

Oswajamy jutro:
Mierzenie się z wyzwaniami polskiej starzejącej się populacji
Taming tomorrow:
Meeting the challenges of Poland's aging population

1. Zarządzanie potencjalnym wzrostem wydatków na zdrowie dla starzejącej się populacji
Managing potential increases in spending on health for an aging population
2. Przygotowanie systemu opieki zdrowotnej w celu zapewnienia lepszej opieki pacjentom chorym na raka
Preparing the health system to provide better care for patients with cancer
- 3. Polepszenie doświadczeń pacjentów i zaufania w interakcjach z systemem opieki zdrowotnej**
Enhancing patient experience and trust in interactions with the health system

1. The Context

One change that will become very visible in a matter of years is the age profile of people in the waiting rooms of physicians and hospitals in Poland. With the population aging rapidly, there will be far more older patients demanding far more services than younger patients. At current rates of consumption, more than five and a half million people 65 years or older and a little less than three million younger patients will be lining up in physician offices and hospital lobbies, waiting for their turn to see a healthcare provider. Not only will the older patients demand more services, most will have quite a lot of available time for lengthy interactions with the healthcare system. Building on past successes, Poland must further strengthen its health system and prepare it to provide high-quality value-based services to its aging population.

The graying of Poland's population has profound implications for the country's mortality and morbidity profile. Ischemic heart disease, strokes, Alzheimer's disease and cancers cause the most deaths today, but cancer will overtake all other causes of deaths and will become the single-largest killer. Noncommunicable diseases, particularly cancers and strokes, will remain the leading causes of premature deaths, while low back pain, falls, headaches and diabetes will remain the principal causes of years lived with disability. Chronic diseases such as these need to be managed effectively, else they can have disastrous outcomes for individuals and society. Direct medical costs associated with treatment and economic costs associated with lost productivity, caregiving and loss of healthy life can be staggering.

Recognizing the need to continually reform its healthcare system for the benefit of the entire society, especially in light of an aging population and increasing expectations among people, Poland has begun piloting a people centered integrated care (PCIC) approach in primary healthcare. People-centered care is "an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways." Integrated care consists of "health services that are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout their life course." (WHO, 2015a; pgs. 10-11). The aim of this approach is to provide the right service at the right place and the right time. It prioritizes integration and coordination of services across the spectrum of care, from promotion and prevention to curative and palliative needs to reduce fragmentation and wasteful use of resources across a health system. Poland's National Health Insurance Fund (NFZ) has developed three models of integrated care for different tiers of Poland's healthcare system in recent years, and has begun testing the POZ+ model, which covers primary healthcare, as a pilot project in various regions of the country.

The patient-centered integrated care approach has many benefits for patients and their families, including improved access to timely care, better relationships with care providers, better care coordination across providers and settings, and increased satisfaction. For patients, increasing their role in shared decision-making with providers increases trust, promotes independence, and enhances the ability to self-manage and control long-term health conditions. Health providers also benefit, especially in terms of optimizing workloads and improving job satisfaction.

Putting patients at the center of the healthcare process is an essential feature of a 21st Century healthcare system. Health systems that persist with a paternalistic approach – the doctor knows best and the patient should be satisfied with whatever the doctor provides – are not only losing the trust of their patients but also, in an increasingly globalized world, becoming irrelevant. Greater expectations from citizens as to their rights, increasing being matched by rising medical literacy arising from a broader range of sources of information and a general deterioration in the trust and standing of professions are just some of the driving forces putting patients at the center of healthcare delivery. But perhaps most critical factor is that there is now irrefutable evidence that levels patient satisfaction and trust are directly correlated with successful health outcomes.

In this chapter we examine the growing evidence that enriching the patient’s experience during interactions with the health system is an important determinant of health outcomes. Section 2 discusses evidence on patient satisfaction and trust and health outcomes. Section 3 provides a review of the extant literature on interventions to improve patient experience and trust. Section 4 concludes, with a brief reflection on implications for the Polish health system.

2. Evidence of patient satisfaction and trust and health outcomes

Numerous studies have reported the positive association between patient satisfaction and patient compliance with recommended medical treatments and care plans (Doyle et al 2013). There is a growing consensus that patient experience is a valuable measure of quality (IOM 2001). And many large healthcare systems, such as the UK, now include surveys of patient satisfaction as part of their measurement of quality of care. This is supported by several studies showing an association between subjective patient-reported quality of life or quality-of-care metrics and satisfaction (NHS, 1999). Overall, the evidence indicates associations between patient experience, clinical effectiveness and patient safety that appear consistent across a range of disease areas, study designs and settings.

