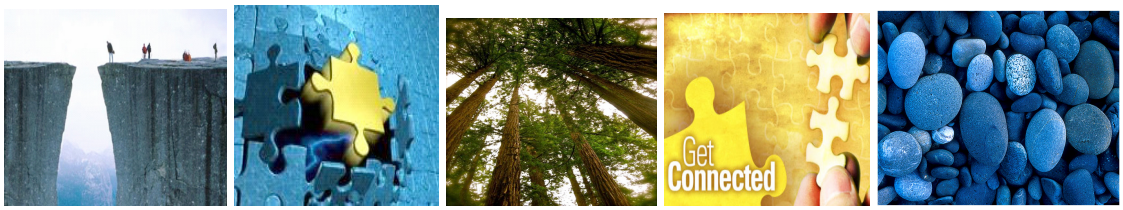


Health investments using Structural Funds

EUREGIO III Case study - John Paul II hospital in Krakow, Poland

EUREGIO III project -Work Package 5: Case material

Produced by:

Mieczyslaw Pasowicz, Agnieszka Latocha-Chaber, Marcin Kautsch, Karolina Durajczyk, Zyta Turek
On behalf of the European Observatory on Health Systems and Policies

Barrie Dowdeswell
European Centre for Health Assets and Architecture on behalf of EUREGIOIII project

The case study was originally published in: *Rechel B., Erskine J., Dowdeswell B., Wright S., McKee M. (eds.): Capital Investment for health. Case studies from Europe. Observatory Studies Series No 18. UK (pp.) World Health Organization 2009, on behalf of the European Observatory on Health Systems and Policies (pp. 41-56)*

The case study is presented here within the context of the project 'Health investments in EU Structural Funds 2000-2006: learning lessons to inform regions in the 2007-2013 period"(EUREGIO III), funded under the EU Health Program (Grant Agreement No. 20081218).

www.euregio3.eu

I. Introduction to the case study

Barrie Dowdeswell

John Paul II is a teaching hospital of just over 500 beds serving the Malaposka province of Poland. The healthcare landscape within which John Paul Hospital operates is typical of circumstances that exist throughout the '12' Member States (almost all constituent regions qualify for Structural Fund (SF) support). The common features are:

- Operating within a social fund model, which constitutes the primary source of income, but which often tends to incentivize acute hospital care as opposed to a transformative shift towards a more integrated and balanced - acute / primary care / social care model;
- Changing demographic and epidemiological trends – an ageing population and an increase in the numbers of patients with (life-style related) chronic illness;
- A continuing tendency to regard hospitals in some respects as social care facilities with a blurring of boundaries between acute and long-term beds
- An under-developed primary care service;
- A history of underinvestment in infrastructure and clinical technology;
- A shift from the former centralist model of planning and operational delivery to a more localized and autonomous system;
- Overall a continuing rise in patient demand across the board with consequent pressures on financial resources.

The following case study presents the hospital as 'seen from the inside'. In other words how the hospital management interpreted the demands on the hospital, how it responded and how it viewed planning and investment decisions. The case study was completed in 2008 and the SF investments formed part of the 2000/6 funding cycle.

At the conclusion of the case study an 'external' perspective reviews the SF investment in light of current circumstance, dominated by the economic slowdown and a growing conviction (endorsed in the EU Council Conclusions of June 2011) of

the need to move on from the established hospital-centric model of care to an integrated whole systems model with a greater diversity of service providers – and overall focused on principles of equity, affordability and sustainability.

II. The case study[1]

The John Paul II hospital in Krakow, Poland, and the use of EU grant funds

Mieczyslaw Pasowicz, Agnieszka Latocha-Chaber, Marcin Kautsch, Karolina Durajczyk, Zyta Turek

Introduction

This case study describes the experience of capital investment in one of the new European Union (EU) member states from Central and Eastern Europe. The John Paul II hospital in Krakow, Poland, has undertaken significant investments in recent years, partly with the help of EU funds. While the hospital has attracted widespread recognition of its achievements, a number of important challenges remain and are discussed here. These include the lack of an overall national health policy framework for capital investment and the cumbersome nature of EU Structural Funds procedures.

Background[2]

The major health issues facing the Polish population are similar to those in other European countries. They include population ageing, as well an increasing number of disabilities and lifestyle-related diseases. Since the beginning of Poland's democratic transition in 1989, the country's health system has seen successive waves of reform.[3] At present, mandatory social health insurance contributions

[1] The case study was originally published in: *Rechel B., Erskine J., Dowdeswell B., Wright S., McKee M. (eds.): Capital Investment for health. Case studies from Europe. Observatory Studies Series No 18. UK World Health Organization 2009, on behalf of the European Observatory on Health Systems and Policies (pp. 41-56)*

[2] This section draws extensively on *Managing Health Services in Poland*, M. Whitfield, M. Kautsch, J. Klich (eds.), Jagiellonian University Press, Kraków, 2000, the chapter *Health and health care – universality and particularity*.

