

Organization and Financing of Mental Health Care in Poland

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Abstract

Organization of care: Health care is provided to patients with mental disorders by the state health care facilities as well as by social help agencies. Mental health care services are provided mostly by mental health facilities and partly by primary care units. Outpatient clinics, separate for psychiatric patients and substance abusers, are the most numerous mental health care units, amounting to a total of 1120. Intermediate care facilities include 110 day hospitals, 23 community mobile teams and ten hostels. The number of hospital beds amounts to 31913, i.e. 8.3 beds per 10000 population. 80% of beds are located in mental hospitals.

Trends of development: The trends in mental health care development are outlined in the Mental Health Programme and accompanying documents accepted by the Minister of Health and Social Welfare. The programme defines specific goals to be achieved by the year 2005 in the primary, secondary and tertiary prevention of mental disorders. In the domain of mental health care accessibility the most important goals are the following: a significant reduction in the number of beds in large mental hospitals, a marked (nearly threefold) rise in the number of beds in psychiatric wards at general hospitals and a significant increase in the number of community-based forms of care (e.g. a fourfold rise in the number of day hospitals).

Financing of care: Before 1999, the health care system was financed from the state budget and the health care spendings were subject to a political auction each year. Allocation of funds among hospitals and health care centres was based on the total previous year budgetary spendings of particular facilities and did not take into account a detailed cost analysis. Such a financing approach, although giving a feeling of a relative financial safety, did not encourage health care facilities to introduce an organizational flexibility and to expand the scope of their services. In psychiatry, it manifested itself in a very slow development of some community psychiatry forms (mostly day hospitals, mobile community teams and hostels). The Health Care Institutions Act has created a legal framework for the financial management of health care units in their new, independent form. Conditions for health care financing through regional sickness funds were thus created. The financing is currently based on contracts made by sickness funds with health care facilities for specific health services. Both the quantity and price of services should be mutually negotiated.

Some simplified measures of services offered were used during the first insurance financing year. In mental hospitals and day hospitals it was a person-day; in out-patient care it was a visit.

Both cost indicators were aggregated, including all the components present so far in the functioning a given unit. Copyright © 2000 John Wiley & Sons, Ltd.

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Organization of Care

The Republic of Poland has approximately 39 million inhabitants, 62% of whom live in towns. Since 1999 Poland has been divided into 16 administrative provinces.

Health care is provided to patients with mental disorders by the state health care facilities, mostly under the aegis of the Ministry of Health (until 1999 the Ministry of Health and Social Welfare), as well as by social help agencies, belonging to the Ministry of Labour and Social Policy. Private practice in psychiatry, so far very limited, has extended considerably during the last decade. The contribution of social organizations and self-help groups to care provision is rather small, with the exception of alcohol- and drug-dependent people (AA, Al.-Anon and Abstainer Clubs, or the Monar association) and the mentally deficient. The mentally ill and their families have only recently started their own organizations.

The legal grounds for mental health care provision include the following acts: the Health Care Institutions Act, the Mental Health Act, the Act on Upbringing in Sobriety and Counteracting Alcoholism and the Act on Preventing Drug Abuse. Trends in the mental health care development are outlined in the Mental Health Programme and accompanying documents.

Mental health care services are provided mostly by mental health facilities. Primary care units deliver services to a large portion of patients suffering from non-psychotic mental disorders, but at present these services quality is far from satisfactory. This results mostly from inadequate qualifications of medical doctors working in primary health care. The majority of them are specialists in internal medicine, as the specialization of the family doctor has been launched only recently.

The most numerous category of mental health facilities are outpatient clinics, amounting to a total of 1120. There are four types of outpatient clinic: psychiatric clinics for adults, psychiatric clinics for children, clinics for alcohol-dependent persons and clinics for drug abuser treatment.

