institutions established to provide healthcare of the population.

1.1 Health care System in Poland

The healthcare system in Poland is regulated by a variety of laws and regulations. This introduces a certain degree of difficulty in legal terms because of the lack of a law that defines all aspects of health care. Table 1 shows the major legal acts on which the health care in Poland is based.

Table 1. Legal acts regulating health care system in Poland.

Name of the Act	**Legal basis**
Medical Practice Act	Journal of Laws from 2011 No. 112 item 654
Law on Health Care Services Financed from Public Funds	Journal of Laws from 2004 No. 210 item 2135
Patients' Rights and Patients Rights Commissioner Act	Journal of Laws from 2009 No. 52 item 417
Law on Health Resort Treatment	Journal of Laws from 2005 No. 167 item 1399
Law on the Occupation of Doctor and Dentist	Journal of Laws from 2008 No. 136 item 857
Law on the Nursing and Obstetrical Professions	Journal of Laws from 2009 No. 151 item 1217
Pharmaceutical Law	Journal of Laws from 2008 No. 45 item 271
Regulations implementing the Act - Pharmaceutical Law	Journal of Laws from 2001 No. 126 item 1382

The healthcare system in Poland is focused on providing medical services to citizens. This is accomplished by providing health care to patients (beneficiaries) by health care providers with the participation of the National Health Fund (NFZ). NFZ has a dual role of public payer and regulator by concluding contracts with healthcare providers and by refunding medicines. National Health Fund is financed from public funds, specifically funds from the mandatory health insurance premiums.

National Health Fund budget in 2008 was almost 49 billion zlotys (about 10 billion euro) [2]. The role of providers in the system act primarily independent public health care institutions (SPZOZ), i.e. hospitals, clinics, outpatient clinics, but also research institutes, foundations and associations, pharmacies, placements for doctors, dentists and nurses. Simplified diagram of the system of health care in Poland is shown in Figure 1.

The basis of the health care system in Poland is so-called 'family doctor' functioning in the structure known as the Primary Health Care (POZ) and co-working with the nurse and midwife. He is responsible for providing treatment and the prevention for 'his' patients. If the patient's condition requires specialist treatment, family doctor gives referral to a specialist clinic or hospital. The primary objective of PHC is to keep patients in good condition, and treatment of most common diseases.

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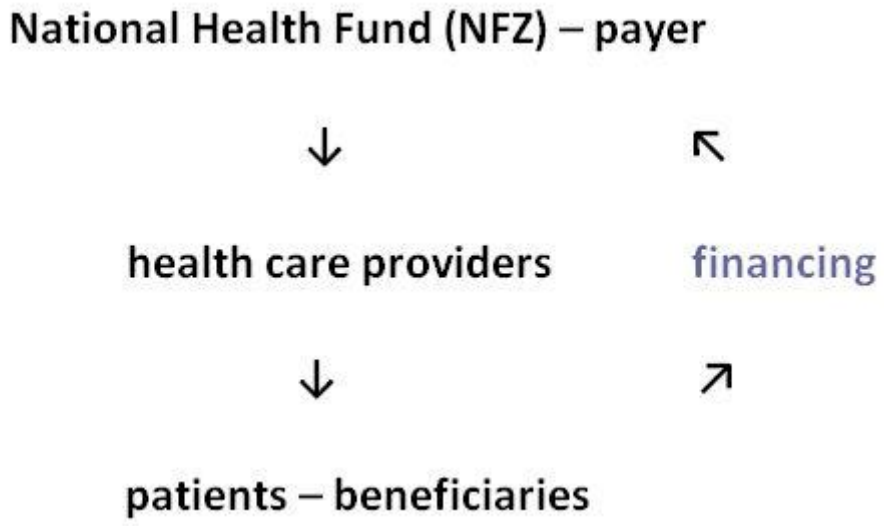

Figure 1. System of health care in Poland.

Family medicine requires a multidisciplinary approach to patient, but in practice it focuses mainly on internal medicine and pediatrics, so often the role of POZ's doctor does not belong to expert in family medicine, but the team consisting of internist and pediatrician. Primary healthcare team consisting of a family physician, nurse and midwife, in carrying out its role, is closely connected with social workers and palliative care teams.

1.2 Organisation of the home health service in Poland

Home health service is implemented in Poland, mainly by the structures of the Primary Health Care (POZ). However, because of the broad spectrum of patients' needs, often POZ is not able to meet the demand for more specialized services and therefore other institutions are included in the health care system. Their specification is provided in Table 2.

Table 2. The main players in the healthcare system in Poland.