[3] Some material in the background section has been adapted from *Health Systems in Transition: Poland,* ed Christian Gericke, Reinhard Busse, European Observatory on Health Systems and Policies, 2005

constitute the main source of health financing. Other sources of revenue include out-of-pocket payments, private insurance schemes, and government funding for highly specialized services. The social health insurance scheme is administered by a National Health Fund, a non-profit body that, in 2003, replaced a decentralized system of 17 sickness funds. Out-of-pocket payments, both formal and informal, are mainly for ambulatory services provided outside of the social insurance scheme, and for drugs and medical devices. In 2006, 30.1% of total health care expenditure came from private payments (WHO Regional Office for Europe 2009).

Responsibility for the management and financing of the health system is currently shared between the Ministry of Health, the National Health Fund, and the "territorial self-government administrations" at the level of provinces (*voivodships*), counties (*powiats*) and municipalities (*gminas*). Since 1989, the Ministry of Health has developed into a regulatory body that is intended to set standards and establish frameworks for major capital investments, medical education, and health policy

The National Health Fund does not own any health care facilities or organizations, but negotiates and concludes contracts with providers for the supply of health services through both national and regional offices. Since 1999, each of the territorial self-government administrations has had health authorities responsible for general planning and strategy, identification of population health needs, health promotion, and management of publicly owned health facilities. Territorial self-government administrations (in particular at the level of provinces and counties) are also owners (so-called "governing bodies") of the majority of health care units in public hands (Kuszewski and Gericke 2005).

As a result of the reforms initiated after 1989, Poland has experienced significant improvements in health care management, most notably a reduced average length of hospital stay to 6.4 days in 2006, compared to 9 in the enlarged EU (WHO 2009), and an increased emphasis on health education and promotion. The number of acute hospital beds per 100 000 population declined from 606 in 1989 to 410 in 2006, which was only slightly above the EU average of 395 per 100 000 population (WHO Regional Office for Europe 2009). Remaining challenges include ensuring equitable access to health care and sustainable financing of the publicly owned health system (Kuszewski and Gericke 2005).

A general move towards a decentralized management of health services, largely abandoning the earlier system of central planning, has strongly influenced the Polish health system. Following the fall of the "iron curtain" and the resulting economic upswing, modern medical technologies have been introduced into many health

care institutions. Advanced technologies were first introduced into university hospitals, followed rapidly by provincial hospitals.

One of the most important pieces of new legislation was the Health Care Institutions Act of 1991. This Act facilitated a radical shift in the financial and organizational arrangements of all health care institutions, and was instrumental in introducing the idea of the family physician. Outpatient specialized care is provided by private practices and hospitals. Reforms from the early 1990s onwards have also introduced regulation of procurement (affecting the purchasing function and the use of all public funds), of pharmaceuticals, and of the medical profession.

The 1993 regulation on contracting increased the scope of managerial autonomy as applied to medical services. The first contracts, although still on a very limited scale, were signed in 1994 with dental technicians, dentists and emergency care services, by the physician-in-chief in Suwalki voivodship. As the number of physicians able and willing to sign contracts grew (strongly influenced by the development of family medicine and independent practitioner services), this created a pressure on public purchasers (at that time, the institution of the voivodship physicians) to begin contracting with them and create a market for medical services.

The Polish health system has faced a continuous debate about hospital expenditure. Although there is an expectation that hospitals will improve their efficiency and work within their allocated resources, experience has shown that the government has been prepared to write off hospital debts. This political interference is seen as counter-productive, as it produced perverse incentives ("moral hazard"), effectively creating the expectation that hospitals would operate in excess of their income.

The health care delivery system in Poland is, in some ways, still shaped by the country's communist past. Primary care in Poland has never been strongly developed and still does not play the role it does in most Western health systems (Kuszewski and Gericke 2005).

Today, hospitals continue to be treated in many respects as social care facilities. Since there is no distinction between acute and long-term beds, many patients with long-term chronic conditions are kept inappropriately in expensive acute facilities. This problem is rooted in the reimbursement mechanism, which is based on infrastructure regardless of activity. To a certain extent, hospitals still receive the same income for beds with low-dependency patients, as they do for beds with high-dependency patients requiring expensive investigations and treatments. When the hospital reimbursement system was changed in 1999 with the introduction of the

Common Health Insurance Act, hospitals admitted low-dependency patients to fulfil or even exceed contract activity obligations (defined as the number of patients), which allowed them to increase their revenue. Prior to 1999, hospitals were paid according to the number of bed days; after 1999 they were paid per admitted patient. Attempts to separate care facilities for low-dependency patients (such as day care or home care) have fallen foul of difficulties in the reimbursement system from both the voivodships (before 1999) and, currently, the sickness funds. Specifically, the problems in the reimbursement system concern a lack of interest in calculating correctly the cost of services. There is also an institutional reluctance to move low-dependency patients out of the acute hospital environment, which would inevitably result in some hospitals becoming home care institutions, coupled with a failure to increase payment levels for high-dependency patients. There continues to be a shortage of chronic and palliative care facilities, and primary care continues to be considered a low priority.