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These clinics usually work on a daily basis, but about 30% of the units are open on some days only. Almost all outpatient clinics constitute a part of health care centres, including also general hospitals, outpatient primary care and some other ambulatory settings. In the last years nearly 2% of Polish citizens have visited outpatient mental health clinics yearly.¹

Intermediate care units are a part of either health care centres or of mental hospitals. They include 110 day hospitals, 23 community mobile teams, 10 hostels and four units of foster family care.¹

The number of psychiatric beds amounts to 31913, i.e. 8.3 beds per ten thousand population. Though the number of beds in mental hospitals has been constantly decreasing over the recent years, still a vast majority of beds are located in mental hospitals and only 12% in psychiatric wards of general hospitals. Due to an uneven distribution of inpatient resources and over concentration of beds in large hospitals, the availability of inpatient care to a large portion of the population is insufficient. In the last four years the number of people treated in psychiatric inpatient facilities was pretty stable, amounting to 3.68 per 1000 population.¹

Psychiatric services and alcohol or drug treatment facilities are staffed by about 2200 psychiatrists, about 1500 psychologists, 400 other therapists with a university education and about 400 social workers. The biological approach predominates in therapy, although psychotherapy and other psychosocial methods are also extensively used in the treatment of some categories of patients, mainly those with neurotic disorders and alcohol dependence.

Psychiatry, as well as some other medical specialities, is subject to specialist supervision. The supervisory system serves to implement medical scientific achievements in psychiatric practice, to evaluate the level of mental health services and to prepare reports and conclusions for subsequent application in practice, so as to improve the mental health care system. Specialist psychiatric supervision is organised both at the national and provincial level.

Developmental Trends

Trends in the mental health care development are outlined in the Mental Health Programme.² The programme, drafted in 1994, was approved for implementation by the Minister of Health and Social Welfare in 1995. Hopefully, the document will be soon accepted as a governmental programme. The programme consists of the following five parts:

- (1) Diagnosis of the current status and risks in the field of mental health in Poland. A sociomedical analysis.
- (2) Current status of primary, secondary and tertiary prevention.
- (3) Mental health promotion and primary prevention programme.
- (4) Programme of health care and other forms of assistance provision to people with mental disorders (secondary and tertiary prevention).

- (5) Fourth-level prevention: scientific research and development of health information systems.

The major part of the programme is that dealing with provision of health care and assistance to people with mental disorders. The main goal of this programme is to develop a community-based psychiatry model, where the basic form of care should be outpatient clinics and intermediate care facilities, while hospital care is to be provided mostly in psychiatric wards of general hospitals. In order to attain these goals several tasks should be fulfilled (**Table 1**). For every task detailed measures required are specified. In the part dealing with an improvement of accessibility and differentiation of psychiatric care, a minimal accessibility is defined for particular types of setting. E.g. psychiatric mobile community teams for adults are expected to provide intensive care to one person per 10000 population. As regards the inpatient psychiatric care for adults, there should be four

Table 1. Mental health programme

Programme of health care and other forms of assistance provision to people with mental disorders (secondary and tertiary prevention)	
	A. Goal and tasks
	B. Means and methods of task fulfilment
1.	Implementation of legal acts regulating mental health issues
2.	Legislative measures
3.	Improvement of the quality of primary health care service provision to persons with mental disorders
4.	Improvement of the psychiatric care and alcohol and drug treatment level
4.1.	Increase in the number of staff
4.2.	Improvement of staff qualifications
4.3.	Improvement of accessibility and differentiation of psychiatric care delivery to adults
	4.3.1. Community-based care
	4.3.2. Inpatient care
4.4.	Improvement of accessibility and differentiation of psychiatric care provision to children and adolescents
	4.4.1. Community-based care
	4.4.2. Inpatient care
4.5.	Improvement of accessibility and differentiation of alcohol treatment provision to alcohol dependent and co-dependent persons
	4.5.1. Community-based care
	4.5.2. Inpatient care
4.6.	Improvement of accessibility and differentiation of drug treatment provision to drug dependent persons
	4.6.1. Community-based care
	4.6.2. Inpatient care
4.7.	Improvement of continuity and quality of care
5.	Increasing the role of social welfare facilities and other forms of assistance

beds per 10000 population, and the distance between the patient's home and the inpatient facility should be less than 50–60 kilometres. Indices of minimal accessibility were established on the grounds of experiences of modern Polish centres providing intermediate care and data on utilization of psychiatric facilities in particular administrative regions, as well as opinions of WHO experts and experts from Western Europe.