The evidence regarding the relationship between how much patients express trust in the healthcare provider and outcomes is also reasonable robust. One meta-analysis of 34,817 participants from 47 studies in different clinical settings concluded “that patients report more beneficial health behaviors, higher satisfaction and health-related quality of life, but also better symptom-oriented subjective outcomes when they had higher trust in their health care professional.” An important caveat regarding this evidence is that almost of all of it is based upon observational and retrospective studies. There are few randomized control trials (RCTs) and therefore the causal link between patient satisfaction or trust and better outcomes is difficult to state definitively. A recent systematic review identified 13 RCTs of patient-clinician relationship and health outcomes. They reported a small but significant effect. Even so it was larger than the effect found of, for example, use of aspirin on reducing myocardial infarction.

In any case, there is good conceptual basis for valuing the importance of these aspects for outcomes. Clear information, empathic, two-way communication and respect for patients’ beliefs and concerns has been shown to lead patients being more informed and involved in decision-making and create an environment where patients are more willing to disclose information. Similarly, increased patient agency can encourage greater participation in personal care,

compliance with medication, adherence to recommended treatment and monitoring of prescriptions and dose.

Excellent clinicians strive to master not only the theory of disease and treatment, but also to cultivate a therapeutic presence that is commonly believed to improve the experience of patients and to have a beneficial effect on medical outcomes. Doyle (2013) found evidence from 55 studies, indicating consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, settings, outcome measures and study designs. It demonstrated positive associations between patient experience and self-rated and objectively measured health outcomes; adherence to recommended clinical practice and medication; preventive care (such as health-promoting behavior, use of screening services and immunization); and resource use (such as hospitalization, length of stay and primary-care visits). It noted that there was some evidence of positive associations between patient experience and measures of the technical quality of care, and that it was relatively common to find positive associations between patient experience and patient safety and clinical effectiveness than no associations.

3. Interventions to improve patient experience and trust

Unpacking the evidence suggests that there are two important aspects that are essential for clinical excellence and that shape patient satisfaction and trust. These are “relational” and “functional” (Table 1).

Table 1. Two components of patient experience

Relational aspects	Functional aspects
<ul style="list-style-type: none"> ● Emotional and psychological support, relieving fear and anxiety treated with respect, kindness, dignity, compassion, understanding ● Participation of patient in decisions and respect and understanding for beliefs, values, concerns, preferences and their understanding of their condition ● Involvement of, and support for family and carers in decisions ● Clear, comprehensible information and communication tailored to patient needs ● Transparency, honesty, disclosure when something goes wrong 	<ul style="list-style-type: none"> ● Effective treatment delivered by trusted professionals ● Timely, tailored and expert management of physical symptoms ● Attention to physical support needs and environmental ● Coordination and continuity of care; smooth transitions from one setting to another

Traditionally interventions in improving both the functional and relational aspects have been focused upon training and building the capacity of medical practitioners. Whilst there is good evidence of the effectiveness of many individual and group training and capacity building interventions, there are very few examples of where such interventions by themselves have been sustained and none where they have achieved large scale impact. One piece of evidence for the

large-scale failure to make changes is a recent global survey finding that 77 percent of respondents want more control when it comes to their health care decisions. Without doubt it is increasingly becoming difficult to nurture many of the aspects of good care identified above in an environment that is increasingly dominated by market forces and routinized practices.

This observation re-enforces the aphorism that: “Every system is perfectly designed to achieve exactly the results it gets.” Even if it was possible to successfully train all the health workers in providing more person-centered care there would only be a marginal improvement in patient satisfaction and trust as the critical aspects are far more determined by the design of the systems in which people work (such as culture, norms and expectations, the learning environment, the organization of care processes, and incentives) than by the people themselves.