At the same time, the Polish economy has been among the fastest-growing in Europe, and GDP per capita has increased substantially. This has resulted in an increased availability of funds for health services. The most important new source of funds available in the health sector in recent years has been EU pre-accession and regional fund programmes.

The John Paul II hospital

The John Paul II hospital is located in Kraków, the capital of the Ma³opolska province. It is a province-level hospital with some university wards and responsibilities for highly-specialized care, teaching and research. The profile of the hospital aims to reflect the needs of the population across the province, and is designed to ensure specialist medical care of the highest quality, in particular with regard to cardiovascular, respiratory and infectious diseases. In 2008, the hospital had 526 beds in 13 wards (including 4 clinical wards). Over 20 000 patients are admitted annually, and over 80 000 outpatient consultations are taking place per year (see Figures 1 and 2).

The hospital provides each year approximately:

- 8000 procedures in interventional cardiology;
- 2500 open-heart operations;
- 1300 thoracic procedures and operations;
- 1000 cardiac pacemakers and defibrillators;
- 800 000 laboratory tests.

Figure 1 Number of diagnostic services in John Paul II hospital, 2002-2008

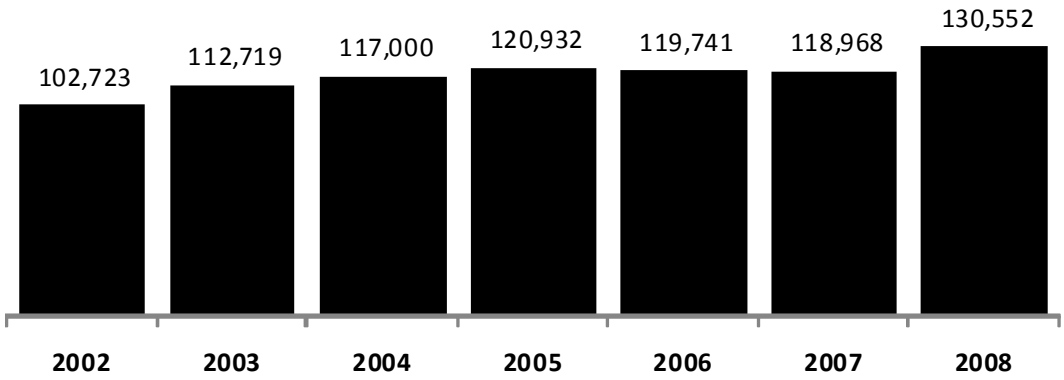
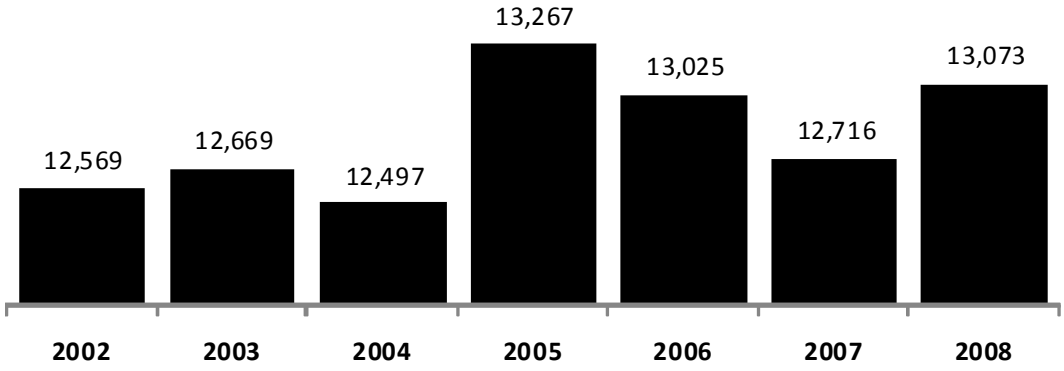


Figure 2 Number of procedures and operations in John Paul II hospital, 2002-2008



The present and planned future configuration of the hospital is designed to extend the range of medical services and to assure continued treatment through the modernization of existing facilities and, if necessary, the construction of new ones.

Construction of the original hospital, called then "Municipal Institutes of Health", within a tuberculosis sanatorium was completed in 1917. Evolving patient needs and a changing health system have prompted an updated vision, with an emphasis on innovative, preventative treatments, and new technologies that can be used to develop programmes of care for children, young people and adults that include education, prevention, early diagnosis, up-to-date treatment, and scientific research.

The hospital's administration and clinical management envisage implementing a holistic concept of health, to include not only the traditional range of hospital services but also, for example, a gym and swimming pool, health promotion programmes, and education on diet and exercise. The long-term goal is to create a technologically advanced health care facility, incorporating new medical and technical solutions and collaboration with leading medical centres in Europe. Achieving such goals requires both development of research infrastructure and technology transfer. At present, the John Paul II hospital is recognized as a unique institution in Poland. Its state-of-the-art technology including a broad range of diagnostic imaging modalities allows it to provide a diagnostic and therapeutic continuum, particularly in its specialty area of cardiac diseases.