Along with principles of accessibility and differentiation of care outlined in the Programme a document, 'The target network of public mental health facilities', was elaborated as a project of an ordinance to the Mental Health Act.³ The document states the number, size and location of specific community-based and inpatient facilities that should exist in particular provinces in the year 2005. It is estimated that in the year 2005 the number of all psychiatric beds will be lower by almost 20% than that nowadays. Some 100 new psychiatric wards in general hospitals should be established and the number of beds in mental hospitals should be markedly reduced (Figure 1). As shown in Figures 2 and 3, a dramatic enlargement of the intermediate facilities network is expected, especially as regards the number of mobile community teams and day treatment or day care units.^{4,5}

The document in question has not gained the status of an ordinance to the Mental Health Act yet, since it had to be updated due to the administrative and health insurance reforms (both introduced in January 1999). Proposals previously accepted by local authorities of 49 former administrative regions had to be re-negotiated with self-governments of the current 16 provinces. In some provinces re-negotiations are still in progress—the most difficult issues turned out to be those concerning establishment of new

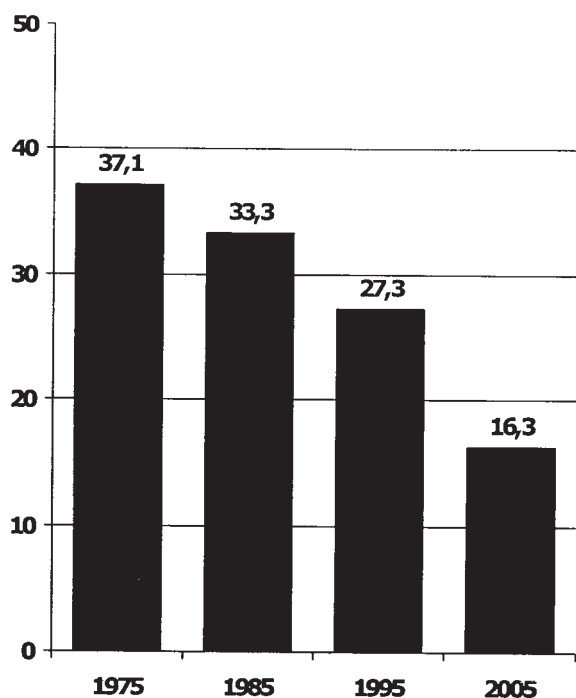


Figure 1. Number of beds in mental hospitals: Poland, selected years, 1975–2005 (in thousands)

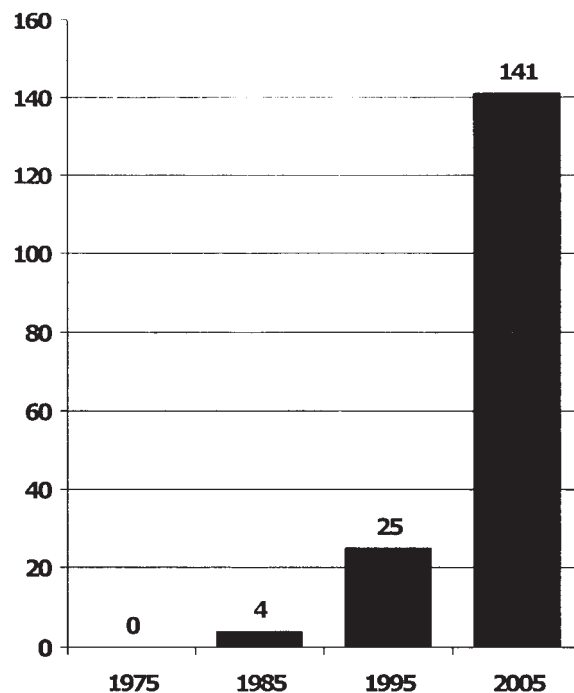


Figure 2. Intermediate care facilities. Number of mobile community teams: Poland, selected years, 1975–2005