Subject	**Care implementation**
Primary Health Care	– Family doctor – Nurse – Midwife – Therapist
Home Hospice	– Doctor – Nurse – Physioterapist – Psychologist
Municipal Social Assistance Centre	– Health carer
Other organisations, including foundations and voluntary services	– Volunteers without medical training

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2. Main national trends

Depending on patients' demand system for home care in Poland offers a wide range of services. As mentioned earlier the most common is primary health care, in which the key role have the nurse, often visiting the sick, and the doctor. If the situation requires care other than a basic home visit, then doctor gives referral to a specialist clinic, referral to hospital or immediate transport to hospital. The second most common form of health care services is provided by home hospices. They offer care for chronically ill patients, often in the terminal state. A significant majority of patients in home hospice are people with advanced cancer. Unlike stationary hospice in home hospice, health carers take care of a patient in his home environment. Should be highlighted that in Poland, hospices have specialized in two groups: for the elderly or for children. The general opinion is that hospices for children are the most developed form of health care services in Poland. In addition to primary care and home hospices in the system there are also Municipal Social Assistance Centres, where health carers are providing assistance to a much lesser extent than nurses, focused far more on social than medical support. There are also several foundations or other organizations offering help of volunteers without medical training.

It should be emphasized that all forms of health care services in Poland, especially primary care and hospices operate in both the state scope, financed by public funds (NFZ) and in the private system, financed by private funds (private health insurance or direct payments). The costs of services in the private sector are very diverse and vary in a wide range depending on the type of services offered.

2.1 Primary Health Care (*in polish 'POZ')*

In the structure of primary health care key functions have the family doctor and nurse. A doctor working in primary health care to become a family doctor, according to the system of postgraduate education, has to do a specialization in family medicine which lasts about 5 years. In Poland there are about 150,000 practicing doctors, including more than 8,000 specialists in family medicine, this is one of the largest specialties (Figure 2).

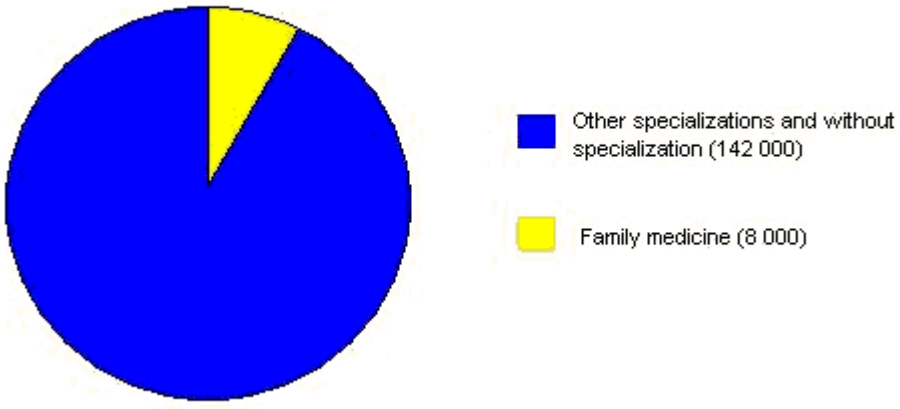

Figure 2. Number of family medicine specialists in Poland.

Each patient, on the basis of his residence, selects a primary care physician. Such doctor in addition to primary services in a clinic also provides assistance in terms of home health care. The availability of family doctors in Poland is generally satisfactory, but it should be noted that it varies in a wide range depending on the region. Example of province - Zachodniopomorskie (Figure 3) shows that for 10,000 patients may be from 3 to 8 primary care physicians (average 5.6) and in that from only 0.3 to 4 (average 2.1) family medicine specialists [5].

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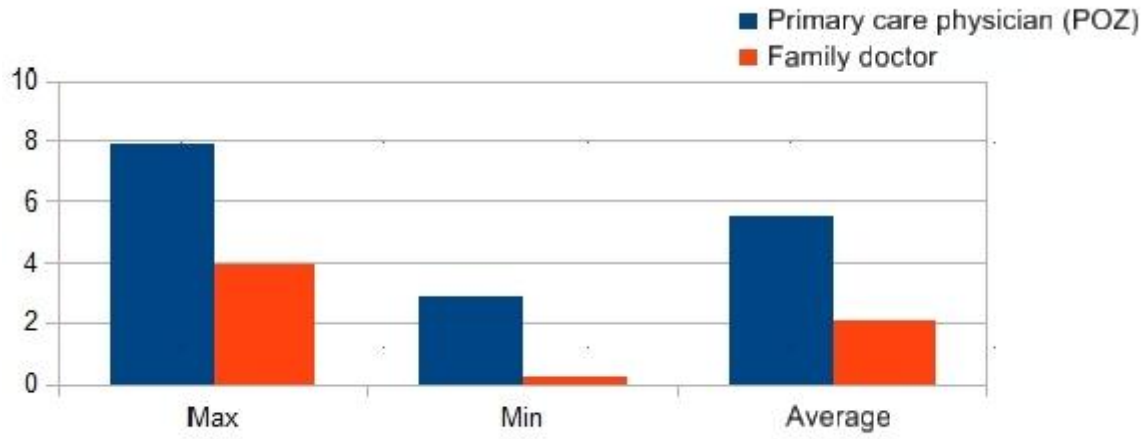