As a tertiary hospital, the John Paul II hospital admits patients who have been referred from physicians working in primary or secondary care, although in emergency cases a referral is not required. Changes made with the introduction of the National Health Fund allow patients to be admitted from any part of the country.

Decisions concerning the operation of the hospital are taken independently by the hospital chief executive officer (CEO), although the CEO may delegate some of his/her responsibilities to deputy directors. Financial and investment decisions are approved by the Non-Executive Board, an advisory body, which (by law) is appointed by the owner of the hospital (the Ma³opolska voivod government). The hospital Chief Executive reports to the provincial government.

In 2007, the hospital employed 1473 persons, including 259 physicians, 568 nurses, and 357 paramedical staff. The hospital has prioritized investment in the quality of care provided by its staff and was certified to ISO 9001:2000 standards for quality management of in-hospital and out-patient treatment, care, diagnosis and rehabilitation in 2004, the first Polish hospital to achieve this.

The John Paul II hospital in relation to primary and community care

As already noted, the Polish health system remains focused on hospital capacity and, despite some recent advances, primary care is still underdeveloped. The John Paul II hospital has, however, developed outreach activities in the areas of health promotion and disease prevention. An example is its participation in the Ma³opolska Programme for Prevention and Treatment of Cardiovascular Diseases 2007-2013, funded by the provincial government. The hospital's educational work also includes the programme "Health education and cardiovascular and respiratory prevention in young people", carried out by the Centre for Diagnosis, Prevention and

Telemedicine in cooperation with Krakow municipality and local schools. Because smoking cessation programmes play an important role in the prevention of cardiovascular disease, the hospital has, in a similar vein, implemented the preventive programme "Prevention of nicotine consumption – comprehensive treatment of nicotine abusers".

Looking ahead, the hospital also plans to develop a centre ("Help & Hope") for health promotion activities, which is envisaged to provide training programmes for health educators and the population of the province. These plans have been already approved and funds secured.

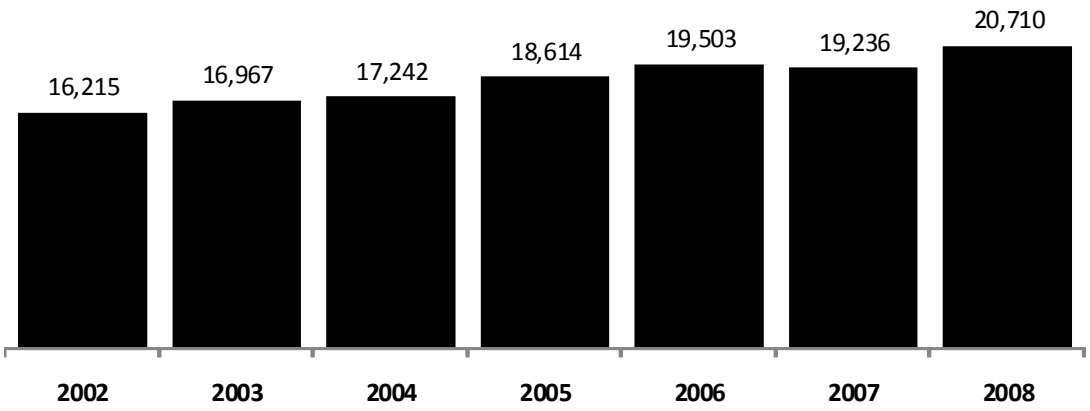
The John Paul II hospital belongs to the Polish Network of Health Promoting Hospitals, established in 1992 and comprising over 120 hospitals. Participating hospitals commit themselves to implementing activities in the following five areas:

- health promotion;
- health education activities;
- health and nutrition;
- anti-tobacco and anti-alcohol activities;
- collaboration with local communities and governments in health-related projects.

Activity levels

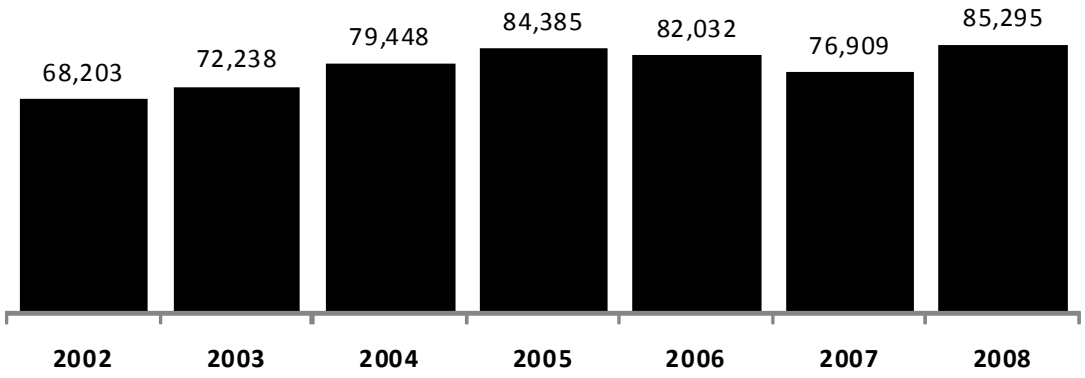
The number of in-patients in the hospital has been increasing (Figure 3), for several reasons. Apart from an ageing population and better awareness of, and access to, modern medical technologies, the mechanisms for purchasing health services have been particularly important. Payment mechanisms of the National Health Fund provide an incentive for health care providers to maximize in-bed treatment and decrease the number of out-patient services.