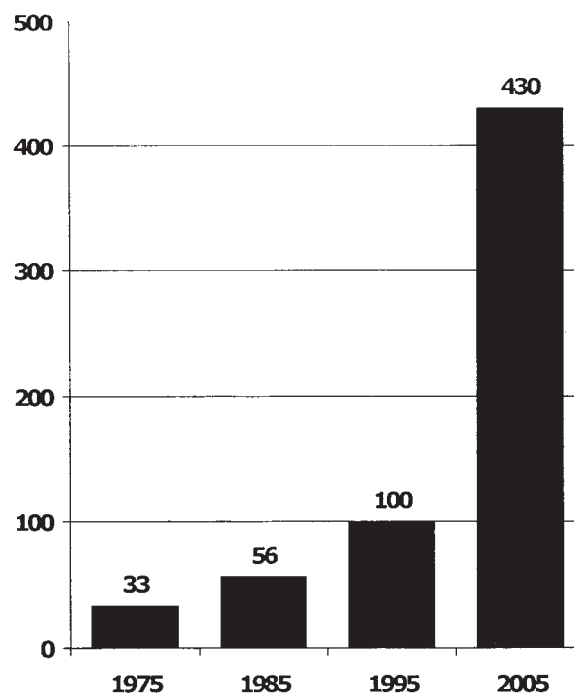


Figure 3. Intermediate care facilities. Number of day treatment/day care units: Poland, selected years, 1975–2005

psychiatric wards in general hospitals. Thus, it is generally felt that the date for the target network full implementation should be postponed until the year 2010. In this time span it seems feasible to develop desirable quantitative minimal indicators of care accessibility. It cannot be excluded though that the desirable density of inpatient care facilities (aimed at equalization of this form of care accessibility all over the country) will not be fully attained.

Financing of Care

Over five decades, the Polish health care system was financed from the state budget. Until 1990 the system was rigid and directive to a great extent, both as regards funds allocation and assessment of their use. It was also prone to political pressures. Provincial administration was a payer as well as an owner of facilities.

Allocation of operational funds was made on the basis of the previous year's budget execution. The budget was determined mainly on the basis of the facility size and number of employees. Supervision of facilities had an administrative and bureaucratic nature. Their economic evaluation was limited to the analysis of 'budgetary indices' execution, such as the number of beds, bed-days and employees, as well as of the total expenditure groups (personal expenditures, asset expenditures and investments). Parameters giving more detailed information on the activity, e.g. the number of patients treated by their diagnosis and length of stay, were not taken into consideration. Evaluation of the psychiatric care standard, made by expert specialist supervisors, had no financial effect on the facility under audit.

Health care facilities were budgetary units lacking economic self-dependence. Their reporting and accounting system did not require any analysis of the particular units' expenditures. So, global costs of running a large hospital were known, but it was not possible to determine the patient-day cost in a particular type of ward. Until 1992, only medication costs were analysed in a formal way, while other real costs of particular wards and other organizational units were exempt from analysis.

However, in spite of a lack of economic mechanisms, some progress in mental health care was noted before 1991. There were advantageous organizational changes, the health care standard improved, the network of psychiatric wards at general hospitals was gradually growing and some day wards and other community care forms were created. The credit goes mainly to the reform-oriented psychiatric circles who widely applied persuasive and educational methods, and also made use of their administrative and political influence to defeat decision-makers' and payers' resistance.

The process of a total economic transformation of the state started in 1990 meant long-term, very stringent financial rigours imposed on each state budget-financed activity, with the health care system included. For many psychiatric facilities, formerly under-financed, a critical period came. They were forced to cope with small and delayed funds allocated in inadequate instalments. In spite of looking for off-budget funding (e.g. the so called 'donations'), health care facilities inevitably ran into debt.^{6,7} Financial management of health care facilities continued to be that of budget units, even though the Health Care Institutions Act of 1990 announced that legal grounds would be provided for their becoming self-dependent.