Figure 3. Number of primary care physicians and family doctors for 10000 patients in Provence – Zachodniopomorskie in Poland [5].

The reasons for such a large fluctuation in access to family doctors should be sought in place of their practice - the vast majority chooses to work in urban health clinics while the common standard in rural areas is one family physician for all the patients in the village. Specialization in the field of family medicine lasts about 5 years and among doctors it is seen as a desirable career path selection, which results in relatively high proportion of doctors choosing to specialize in this field. According to the orders of the NFZ one primary care physician can take care of not more than 2750 people. Median earnings declared by specialists in family medicine is 5600 zlotys (about 1,300 euro), it should be noted that often these doctors are employed at more than one position and their monthly revenue is about 8000 zlotys (about 1,800 euro), approximately 20% of the physicians declare that they earn more [6]. For comparison, the average salary in Poland amount to 3719 zł which is about 830 euro (as of April 2012) [7].

Another basic link next in the primary health care next to a family doctor is a family nurse, also called environmental nurse. As with doctor working in POZ who does not have specialization in family medicine, the nurse can work in POZ without specialization or while postgraduate training in the field of family medicine. In the profession of a nurse we can also distinguish the so-called qualification courses, also in the field of family medicine. The difference between specialty and qualification course is based on the number of hours of training and its duration - qualification course lasts from 3 to 6 months, the specialization of about 1.5 to 2 years. In contrast to the physicians in the group of nurses postgraduate education is not very popular, which is reflected in the number of specialists in family medicine – from a number of 215 000 nurses, only a little over 2000 has such specialization (Figure 4).

It should be emphasized that the home health care in POZ has the same serious problems with the nursing staff as in all of the Polish health care centres, hospitals and clinics. The significant lack of staff, very low wages and relatively low prestige of the profession makes it that less and less people are choosing the nursing profession. This trend, combined with growing older staff who will be soon on retirement, may be a reason of serious problems threatens in the market for nursing services in Poland in the near future because of the lack of professionally active nurses.

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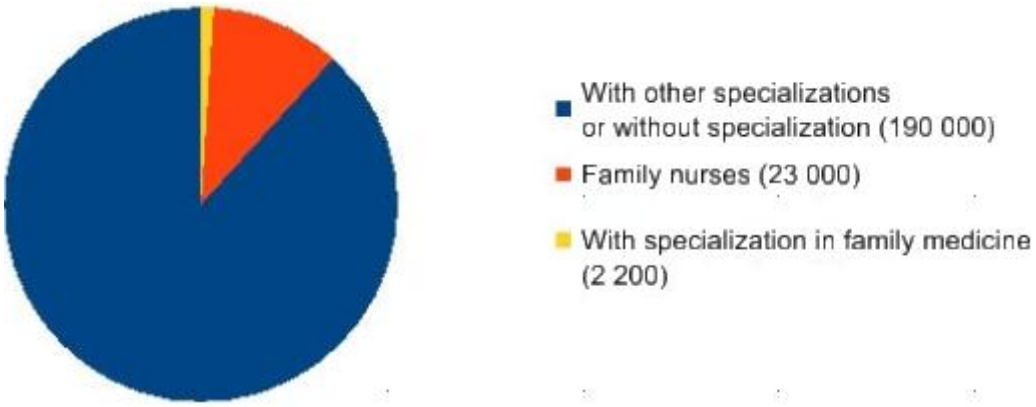

Figure 4. Number of nurses in Poland [3, 4].

Seriousness of the situation shows the number of professionally inactive nurses, who despite having the right to work as a nurse, have changed their profession. According to the Supreme Chamber of Nurses and Midwives in 2011 to 275 652 registered nurses in Poland [8], only 214 349 were professionally active [9], which is 77%. No financial benefits and significant career advancement also discourages nurses to begin postgraduate education in family medicine. On average, only about 50 nurses a year finishes such specialization (Figure 5). This number is dramatically low. One of the reasons is obviously the high cost of education, which, with rather poor salary is often beyond the reach for nurses. The situation is better when we look at qualification courses in family nursing, in average 1500 nurses per year does such courses (Figure 6), but this is merely a system for raising qualification and not getting the specialization. Currently, from more than 23000 nurses working as a family nurse only less than 10% have a specialization in family nursing [3, 4].