Figure 3 Number of inpatients in John Paul II hospital, 2002-2008



Source: Authors' compilation

Figure 4 Number of outpatient consultations in John Paul II hospital, 2002-2008



Source: Authors' compilation

In response, the hospital has expanded its range of programmes, both for in-patients and out-patients. Implementation of projects co-funded by the European Union has resulted in major alterations of the hospital structure, enabling new modalities of diagnosis and treatment. These projects and the health promoting activities of the hospital are believed to have improved the quality, scope and availability of medical services, shortened waiting lists and increased the number of admissions.

While the hospital introduced changes and innovative medical technologies in the past, these efforts have been strengthened through accession to the EU.

While its community outreach programmes are expected to bring long-term benefits, they do not affect waiting lists for medical services in the short term. Because primary care, health promotion, and preventative medicine have never been a government priority, there is little incentive for public purchasers to invest adequately in improved primary care measures. .

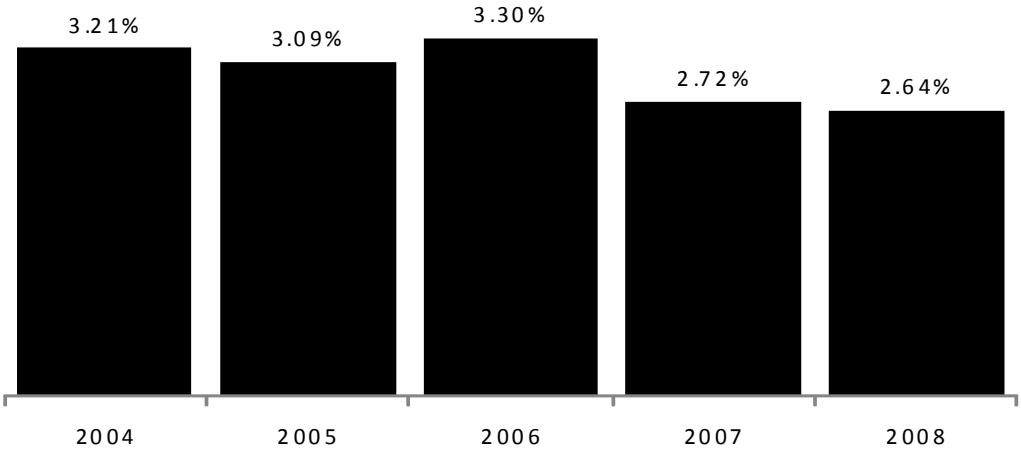
Funding of services

Prior to the major reform of health financing in the late 1990s, the hospital, as all other publicly owned health care providers, was financed from the state budget. All funds, including both current expenditure and capital investment, came from the same public source. The switch from a tax budgetary system to a health insurance model changed this. The hospital is now an independent health care institution which provides medical services on the basis of contracts with the National Health Fund. Health care services include inpatient care, outpatient consultation, diagnostic services, rehabilitation, prevention, some highly specialized procedures, home oxygen therapy, and medical transport.

Persons covered by the compulsory health insurance system are entitled to free hospital or outpatient treatment and diagnostic tests if they have a referral from a physician who has signed a contract with the National Health Fund. Highly specialized diagnostic tests (magnetic resonance, computed tomography, scintigraphy, and angiography) are also performed following referral by a specialist or a hospital that has signed a contract with the National Health Fund. Highly specialized procedures, such as heart transplantation or operations requiring extracorporeal circulation, are financed from the central government budget on the basis of contracts with the Ministry of Health rather than the National Health Fund.

The hospital also carries out procedures on a private basis. Uninsured patients or those who do not have a referral cover the costs of treatment from their own resources or from voluntary insurance. Although the hospital seeks to expand its private health care, it still constitutes only a small proportion of the total budget (Figure 5).

Figure 5 Proportion of the hospital's overall income from private health care



Source: Authors' compilation

Note: 2008 data are provisional

National, regional, and local planning

The concept of central planning of health care attracted little support in post-communist Poland and has suffered from a lack of legislation that would make it possible to translate the government's overall goals into tasks and programmes. This has jeopardized Poland's ability to access EU funds (see below). The lack of consistent strategic policies at the national level concerning investments in the health sector has made it difficult for hospitals to carry out capital investment programmes. This can to some degree be overcome by regional authorities. Some regional authorities, including Ma³opolska, have developed strategies that are adapted to their health needs. Furthermore, there has always been a strong health component in the Ma³opolska over-arching regional strategic development plan. The John Paul II hospital has endeavoured to match its activities to regional health needs and to the regional strategic development plan, which has helped to attract the support of decision-makers and to raise substantial funds for development.