Under these generally difficult circumstances, when awaiting self-dependence regulations, first local attempts have been made (also by some psychiatric facilities) at allotment and utilization of budget resources on the basis of an

analysis of the population's health needs and using more precise methods of cost estimation. As soon as the legal basis (the ordinance of May 1995) was available, these units were the first to gain the status of economically self-dependent facilities, having legal personality and bearing responsibility for their obligations. However, only a few mental hospitals participated on their own initiative in the process of budget units' transformation into self-dependent facilities by the end of 1998. This group included the facilities that had completed their restructuring before gaining self-dependence. Due to their transformation they have acquired more experience in precise cost estimation and in negotiating financial resources for their activity. The remaining units were transformed into self-dependent facilities in late 1998, in accordance with the provisions of the Act on Universal Health Insurance.⁸

For over a year now psychiatric services, as well as the whole health care system, have been functioning under new conditions as defined in the Act on Universal Health Insurance. The functions of the owner and payer were separated. As a result of the country's administrative division reform implemented at the same time, local self-governments at the provincial level became owners of psychiatric facilities, and new institutions (sickness funds) appeared as independent and main payers.

From the beginning of 1999, the word 'contract' has become the most important one. Health care facilities started their game with sickness funds. The funds are in a privileged position as they make decisions concerning the shape of a contract signed on the basis of a given facility costs and services offered. Both parties started their contract negotiations not equipped with such important instruments as the medical procedure standards, services rendering conditions and staff qualifications required. As a result, unspecified aggregated indices covering very non-uniform standards of diagnosing, treatment and care conditions were used as a basis for service contracts conclusion. A 'bed-day' index was commonly used in contracts with psychiatric hospitals, while that of 'hospitalization' was commonly used in general health care. An appointment became the basic index for outpatient care. Detailed prices of services were established by particular sickness funds on the basis of averaged costs of these services in previous years. Numerous problems appearing since the reform implementation has started show that the contracting parties—both facilities and funds—were not prepared for the new circumstances.

Usually, the power of bargaining psychiatric facilities depended on the scope of their monopoly on the services market in a given area. In regions where the supply of services in relation to demand was moderate, health care facilities had a better chance to perform the contracted services, and even to attain a positive financial outcome. Two groups of facilities representing two different models of psychiatry functioning are now in a peculiar financial situation.⁹⁻¹¹ The first group consists of large, traditional mental hospitals, offering a significant surplus of services as compared to the population needs in the region served by a given sickness fund. It is the financial position of these

hospitals in the period of contracting services that was most affected by two disadvantageous overlapping factors. The first factor involved the contract range, limited almost exclusively to 'own' patients (i.e. those belonging to a given sickness fund), while the other consisted in too low detailed prices (due e.g. to underrated costs). In consequence, the hospitals were at risk of going into bankruptcy. The second group of facilities consisted of modern psychiatric centres with a small number of beds and well developed community care forms (day hospitals, hostels, clubs, occupational therapy workshops). Sickness funds did not evaluate properly the importance of differentiated care forms, and estimated the cost of their services inadequately. Such an approach may result in a limitation of the range of services offered and in pushing psychiatry back to the old-fashioned model, where the mental hospital plays a dominating role.

The future shape of psychiatry depends to a large extent on the approach of sickness funds to the assumptions and guidelines outlined in the Mental Health Programme, discussed earlier. Three main courses of action should be taken by the funds if they want their policy to be in line with the programme:

- (1) Allocation of larger funds for the purchase of psychiatric services provided by out-patient clinics, day hospitals, hostels and mobile community teams, i.e. services close to patients' homes and diminishing the need of hospital treatment.
- (2) Offering to buy in-patient psychiatric services in general hospitals located in areas remote (over 50–60 km) from psychiatric centres, thus encouraging the general hospitals to establish psychiatric wards there.
- (3) Offering to buy services of rehabilitation and custodial wards for chronic patients in large mental hospitals so as to encourage the hospitals to create such wards.

Local self-governments, responsible for the establishment and running of psychiatric facilities according to the needs of the province population also play an important role in supporting these actions.

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