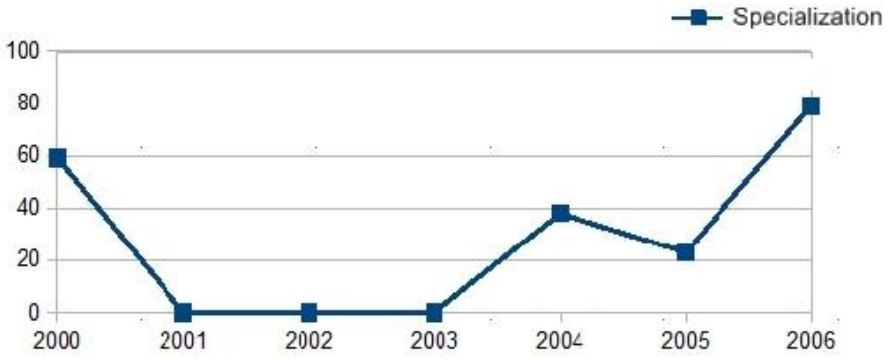

Figure 5. Number of nurses getting a specialization in family nursing in years 2000-2006 [3].

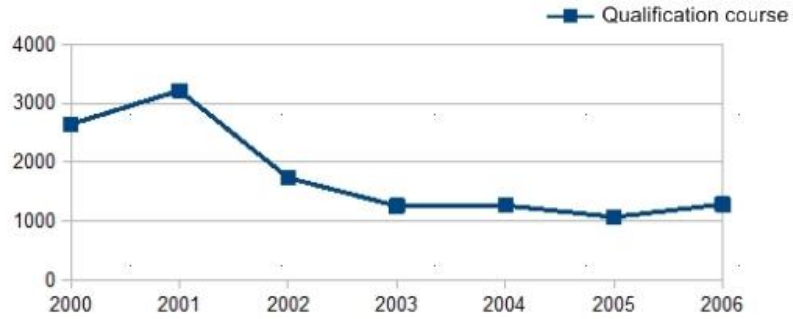

Figure 6. Number of nurses finishing qualification course, in years 2000-2006 [3].

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These data is even more worrying if we consider that in the home healthcare system the nurse plays a key role. A nurse appears much more often than the doctor, doing the assigned treatments often over a long period of time. Long-term care in primary health care is carried out largely by nurses, so the fact that there is less of them has an impact on the quality and availability of services. Although a national consultant in the nursing home assessed the availability of nurses as quite well [3], attention should be drawn that Poland has one of the lowest number of nurses per 1000 inhabitants in the European Union - which is 5 with a mean of 8.6 (Figure 7). For comparison, in Germany the rate was almost twice higher than in Poland and stands at 9.6.

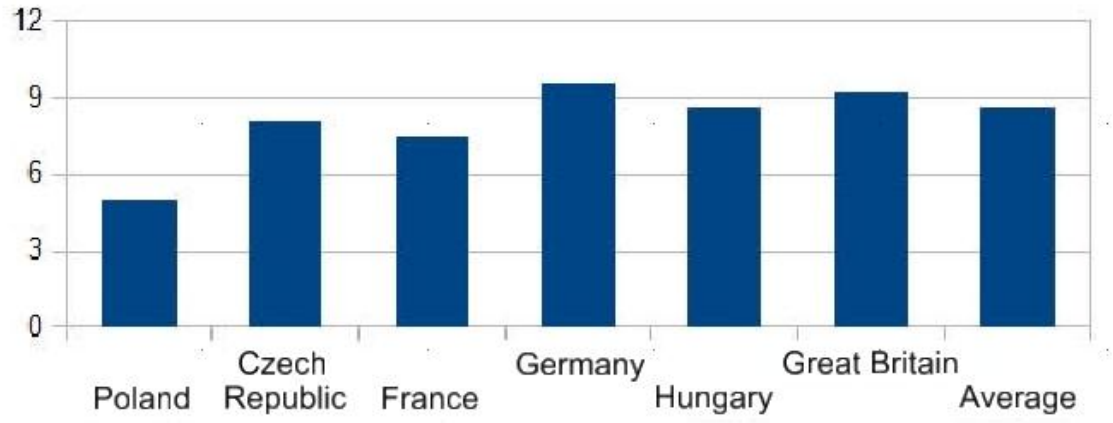

Figure 7. Number of nurses for 1000 citizens in EU countries [4].

