Implementation of the 2017 system of basic hospital services provision in Poland – what is the impact on the sector governance?

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Context

The Polish hospital sector is characterized by a historically oversized infrastructure. The number of hospital beds, both total and for acute care is higher than the EU average. The existing beds are characterized by a relatively low occupancy ratio (66.2% for general hospitals in 2016). Also, the high number of acute hospitals beds is accompanied by huge deficits in the long-term care sector.

The majority of hospitals are public (Table 1). Regardless of the ownership structure, the vast majority of services provided by hospitals is financed from public sources - 95% in 2014. The share of hospital costs in the main public payer budget (NFZ) was 49.68% in 2016.

Table 1. The organizational and ownership structure of hospitals in Poland in 2016.

Hospital organizational form and ownership		Number of entities†	Number of beds	Beds share (%)
PUBLIC		**592**	**183,695**	**87.73%**
SPZOZ	Municipalities	9	646	0.31%
	Counties and city counties	213	55,581	26.55%
	Voivodeships	159	64,150	30.64%
	Ministries ‡	52	13,787	6.58%
	Medical universities	36	19,514	9.32%
Corporatized	Companies owned by local governments	123	30,017	14.34%
PRIVATE		**326**	**25,687**	**12.27%**
TOTAL		**918**	**209,382**	**100.00%**

† includes only entities having more than 10 beds; ‡ includes 15 hospitals functioning in the form of institutes being supervised by the Ministry of Health

Beginning in October 2017 a system of basic hospital services provision, popularly called 'hospitals network' was implemented in Poland. It covered a total number of 594 hospitals, vast majority of which are public. Within the network the hospitals are divided into seven groups/levels, depending on the type of services provided (Table 2). Assignment of entities to the groups is valid for four years and done by the directors of regional NFZ branches based on a set of predefined criteria. The services provided within the network include, in addition to inpatient care, also ambulatory specialist care in outpatient units functioning in hospitals, rehabilitation services and services provided during the night and over holidays.

Table 2. Hospitals included in the hospital network implemented in October 2017

Hospital network level		Type of hospitals	Number of hospitals included
basic	level 1	general, county hospitals (providing services in at least 2 out of 5 specialties: general surgery, internal medicine, gynaecology and obstetrics, neonatology, paediatrics)	283
	level 2	hospitals providing more complex procedures (minimum 6 specialties, including anaesthesiology and intensive therapy)	96
	level 3	multi-profile specialist hospitals (minimum 8 specialties, including anaesthesiology and intensive therapy, infectious diseases)	62
specialist	paediatric	single specialty - paediatric	13
	oncology	single specialty - oncology	20
	pulmonology	single specialty - pulmonology	30
	pan-regional / national	institutes and clinics/university hospitals	90

The **aims** of the analysis were to assess the regulations impact on the hospital sector governance at three levels: macro-health system; mezzo-regional policy and micro-individual hospital management.

Methods

A mixed methods approach was applied, including: desk analysis of the key national regulations related to hospital sector functioning; international and national literature review on hospital sector governance; analysis of available statistical data on Polish hospital sector; in-depths interviews with 5 hospitals' managers and 3 regional health policy decision makers.

Results

Implementation of the hospital network regulation influenced the governance of Polish hospital sector at all three strategic levels: macro, mezzo and micro, yet within different frameworks. In case of system and regional level governance the impact of this regulation must be analyzed in connection with two additional regulatory changes implemented between 2016 and 2017, that is: introduction of healthcare needs maps and an instrument for capital investment assessment (Table 3). These provided a basis for hospital sector governance, yet still need mutual coordination, ongoing evaluation and adjustments. The major challenge seem to be imbedding the new regulations into the overall health system strategy. Due to the lack of such a strategy, the practical implementation of the ad hoc changes which have been introduced shows some inconsistencies.