Unfortunately, too many attempts to improve the experience of patients with the health care system focus on individual clinical encounters – a myopic perspective reinforced by dichotomous metrics, fragmented payment systems, and simplistic targets. Instead, we emphasize the need to consider the systems as much as the individual practitioners and interactions. Our review of the literature reveals a few common strategies that can achieve significant improvements in patient satisfaction:

- *Fostering Communication*: Physicians and nurses who try to establish rapport, encourage patients to discuss their concerns and ask open-ended questions are more likely to have a positive impact on satisfaction levels. Even something as fundamental as asking patients how they are feeling can have a positive effect on satisfaction.
- *Reducing Wait Times*: Extended wait periods are a leading cause of patient dissatisfaction, as waiting tends to increase anxiety levels. There are several cost-effective strategies that have been shown to reduce waiting times or at least reduce the anxiety it can generate.
- *Leveraging Technology*: Giving patients access to communication devices that enable them to contact staff, interactive education systems that provide information about their care and other user-friendly technologies are just some examples of how technology can increase comfort and enhance their experience.
- *Providing and Using Patient Satisfaction Surveys*: Systematic collection of patient satisfaction with services received ideally just after the consultation not only signals that their experiences are appreciated but also provides valuable feedback to improve the level of care.

We discuss these in turn.

Fostering Communication

Although patients may be satisfied (or dissatisfied) because of factors unrelated to communication (e.g., wait times and other attributes of the encounter), the available evidence indicates that patient satisfaction is strongly associated with the communication behaviors that occur during the physician-patient interaction. Effective doctor-patient communication can be a source of motivation, incentive, reassurance, and support. A good doctor-patient relationship can increase job satisfaction and reinforce patients' self-confidence, motivation, and positive view of their health status, which may influence their health outcomes (Ha 2017). Based in part on the

evidence that has emerged to date, there is a remarkable consensus about what constitutes competency in physician-patient communication in general and in patient-centered communication. This consensus is organized around 6 core functions (or goals) for medical encounters: (i) fostering the relationship; (ii) gathering information; (iii) providing information; (iv) making decisions; (v) responding to emotions; and (vi) enabling disease- and treatment-related behavior (King et al 2013).

Multiple studies have shown that communication skills can be improved with effective training, and that effective communication improves medical outcomes, safety, patient adherence, patient satisfaction, and provider satisfaction and efficiency. In the Cleveland Clinic, USA, a large nonprofit multispecialty academic medical center employing more than 3,000 physicians a communication skills course was designed and implemented to measure its impact on patient satisfaction, physician empathy, burnout, and self-efficacy. Following the course, adjusted overall scores for physician communication were higher for intervention physicians than for controls (92.09 vs. 91.09, $p < 0.03$). No significant interactions were noted between physician specialty or baseline score and improvement following the course. Interestingly Physicians reported high course satisfaction and showed significant improvement in empathy (116.4 ± 12.7 vs. 124 ± 11.9 , $p < 0.001$) and burnout including all measures of emotional exhaustion, depersonalization, and personal accomplishment. Less depersonalization and greater personal accomplishment were sustained for at least 3 months (Boissy, A. et al 2016).

Investigators at the UMass Memorial Medical Center, in Worcester, Mass., studied the effectiveness of assembling the entire care team (i.e., physicians, including residents and attendings, nursing, and clinical pharmacy) to round at the patient's bedside each morning – in lieu of its traditionally separate rounding strategies – on one unit of its academic hospitalist service for an internal quality program. The investigators used a validated patient satisfaction instrument and surveyed patients from the intervention group and patients on the same unit who did not experience this collaborative rounding on their day of discharge. The intervention group had higher satisfaction scores at most of the time points.

One reason why the strategy of collaborative rounding yielded positive results was that the entire team was on the same page and consistent information was given to the patient. Doctors had an increased understanding about nursing concerns and the nursing staff expressed improved understanding of patients' care plans. Face time with the patient was also extended because much of the academic discussion occurred at the bedside instead of at another physical location without patient awareness. "While this rounding strategy is not the most convenient rounding strategy for nurses or doctors, it consolidates the discussion about the patient's clinical condition and the plan for the day...the patient experiences a strong sense of being cared for by a unified team and receives consistent messaging" (Appold 2017).

Collaborative communication is a reciprocal and dynamic relationship, involving the 2-way exchange of information. This requires the doctors to take time or set up opportunities to offer and discuss treatment choices to patients and share the responsibility and control with them. Successful information exchange ensures that concerns are elicited and explored and that explanations of treatment options are balanced and understood to allow for shared decision making. In this approach, the doctor facilitates discussion and negotiation with patients and the

treatment options are evaluated and tailored to the context of the patients' situation and needs, rather than a standardized protocol. Care options need to be collaborative between doctor and patient, taking into account patient expectations, outcome preferences, level of risk acceptance, and any associated cost to maximize adherence and to assure the best outcome (Ha 2010).