The strategic goal of the Ma³opolska health care programme is to improve the health and quality of life of the population of Ma³opolska province through modification of health promoting factors, reducing inequalities in health and in

access to medical services, and improving the quality and efficacy of the regional health care system.

Capital investment funding

At present, there are no legal restrictions on financing capital investments and the hospital uses various sources of funds, including those from the central and regional government and the EU.

Central and regional government funding

Central government funds are available for capital investment in infrastructure and equipment needed for highly specialized care, based on annual contracts with the Ministry of Health. This includes heart and lung transplantation and other major cardiovascular procedures, undertaken within the framework of the National Programme for Prevention and Treatment of Cardiovascular Diseases. In addition, the Ministry of Health, via the province government of Ma³opolska, has supported the hospital's activities and facilities in relation to early diagnosis.

One of the main sources of funds for capital investment is the government of Ma³opolska province. The province owns the facility, and its capital investments have to be approved by the regional parliament as part of the provincial budget. The most recent investments funded in this way amount to total costs of PLN 11.57 million (€3.13 million), with the hospital contributing PLN 2.23 million (€605 000) from own funds:

- modernization and development of the thoracic surgery ward,
- modernization of the hospital chapel,
- development of an out-patient department and early diagnostic centre.

International funding

Support from EU programmes has been essential for the development of the hospital and while most of the initiatives that have received financial support from the EU would have been undertaken with funds from other sources, but they would have taken much longer and would have been more limited.

The hospital participates in the eTEN (Deploying Trans-European e-Services for All) programme. This EU programme helps to stimulate the deployment of innovative, trans-European e-services of social or economic interest. Within the eTEN programme, the hospital participates in the Medical Care Continuity (MCC) project,

which is developing a new service for hospital at home care. This allows oncology patients to be followed up at home using the internet and a call centre. Other partners in the project are in Belgium, France, and Italy.

The hospital has also started a project entitled "Health incubator" (the investment module) within the framework of the Integrated Regional Operational Programme (EU Structural Fund support for socio-economic development) to improve its competitive position by considerably enhancing the diagnostic capabilities of the hospital. The project consists of:

- upgrading the MRI scanner and purchasing state-of-the-art medical equipment, i.e. linear transducers, upgrade to Leonardo Circulation, nucleic acid detection module, open-magnet MR scanner of medium field strength and digital densitometer;
- modernization and acquisition of equipment for digital imaging facilities to assure integrated and comprehensive image analysis and interpretation.

Aside from capital asset funding, the hospital collaborates with Health ClusterNET: a network of European regions supported by the INTERREG IIIC initiative (an EU-funded programme that helps Europe's regions form partnerships to work together on common projects). It comprises 13 European regional partners working together to improve the contribution that health care sector spending – including capital asset investment – makes to regional development (Dowdeswell, B., Erskine, J., Watson, J, 2006).

Using EU Structural Funds

In broad terms, EU Structural Funds aim to promote economic and social cohesion, achieve the strategic objectives of employment policy, and facilitate structural reform in agriculture, rural development, and fisheries among other sectors. Health in general, and health capital investment in particular, have so far not been included specifically in the structural fund programmes. However, the programmes include explicit mention of "productive investment", "infrastructure", and "local development initiatives" (European Commission 2008). Numerous institutions across the EU, especially in the new member states, have made a strong case for co-financing investments in health infrastructure on the grounds that such projects help to improve access to health care, remove some of the inequalities between regions, and decrease population health inequalities among member states. The John Paul II hospital has been successful in applying for Structural Funds and in implementing co-financed projects. It is worth considering in some detail the

process that institutions have to undergo to make a successful bid, and the advantages and disadvantages inherent in this process.

In common with similar procedures in other member states, Polish health care institutions have to obtain approval by the Ministry of Health that their proposal is in line with the National Development Plan, and to check eligibility with the European Commission's Operational Programmes before submitting any project for Structural Fund support. The next step is the preparation of the Programme Complement which sets out the strategy for realizing the goals defined in Operational Programmes. The Programme Complement within each priority gives details of activities that can be funded, project selection criteria, final recipients of the benefit, and how the programme will be monitored. The Programme Complement also describes the system of implementation, including the tasks to be performed by the institutions responsible for the management, implementation and monitoring of activities and the project selection criteria.

The preparation of the Programme Complement is time-consuming and a considerable drain on resources. Time and resources spent on preparation also have to be contrasted with the time that a project would take to be approved if it were funded solely from state funds or the private sector.

The call for proposals begins with a long, somewhat tedious process of preparing a grant application. The experience of the John Paul II hospital is that the relevant EU websites often contain only limited information, and much important information only comes to light during the actual practice of preparing a project proposal. It is true that assistance is generally available from the European Commission and in emergencies one can count on direct contact with the DG-Regio desk office to obtain clarification or explanation, but the lack of concrete information (for example, on reporting protocols for project progress) still hampers the detailed creation of a financeable project.