Following the trend of an aging population and increasing expectations for quality and accessibility of medical services we should expect a significant increase in demand for nursing services, including services in home health care. Therefore, some action is needed to increase the number of professionally active nurses.

Implementation of home health care by nurses is based on primary care doctor's referral or referral from a doctor who was taking care of a patient in a hospital. Chronically ill patient requiring long-term nursing services may be classified to:

- Long-term care realized at home
- Stationary long-term care centre or
- May be offered health care by a primary care nurse [10]

Necessary complement to the above tasks are specific nursing care services, for which are responsible family members, committee or - if there is such need - social welfare institutions.

If at least one of the services listed below is necessary for the patient, then a doctor gives a referral and a home care nurse becomes responsible for taking care of a patient:

- drip infusions
- treatment for wounds, pressure sores or leg ulcers
- tube feeding
- feeding with fistula
- fistula care
- using catheter
- bladder lavage
- tracheostomy tube care

Assessment of the patient qualified for home care, is updated once a month. The doctor making this assessment should take into account daily activities that the patient can do on his own or with assistance, or cannot do them at all. Taken into account are criterias such as: ability to eat, to change

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positions, to move, to maintain personal hygiene. It is worth emphasizing that the role of family nurse is not limited to the medical treatment. Actions taken by primary care nurses are also designed to prepare the patient, as soon as possible, to function independently with disease or disability, as well as educating family and committees to provide patient with assistance in the daily activities. According to the provisions of the National Health Fund, a nurse, directed to home care, should perform her functions on weekdays from 8.00 to 20.00 and on Saturdays, Sundays and during public holidays only in the medically justified cases. Direct care of one patient may not be less than 1.5 hours per day, on average four times a week. The duration of a long-term nursing care is dependent on the patient's condition, but cannot exceed 6 months.

In the home care under services of POZ, doctor and nurse's activities complements family midwife. Family midwife is a midwife employed in primary health care, realizing the tasks of family care, especially in the field of obstetrical and gynecological care and taking care of a child. In general, because of the nature of services, family midwife is taking action in the following fields [11]:

- health promotion
- preventive treatment
- care services
- medical services
- diagnostics services
- rehabilitation services

To midwife's responsibilities also belong:

- care before conception
- care during pregnancy (of a woman, infant and family)
- care in gynecological and oncological diseases
- ta king care of a faetus, newborn and infant
- taking care of a woman in every stage of life

It should be emphasized that the above-described problems of the nursing environment are equally valid in the case of midwives. Significant gaps in staff and low salaries cause that we can often face the shortage of midwives and it is even greater than in case of nursing staff. In Poland the right to work as a midwife have 33 841 people [8], of which professionally active is 24 844 [9], which is 73%. Leaving the profession rate is thus even greater than that of nurses - 27% (23% for nurses).

2.2 Home hospice

Services of palliative and hospice care is a comprehensive, holistic care for patients suffering from incurable, progressive diseases. Such care is designed to prevent pain and other somatic symptoms and their relieving, alleviating suffering. Benefits of palliative care and hospice care can be provided either in the stationary form, where the patient is placed in a given institution and stays there all day, or at home with the participation of the family. In case of hospice care at home are involved - the doctor and palliative care nurse, who work closely with primary care physician, family nurse and if necessary, the family midwife. The organizational structure of palliative - hospice care in Poland illustrates Figure 8.

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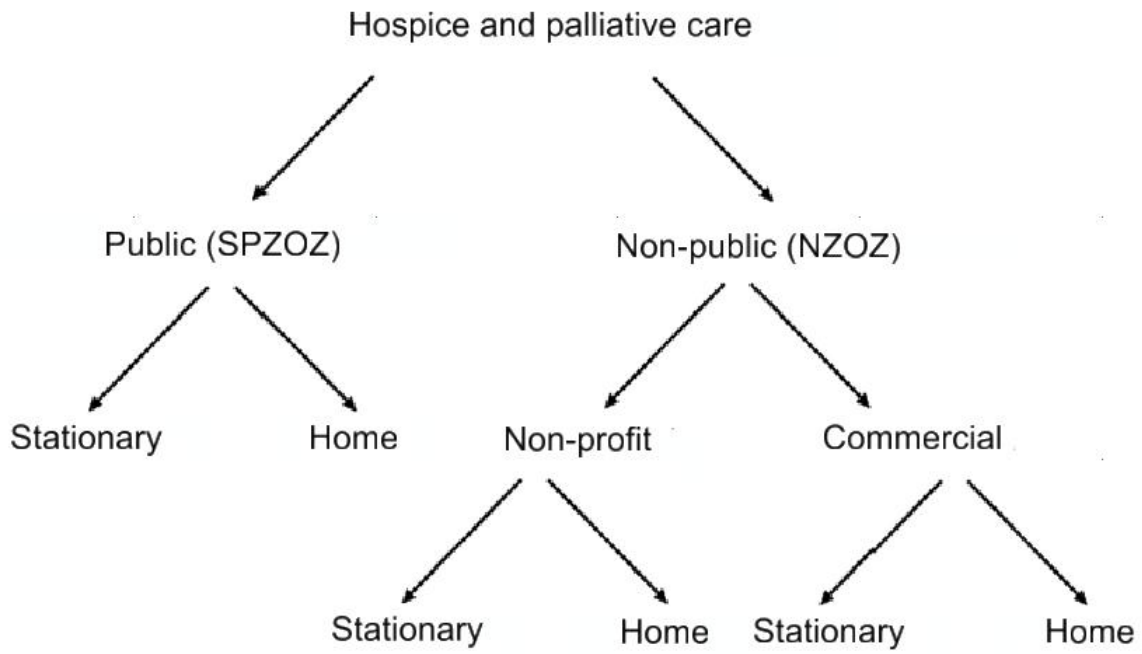