Communication between physicians and patients is a key pillar of psychosocial support for enhancing the healing process of patients and for increasing their well-being and quality of life. A narrative review of studies looking at the potential effect of mindfulness and compassion-based strategies to enhance the physician-patient relationship. The review found that mindfulness and compassion-based strategies are effective for improving communication between physicians and their patients, enhancing physician's empathy and quality of care. Being empathic is a crucial factor contributing to enhancing the patient-physician relationship. Empathy has been named as an essential learning objective by the American Association of Medical Colleges and it is believed to significantly influence satisfaction in patients, health care professionals, and with clinical outcomes (Amutio-Kareaga et al 2017).

Reducing Waiting Times

The issue of waiting times is a salient issue for numerous countries, including Poland. Several proven ways to reduce waiting times are present in the literature. Countries and teams have implemented various methods that have yielded outcomes to reduce and improve waiting times in various settings within health care, including: (i) open access scheduling; (ii) activity-based funding (iii) information technology and integrated management systems; (iv) process improvement team approaches; (v) waiting time guarantees and combined policies; (vi) electronic communication and telephone follow-ups. We explore these in turn.

Open access scheduling, also known as same-day scheduling or advanced access, aims to reduce waiting times by keeping around half of physician's working day open for clinically-necessary unplanned follow-up appointments that are filled during the same day as patients call in. Only longer or foreseeable routine appointments are scheduled ahead of time, providing a better understanding of demand (Ansell et al 2017, Gupta and Denton 2008, Health Council of Canada 2015, Cameron et al 2010). Evidence from studies conducted in the US, Canada, and the United Kingdom, shows that the open access model allows for more flexibility in scheduling, eliminates delays, and improves patient satisfaction (Ansell et al 2017, Murray and Berwick 2003, Murray and Tantau 2000, Pierdon et al 2004, Bennett and Baxley 2009, Cameron et al 2010). For instance, a study conducted in Canada in 2008 in an academic family practice, showed a reduction from 13.7 waiting days to 3.6 after the adoption of an open-access scheduling (Cameron et al 2010).

The introduction of freedom of choice of providers (hospitals, surgical clinics, among others) by patients, especially when combined with *activity-based funding* (ABF), is one of the key features among nations with no waiting times. Freedom of choice introduces market-based incentives that induce competition between providers to attract and keep patients, while activity-based funding involves the implementation of a tariff system whereby the "money follows the patient". For example, Denmark implemented such policies successfully with the introduction of activity-based funding paired with free choice of hospital within or outside the patient's region. In doing

so, it realized an estimated 17 percent decrease in waiting times and a 13 percent increase in surgical activity (Siciliani and Hurst 2005, OECD 2013, Nadeem 2013).

The case of Portugal evidences the relevance of utilizing *information technology* for the management of waiting lists. In 2005, Portugal successfully implemented a combination of waiting time guarantees tied to an integrated information system (i.e. the Integrated Management System of the Waiting List for Surgery (SIGIC)), which systematically collects waiting time information from all hospitals. The SIGIC manages all NHS patients seeking surgical treatment and involves all public healthcare providers with surgical services (58) and 60 private healthcare providers with agreements for surgical treatment within the NHS. Every year it covers 500,000 surgeries, 4.5 million surgery appointments. The utilization of this management system shifted the control of waiting lists from hospitals to a central IT system while concurrently moving the focus of attention from waiting lists to the effective waiting times of patients. Patients are also allowed to find other providers through the IT system if the waiting list reaches 75 percent of the maximum guaranteed waiting time (OECD 2013).

As a result of the implementation of the SIGIC, mean and median waiting times for key procedures decreased significantly: the national waiting list for surgery declined by 39% from 2005 to 2010. Further, Portugal achieved a significant decrease in the (median) waiting time for surgery, e.g., from 8.6 months 2005 to 3.2 months in 2011 (OECD 2013). Although the success of the SIGIC has been noted by the OECD, it is worth mentioning that that the success of the SIGIC cannot be isolated from the concomitant effect of waiting time guarantees and the introduction of choice (OECD 2013).