For the beneficiary of EU Structural Funds, there is a long list of duties and responsibilities, including preparation of the proposal, forming relationships with other potential partners, assuming legal responsibility for the contract with the fund provider, establishing machinery for project management and monitoring, and setting up procedures for accountancy and information management.

It is worth noting that even once approved and underway, the contract for a project can be terminated if there are significant irregularities in the way the project is carried out (such as a breach of Community law; any act that has caused fiscal damage to the European Commission budget; any breach of regulations regarding

EU funding or national public funding). Furthermore, if a contract is terminated, funds hitherto received must be returned.

Despite the administrative and fiduciary baggage that accompanies EU structural funding, the projects thus co-financed at the John Paul II hospital have helped to achieve important goals, such as:

- installation of up-to-date technology in hospital wards;
- increased availability of comprehensive medical examinations;
- improvements to the overall quality of medical services;
- better research and development infrastructure;
- more and better communications (internet services, promotional materials, facilitation of conferences and seminars);
- creation of databases and systems of data exchange.

Two examples of projects co-financed by the EU (within the framework of the Integrated Regional Operational Programme – IROP, one of seven operational programmes used in implementing the 2004-2006 National Development Plan/Community Support Framework that sets the national framework for the use of Structural Funds) are:

- digitization of the echocardiographic and mammographic system of the hospital (EU funding 75%; hospital funding 25%);
- the John Paul II hospital - eHospital: formation of a digital platform for medical data and teleconsultation (EU funding 75%; hospital funding 25%).

In recent years, the most important investments in the hospital, including the development and modernization of facilities and capital investment in equipment for wards and administration, have been completely or partially funded from EU sources, with contributions from hospital resources and other funds. Medical equipment was purchased either as separate purchasing projects or within the framework of major investments encompassing refurbishment and reconstruction.

Three recent examples are:

- The Centre for Diagnosis, which has been equipped with a modern digital mammography system and new echocardiography equipment within the Digitization of Echocardiography and Mammography Systems Project, co-financed by the Integrated Regional Operational Programme. The total

cost of the project was PLN 2.9 million (€784 225), of which PLN 2.1 million (€572 111) were financed by the EU.

- The Centre for Diagnosis obtained a Magnetic Resonance Imager within the Health Incubator project (investment module). The total cost of the project was PLN 4.8 million (€1.3 million), including co-financing by the European Regional Development Fund – ERDF of PLN 3.6 million (€965 560) and the central government budget of PLN 1.2 million (€321 840).

- A Computerised Tomography scanner installed at the Centre for Diagnosis and Rehabilitation of Heart and Lung Diseases, Poland's and Central Europe's first institution introducing this equipment.

Although these expenditures seem modest by reference to programmes elsewhere, they are significant in terms of the investment otherwise made by the hospital during recent years, or that which would have been feasible in the same time frame from national, regional and hospital own resources.

The primary aim of these projects has been the improvement of medical services with the application of modern diagnostic and interventional techniques using state-of-the-art digital technology.

The experience and lessons learned during realization of the above projects enabled the hospital to be better prepared for the 2007–2013 programming period. It initiated two large regional projects on emergency medicine and medical technology research, with total funding exceeding € 35 million. Both projects were envisaged to be co-funded through EU structural funds.

Conclusions

The John Paul II hospital in Krakow now provides up-to-date treatment unavailable in many other centres in Poland. The achievements of the hospital have been recognized by various organizations and the institution has won numerous awards and prizes. EU structural funding has been a valuable resource in achieving this progress but available funds so far fall significantly short of what is needed to meet current investment demands. Further, there have been problems, such as difficulty in absorbing Structural Funds, due to the limited timeframe in which these funds are to be used. Finally, the absence of an explicit health policy at the national level, coupled with frequent changes of government, has produced instability. Since there are no clearly defined national goals, it is difficult for health care providers to count on the long-term support by the central state.

III. Conclusions – an 'external' viewpoint

Barrie Dowdeswell

The strategic goal of the Malaposka healthcare programme is to improve health and quality of life through:

- Improving the range and scale of health promotion
- Reducing health inequalities, and improving access to medical services, and
- improving quality and efficiency

One of the key innovative steps taken by the hospital to support these objectives was to become part of a network of European health promoting hospitals which aim to use their prominence in the community and their access to significant 'at risk' patient populations to engage patients as co-producers of care, in other words look after their own health better. The hospital also aims to extend this influence to encompass primary and social care. This is an underdeveloped and underestimated role for acute hospitals.

However, the principal focus for capital and SF investment in the hospital tends to be aimed towards modernization of facilities and clinical technologies. This is understandable given years of under investment. Support from the EU in the form of Structural Funds has been essential; it has accelerated funding capital availability and with matched funding from other sources extended the scope and scale of modernization.