Figure 8. The organizational structure of palliative - hospice care in Poland.

The system of home hospice and palliative care is one of the areas in which non-public health activities are the most developed. In addition to public SPZOZ providing services free of charge for those insured in the National Health Fund there is a number of private institutions. These institutions because of the financial profile of activity can be divided into two basic types: non-profit organization and commercial companies. Among the non-profit organization, we can distinguish associations, foundations, religious congregations, and Caritas. They hire volunteers carrying out their duties free of charge. While commercial companies for their services charge a fee, depending on the scope of services and the region in which they operate price may vary widely, but it can be assumed that the average price for one hour of taking care of a patient is about 90 zloty (20 Euro). The share of non-public hospices in the Polish market is 43% and their total number stands at 284 (Figure 9). In home hospice care, you can set a clear division between hospices for adults and children.

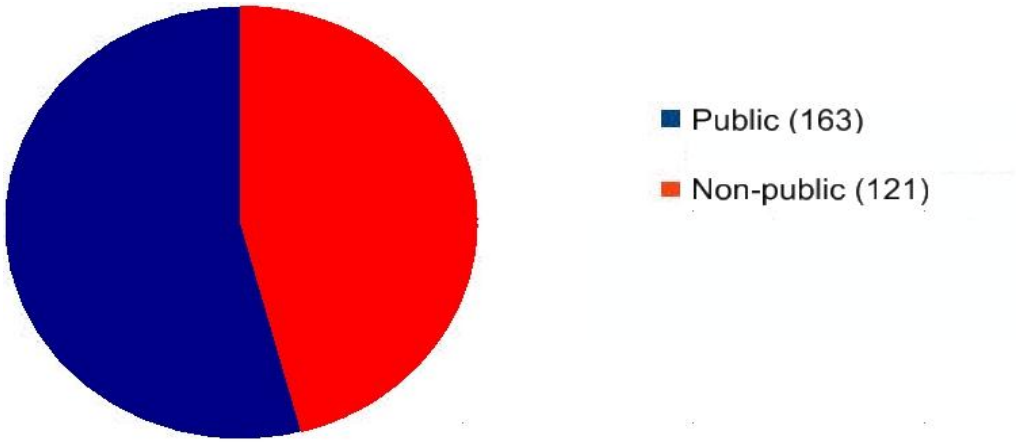

Figure 9. The share of public and non-public hospices in Poland.

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3. National bodies in charge of the home health service

As mentioned earlier in the Polish health care system a key role plays the National Health Fund, which is the payer and the intermediary between patients and health care institutions. At the national level to institutions managing and controlling the health care system we can add:

- State Sanitary Inspectorate,
- State Pharmaceutical Inspectorate,
- Health Service Ombudsman.

Institutions managing the health care system at the regional level, so entities of local government are local municipalities, districts and provinces. They have very important and responsible task, because a local government is a unit that is setting up the public health care centre (SPZOZ). Therefore, as the founder, the local government has the right by resolution to create, transform and eliminate SPZOZ. The local government has also responsibility to decide on status of the unit and to identify, through the competition, the manager of SPZOZ.
In addition, local government is controlling the subordinate institutions. Because of such extensive powers, in practice local governments are shaping the health care system in Poland. They implement national policies of the Ministry of Health, but it should be noted that they have considerable autonomy. Other tasks of local governments in health care system are listed in Table 3.