Table 3. Regulatory changes influencing hospital sector governance implemented between 2016 and 2017

Regulation	Healthcare needs maps	Capital investment assessment	Hospital network
Date of implementation	April 2016 (adopted March 2014)	September 2016 (adopted July 2016)	October 2017 (adopted March 2017)
Objectives	*"(…) to support services distribution in accordance with present and forecasted patients' health needs; to support evidence-based health policy making."*	*" (…) to stop chaotic and short-sighted investments in the medical market with simultaneous improved efficiency of public spending."*	*"(...) to improve the organization and coordination of services delivered by hospitals (both in- and out-patient); to improve access to services; to optimize the number of specialist wards; to improve hospitals' management."*
Main elements	• 16 regional health needs maps and one national • each map includes three analysis: • demographic and epidemiological situation; • available health care resources; • prognosis of future health needs; • documents defining 'Priorities of regional health policy'	• online tool based on a list of questions with a predefined algorithm of point allocation • a positive opinion as a prerequisite in applying for public support for a given investment (the project must be in line with healthcare maps and the priorities of regional health policy)	• introduction of a system of basic hospital services provision • classification of hospitals into groups of six levels • four-year guaranteed financing for hospitals included in the network in the form of a global budget
Problems / controversies related to practical implementation	• controversies related to quality of the data used • maps are too general and soft in their recommendations • lack of strong steering entity at the regional or central level, with appropriate decision-making power the that could coordinate the health maps implementation	• depending on the region, the 'Priorities of regional health policy' might have general and descriptive character (lack of precise recommendations /metrics on types of investments needed) • lack of any cost-effectiveness criteria	• network inclusion criteria based on existing infrastructure, not on identified health needs • one-day hospitalization procedures do not included • lack of any quality of care, health outcomes and/or efficiency measures in the network inclusion criteria

The major impact of hospital network regulation can be seen on the level of individual hospitals and is related to change in the payment mechanism: from annual contracts to a four year guarantee of financing based on a global budget method (Table 4). From the hospital managers perspective it allowed for a more flexible financial management and supported strategic planning decisions.

Table 4. Comparison of hospital payment methods as of October 2017

Scope of services	included in the network		not included in the network[+]
Payment timeframe	a four year guaranty of financing		annual contract
Method	global budget calculated on a basis of the number of services delivered in previous reporting period	services financed separately – a list of 24 types of services financed outside the global budget amount	a contracting procedure which takes the form of competitive tenders
Management flexibility	a flexible management of the services structure		the hospital can shift the contracted budget between different types of services (up to 15%-20%), based on agreement signed with the payer
Incentives for services structure changes	a 1% increase of the budget value in case of reporting bigger number of out-patient services (by at least 10%) as well as the budget value 1% decrease in case of reporting lower number (by at least 5%) of out-patient services		no direct, positive incentives to shift to out-patient nor providing one-day hospitalizations.
Incentives for quality assurance	the possibility of 1-2% increase of the budget value, depending on number of points acquired in the accreditation process		the assessment of the provider offer is done based on the following criteria: quality, complexity, availability, continuity, price

[+] unchanged method (the same as prior the network implementation)

Discussion & cocnlusions

Although the official term 'hospital network' is used to describe the 2017 hospital sector reform in Poland, its actual meaning is not consistent with commonly accepted definition (as it do not involve the element of cooperation between hospitals). The regulation main feature was changing the financing principles for pre-defined scopes of services while the major controversy is the lack of quality of care, health outcomes and/or efficiency measures in the network inclusion criteria.

Hospitals throughout the world operate in heavily regulated environments. For the hospital sector governance to be effective - the strategic decision at the macro and/or mezzo level must be complemented by appropriate individual hospitals' management. Polish hospital sector is characterized by oversized infrastructure and major fragmentation of the ownership structure. The former contributes to divided responsibility. Thus, from the system point of view creating a proper set of incentives is of crucial importance. Recommended strategic directions are:

- centralization of highly specialized hospital services;
- shifting to out-patient and/or coordinated care models;
- reducing or restructuring (for example by transforming into long-term care) excessive infrastructure.

The network regulation provided a tool by which these objectives can be pursuit, yet its efficiency depends on the practical details of implementation. Better connection to the actual health needs, regular monitoring and impact evaluation as well as incorporating quality of care measures are of crucial importance.