An evaluation of the literature demonstrates that a *process improvement team approach* for evaluating and redesigning the patient care system can be successful in reducing waiting times and raising patient satisfactions (Adamu and Oche 2014, Li and Zhang 2013, Liu 2017, Spaite 2012, Sun et al 2017, Zhao et al 2012). For instance, Sun et al. conducted a three year (2014-2017) longitudinal study in a public tertiary hospital in Southern China to assess the hospital's efforts to achieve the organizational and structural changes to reduce waiting times for consultations and filling prescriptions. To this end, the hospital setup and empowered an interdisciplinary taskforce which conducted baseline investigations to identify the shortfalls and subsequently implement various demand and supply-side interventions. As a result, the monthly average length of waiting time decreased 3.49 min ($p=0.003$) for consultations and 8.70 min ($p=0.02$) for filling prescriptions in the corresponding month when respective interventions were introduced. Sun et al (2017) conclude that a long-lasting reduction effect was observed because of carefully designed continuous efforts, rather than a one-time campaign, were implemented by the Taskforce.

A *waiting time guarantee* states that no patient in need of care should wait more than a pre-determined amount time (OECD 2013). Over the past decade, waiting time guarantees have been the most commonly used policy tool to tackle long waiting times, although evidence shows that they may only be effective if they are enforced. The OECD discussed that there are two approaches to effectively enforcing waiting time guarantees: (i) holding health providers to account for achieving the targets, or (ii) allowing patients to choose alternate health providers, including the private sector, if patients must wait beyond a maximum time.

Acknowledging the need to enforce the guarantee, countries such as the United Kingdom and Finland have backed such guarantees by setting targets for providers and applying sanctions or penalties when these targets are not fulfilled. Evidence shows that combining waiting time guarantees with sanctions significantly reduces waiting times vis-à-vis the implementation of waiting time guarantees without such enforcement. For example, using Scotland as a control group (where no such penalties were introduced), Propper et al (2008, 2010) found that waiting times were cut significantly: the proportion of patients waiting more than six months reduced by 6 to 9 percentage points in England. In recent years, Scotland has also accompanied targets with sanctions and these have been associated with reductions in waiting times. However, there is some evidence to suggest guarantees with sanctions attached may provide an incentive to mis-prioritize patients based on clinical need (OECD 2013).

However, several countries, such as Norway and Portugal (and most recently the direction of the United Kingdom), have link waiting time guarantees to choice, competition and an increase in supply (in the public and/or the private sector). Patients may be treated by another provider if the waiting time guarantee is not met (e.g., Norway) or when the patient reaches a threshold level of maximum waiting times (e.g., in Portugal, 75 percent), providing an incentive to providers to meet waiting time targets.

Telephone follow-ups can effectively reduce waiting times by mitigating the amount of unnecessary and time-consuming face-to-face appointments while maintaining continuity of care (Ansell et al 2017, Pomerantz et al 2008, Miller et al 2012), while at the same freeing slots for additional patients in a given doctor's practice to see their primary care physician in person (Ansell et al 2017, Pomerantz et al 2008, Miller et al 2012 (Ansell et al 2017, Lattimer et al 1998, Coleman and Phillips 2010, Simon et al 2003).

These interventions have shown to be successful in countries such as the United Kingdom in reducing waiting times for primary care appointments and to improve public access to medical information and ensuring adequate follow-ups for individuals affected from chronic care conditions (Ansell et al 2017, Lattimer et al 1998, Coleman and Phillips 2010, Simon et al 2003).

Leveraging Technology

Health care that is safe, effective, timely, efficient and patient-centered relies on the right information reaching the right person (or organization) at the right time. A digitalized information infrastructure that ensures timely and reliable sharing of clinical and other information can improve health outcomes and efficiency and create a repository of valuable data for researchers and system managers (OECD, 2017). Enabling people to access, and interact with, their electronic medical record (EMR) is an important feature that can help people become more involved in their health and their care.

The European Commission's Digital Single Market Strategy includes three pillars to improve the health and care sector across the EU: (i) to secure access to and sharing of personal health information across borders, with the intention of going beyond ePrescriptions and patient summaries and establish full interoperability of member states' EMRs and a European exchange format for electronic records; (ii) to connect and share health data to enable research, better

diagnosis and improved health; and (iii) to strengthen citizen empowerment and individual care through eHealth solutions and new care models (European Commission, 2018).

Many countries are implementing EMRs across health care settings, including in primary care. In a study of EMR use in 15 EU countries in 2016, Oderkirk (2017) finds that about 80 percent of all primary care practices use an EMR, although there are wide variations. While an EMR was used in all or nearly all primary care practices in Denmark, Estonia, Finland, Greece, Spain, Sweden and the United Kingdom, its use was much more limited in Croatia and Poland. In Denmark and the United Kingdom, the proportion of primary care practices using an EMR doubled between 2012 and 2016. In most of these countries, patients can view information contained in their electronic record (with the only exceptions being Croatia, the Czech Republic and Ireland), and in half of these countries (Denmark, Estonia, France, Greece, Latvia, Luxembourg, Spain and Sweden), patients are also able to interact with their record, for example to add or amend information.