Table 3. Tasks of local governments in health care system.

province self-government	– to establish and maintain a provincial center for occupational health – to establish and maintain mental health care facilities – to perform tasks dealing with prevention and solving alcohol problems – to perform tasks in the field of health promotion and disease prevention
county self-government	– to form a county security plan for medical emergency activities – to provide pregnant women with health, social and legal care – to issue referral to other institutions, i.e. nursing care facilities – to determine working hours for pharmacies – to finance the participation of the disabled and their carers in the rehabilitation camps and the provision of rehabilitation equipment – to perform the tasks of sanitary inspection – to perform tasks in the field of health promotion and disease prevention
municipality self-government	– to perform tasks dealing with prevention and solving alcohol problems – to provide nursing services for people with mental disorders

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4. National policies implemented to promote and improve the home health service

The basic policy on health care in Poland, including health care services, is ounced and implemented by the Ministry of Health under the National Health Programme for the years 2007 - 2015 adopted by Resolution No. 90/2007 of the Council of Ministers dated 15 May 2007 on a National Health Program for the years 2007 - 2015. The National Health Program states that fundamental objective is the unification of efforts of society and public administration aimed at reducing inequalities and improving health and therefore quality of life of Poles. This program gives the minister of health the opportunity to influence the actions of other sectors of health and provides a useful tool for joint actions in public health. Including the determinants of health and promotion of health, demographic situation, the health situation of the Polish society and the social and territorial disparities the Programme describes a number of strategic and operational objectives. Objectives directly suited to the improvement of health care services are the following:

- The reduction of morbidity and premature mortality from cancer
- To increase the effectiveness of prevention of infectious diseases and infections
- The reduction of social and territorial disparities in health status of Polish population
- To improve diet and quality of food; to reduce obesity
- To reduce exposure to harmful factors in the environment and its effects and to improve the sanitary condition of the country.

The measures used to achieve the set objectives:

- Activation of local government units and non-governmental organizations for public health
- Improving the quality of health services in terms of effectiveness, safety and social acceptability, obeying the patient's rights
- Improving early diagnosis and offering active care for patients at risk for cardiovascular diseases, cerebral strokes, cancer, complications of diabetes, respiratory diseases and rheumatic diseases, especially through the activities of primary health care
- Using local infrastructure for health promotion and health education.

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5. Strategies and initiatives developed at national and local level to promote and improve the home health service

In addition to the National Health Programme implemented by the Ministry of Health at local level and at the initiative of various societies, there have been developed many programs that affect the improvement of the status, organization and accessibility of health care services in Poland. A number of national promotion programs are implemented by the various units of the health care system. In the field of home health care, such role belongs mostly to Polish Society of Family Medicine, which currently runs programmes such as:

- National Programme of Early Diagnosis and Treatment of Asthma
- National Programme of Promotion of Mental Health
- National Programme for the Protection of Antibiotics

Other programs dealing with home health care, but not directly related to family medicine can be for example, National Programme for cancer pain treatment. In implementing the above mentioned programmes conferences and trainings for medical staff are organized aiming at improving their qualifications. Additionally, the strategic objectives are determined and means to achieve those objectives are proposed.

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6. Description of Training Courses for professional health carers on the issue

The training of medical staff in Poland is based on higher education and postgraduate education. Medical studies last 6 years and finish with a degree of doctor of medicine, nursing studies last for three years and finish with a bachelor's degree in Nursing (there is a possibility to continue education to get masters' degree). Both doctor and nurse can work after graduation in the home health care, but to be an expert in this field, each of them has to complete a specialization in the system of postgraduate education. In case of home health care implemented in primary health care (POZ) it will be specialization in family medicine (name of specialization the same as for doctors and nurses), for hospices the most common specialization are: oncology and pediatrics. For purposes of this study we will discuss specialization of family medicine for doctors and for nurses, it should be assumed that the system of specialization in different fields is similar in terms of organization and working time, there are only different aspects. Postgraduate education for doctors in Poland leads the Centre for Postgraduate Medical Education (CMKP) and for nurses Center for Postgraduate Education of Nurses and Midwives (CKPPiP).

6.1 Family doctor

Specialization of family medicine will take a minimum of 48 months, but most often it lasts up to 5 years. It is possible to shorten the duration of specialization when a doctor has been a specialist in internal medicine, pediatrics or surgery. The specialization programme consists of [11]:

- Preliminary stage – introduction to family medicine
- Stage of education in the hospital and specialist clinics, including internships and shifts
- Stage of education about general practice of a family doctor
- Participation in specialized courses
- Self-education

During the specialization, the progress is checked in tests and exams, doctor is also responsible for developing and implementing programs to improve quality in general practice of family doctor and for the preparation of training materials. Specialization in the field of family medicine is obtained after completion of all courses in the program and passing the State Exam. A detailed plan of specialist training in family medicine is presented in Table 4.