The hospital took advantage of the EU eTEN (Deploying Trans-European eServices for All) that enabled it to invest in eHealth technology to improve the trajectory of care albeit for a comparatively narrow cohort of patients; the aim to reduce demands on hospital based services and enable patients to make better use of local primary care support. This is similar in nature to the accompanying Euregio III 'Brandenburg' case study which further develops the principle of the patient as co-producer of care.

It is noteworthy that the bulk of SF funding was directed towards extending the scale and scope of clinical technologies, as might be anticipated of a major teaching

hospital. This is again typical of the investment focus of SF spending in the acute hospital sector. However when set against the current outlook for healthcare it can be seen that with hindsight significant opportunities may have been missed.

One of the main factors driving transformational change in health systems is strong evidence that for large numbers of patients for whom the acute hospital has become the default model of care, more investment in 'care in the community' – primary and social – offers substantial benefit; better accessibility, higher quality, greater responsiveness and easier affordability.

There are telling signs in the case study of this default role at John Paul II. An acknowledgment that the hospital was still viewed as providing social care facilities, an acceptance of the blurring of boundaries between acute and long-stay beds and continual rise in patient demand. It could be argued that the hospital could have taken steps to redefine its teaching role, delineate services as between its primary function as a regional acute centre and the provision of long-stay / social support beds and apply Structural Funds to reconfigure its services. There are good precedents for this type of strategic repositioning to resolve the problems described above. Many of the more progressive hospitals in Europe are, for example:

- developing a significant range of outreach services through establishing local community polyclinics
- accelerating the provision of minimally invasive treatment centres, again often dispersed within the community
- redesigning the internal hospital services towards the practice of multi-disciplinary clinical organization with a consequent shift away from conventional (and often territorial-based) clinical departments; the hospital of the future as an integrated knowledge centre
- substantially improving service integration with the primary and social care sectors through adoption of clinical pathways supported by eHealth communication systems

These initiatives are all illustrative of hospitals coming to terms with the need for significant reform to ensure that they deliver the most appropriate care, for appropriate patients in the optimum manner; the logic behind the graduated care model. Furthermore this is consistent with the EU Council observation that a shift of services away from the former dominance of the hospital-centric model is one of the most relevant steps that can be taken to ensure that health systems, in responding to the economic crisis, continue to delivery high quality, equitable, affordable and sustainable care.

It is clear however that hospitals such as John Paul II that are reliant to some degree of SF for modernisation are limited as regards the scope and scale of redevelopment funded in this manner. This is due to limitations of the current SF process. The existing system tends to favour discrete stand-alone projects such as exampled here, the provision of clinical technology. The SF process is not sufficiently well designed or implemented in a manner that supports large scale and transformational change particularly where this involves a combination of integrated initiatives e.g. linking eHealth and infrastructure investments or combining ERDF and ESF funding sources.

There is no implied criticism of John Paul II in this overview. At the time and within the SF framework available it took full advantage of the SF programme to modernize its primary service role, specialist regional acute care. There seems to have been no overarching policy of reform of hospital care. This again is typical of an era where high levels of GDP growth enabled hospitals to continue a programme of cumulative growth in capacity to meet what appeared to be a continually rising tide of demand. As will be seen from other accompanying case studies, for example Kymenlaakso, Finland, there has been a rapid and at the time unpredictable change in outlook. The economic crisis that started to emerge in 2008/9 points to an extended period of public sector austerity, there is a better understanding of how to meet the needs of an ageing population with far less reliance on the acute hospitals, new models of care that direct the care of the chronic ill towards a focus on local primary / community care and the need for consequent reform of the acute hospital sector.

The principal lessons from this case study as regards future SF investment suggest:

- That hospitals cannot stand alone in planning future investment, it should form part of an overarching plan that reflects the need for structural change in the way services are delivered. All future SF proposals should be more closely aligned and set within a strategic masterplan;
- The SF process itself should be reformed or at least made more effective to support the need for integrated planning and consequent integrated investment;
- There is a need to improve the competencies and capacity of all those concerned with the SF process – planning, decision-making, implementation and evaluation. This case study forms part of that learning process;
- That project planners find the SF process overly complex and time consuming, which in turn mitigates against undertaking the even more complex planning processes needed for hospital reform.

These and other lessons are echoed in other case studies. The final Euregio report will draw these conclusions together and present an overview and recommendations that should help improve the effectiveness of SF investments in a way that contributes to the transformative change in healthcare delivery promoted by the EU Council Conclusions.

References

European Commission (2008) The European Regional Development Fund [website]. [http://ec.europa.eu/regional_policy/funds/prord/prord_en.htm, accessed 29 January 2008].

M. Whitfield, M. Kautsch, J. Klich (eds.). Managing Health Services in Poland, , Kraków: Jagiellonian University Press, 2000.

Kuszewski K, Gericke C. Health Systems in Transition: Poland. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2005.

Erskine J, Dowdeswell B, Watson J, How the Health Sector can contribute to regional development: the role of capital investment (2006), access via http://www.healthclusternet.org/

WHO Regional Office for Europe (2009). European Health for All database (HFA-DB) [offline database]. Copenhagen, World Health Organization Regional Office for Europe (January edition).