Table 4. Plan of specialist training in family medicine for doctors.

The preliminary stage (introduction to family medicine)	Stage of education in hospitals and specialist clinics								Stage of education about general practice of a family doctor
	Internal Diseases	Pediatrics	Obstetrics And gynecology	General surgery	Psychiatry	Dermatology, Neurology, Infectious diseases Laryngology, Ophthalmology,	Physiotherapy	Fakultative	
2 months	6 months	6 months	3 months	1 month	1 month	4 months	1 week	1 month	24 months

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6.2 Family nurse

This specialization is realized at the time of 18 to 24 months with the possibility to shorten its duration if the nurse has already acquired the same qualifications as in the program of specialization (eg. on a different specialization or during master's studies). The total number of training hours is 995 hours of which 330 hours - general practice, and 665 hours - specialized practice. The purpose of specialization in family nursing is to prepare professional nurses to provide nursing services for healthy and sick people in their own living environment, and in particular to prepare them to:

- provide health care services to individuals, families and people at risk, neglected groups, to the local community in unusual and difficult situations,
- acting as consultant and advisor when it comes to health matters,
- acting as team leader in a team of family nurses.

Nursing Specialization ends with State Exam for Nurses and Midwives. A detailed program of specialization is presented in Table 5.

Table 5. Plan of training for nurses in the field of family medicine.

	Module	Theory	Internship	Number of hours
General practice, common to all specializations	Elements of psychology, Medical education. Sociology of health and disease, Ethics, deontology and law, Organisation and management with elements of health protection, Social Policy and public health, Health assessment and physical examination, Theory of nursing, Research in nursing, Professional development, Informatics and statistics in practice of a professional nurse and midwife.			330
Specialization in family nursing	Selected topics in epidemiology and demography	30	-	30
	Development of Professional practice – quality of care in primary health care	30	-	30
	Form, scope and methods of activation of local communities	15	35	50
	Sociology of the family with elements of cultural anthropology	30	-	30
	Health promotion, health education in family and local community	45	35	80
	Family nursing	30	-	30
	Advanced nursing care in selected health problems	240	175	415

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7. Identification of best practices

The element of health care in Poland that is the most developed is hospice, especially hospices for children, in this area we can find many examples of good practices. Caring for a person in the terminal state is always a great challenge, especially if the child is sick. To ensure the best possible care for a small patient in his last months in a hospice they offer individual, interdisciplinary and involve the family in the whole process. A good example is the Hospice for Children in Opole [15]. Hospice team consists of:

- anesthetist
- two pediatricians
- specialist in pediatric neurology
- two anesthetic nurses
- nurses
- two physiotherapists
- social worker
- psychotherapist
- deacon

This wide range of specialists allows for comprehensive care of the sick child. What is important, even if there is a need for the participation of a physician other than the usual one, he is in the team and is not a stranger to the child. This allows the patient to feel more comfortable, because he is surrounded by the team of people he knows and does not treat them as impersonal doctors who appear only for a moment as it happens in hospitals. This impression is enhanced by a strong commitment of patient's family.

In addition to the permanent interdisciplinary care and parental involvement in the hospice we can find two other examples of good practice - organization of the holiday camps and support groups. Camps are organized annually for young patients, of course the medical team is taking care of them for all the time, such camps are for children very good way to forget at least for some time about their disease and to have fun with their peers.

In the hospice, there is also a support group for the whole families of patients who are in terminal state and also of those who have already passed away.

It is worth noting that hospices play an important role in the promotion of interdisciplinary care, which thus is gaining a wider group of supporters and is implemented in a growing number of institutions, not only in the field of health care services.

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8. Conclusions

Home health care in Poland has to face the same problems as the entire health care system. There is insufficient funding, excessive bureaucracy and a shortage of specialist staff causes that accessibility to health care is often limited. This results in a rapid development of the private sector, to use services which are available for a small part of society, for those who can afford them.

But it should be emphasized that these problems are reflected primarily in specialized medicine, but home health care, implemented mainly in the POZ system, provides better availability. Also, the second core member of the home care are hospices which stand out from the whole, special attention is given to them because of the profile of patients, and the gap of shortage of public institutions fill the private centers, often free of charge - organizations, foundations, Caritas. Despite having a highly qualified medical staff the main problem seems to be lack of sufficient funding.

This problem affects both the further education for personnel which results in shortage of specialist staff, and lack of resources needed during the process of treatment. These problems are slowly but systematically eliminated by the implementation of the National Health Programme.

But it should be emphasized that despite the problems in health care system, in many instances good practices can be identified, mainly due to the enormous commitment of medical staff.

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