Likewise, ePrescribing, which allows prescribers to write prescriptions that can be retrieved by a pharmacy electronically, can improve the accuracy and efficiency of pharmaceutical drug dispensing. Many countries in the EU are transitioning from paper-based prescriptions to ePrescribing, but the implementation varies greatly across the EU. In 2018, over 90% of prescriptions were transmitted to community pharmacies electronically in Finland, Estonia, Sweden, Denmark, Portugal and Spain. On the other hand, ePrescribing has not been implemented yet in several countries (such as Bulgaria, Cyprus, France, Germany, Ireland, Luxembourg, Malta and Poland), although all these countries have stated that they plan to start implementing ePrescribing at regional or national levels over the next few years.

Providing and Using Patient Satisfaction Surveys

Worldwide, survey instruments have been developed to measure patients' perspectives in various types of services, including general hospital care (Darby et al 2005, Jenkinson et al 2002), radiology (Lang et al 2013), pediatric services (Toomey et al 2015), elderly care (Scotti 2005), psychiatry (NHS 2016) and many others. However, the mere implementation of a patient experience survey does not guarantee quality improvement (DeCourcy et al 2012). Although evidence is ambiguous, in the US public reporting of patients' perspectives of hospital care has shown to provide an incentive in enhancing and reinforcing quality improvement efforts in hospitals (Barr et al 2006).

Across EU countries, delivering health care that is patient-centered is becoming a priority in health care policy. Given the importance of utilizing people's voice for developing health systems and improving quality of care, national efforts to develop and monitor patient reported measures have been intensified in recent years. In many countries, responsible organizations have been established or existing institutions have been identified for measuring and reporting patient experiences. These organizations develop survey instruments for regular collection of patient experience data and standardize procedures for analysis and reporting. An increasing number of countries collect not only Patient-Reported Experience Measures (PREMs) but also Patient-Reported Outcome Measures (PROMs) which collect patients' perception on their specific medical conditions and general health, including mobility, pain/discomfort and anxiety/depression, before and after a specific medical intervention (OECD 2018).

The Czech Republic, Denmark, France and the United Kingdom use patient experience data to inform health care regulators for inspection, regulation and/or accreditation. Patient-reported measures are also used in Belgium, Denmark and the Netherlands to provide specific feedback for providers' quality improvement. Several countries including Belgium and Denmark also use patient-reported outcome measures systematically for quality improvement (Fujisawa and Klazinga, 2017; Desomer et al., 2018).

Across European countries, these patient experiences are generally consistent with the perceived quality of family doctor/GP or health centre services as reported in the European Quality of Life Survey. The perceived quality of care is high in Austria and Luxembourg, while it is low in Poland and Greece. Patients generally report positive experiences in relation to communication and autonomy in the ambulatory health care system. For example, the majority of patients reported that they spent enough time with a doctor during consultation (Figure 6.6) and a doctor involved them in care and treatment decisions (Figure 6.7). For these and other aspects of patient experience, Belgium and Luxembourg have high rates with above 95% of patients reporting positive experiences, while Poland has lower rates. For example, only one in two patients report having been involved in their care and treatment decisions during consultation in Poland.

The OECD takes several initiatives on PROMs and PREMs. It monitors PREMs in ambulatory care in 19 countries. PREMs are also part of the Health at a Glance reports. These reports are published bi-annually by the OECD and includes key performance measures with benchmarks for OECD member states. Besides these initiatives the OECD recently launched the PaRIS-initiative (Patient-Reported Indicators Survey), following the recommendation of the OECD Health Ministers to develop internationally comparable PROMs and PREMs.

4. Implications for the Polish healthcare system

A salient challenge before Poland is that of enriching patients' experience in their interactions with the healthcare system to meet the expectations of its aging population for personalized attention and care. Indeed, Poland's success in rebalancing service delivery based on a PCIC model will depend on the health system's ability to produce and deliver high quality services to its citizens. The previous section has listed several initiatives that have worked in similar contexts, from which Poland can draw and adapt as it repositions its health system over the next decade or so.

Reflecting on ways to enrich the provider-patient relationship. Delbanco (1992) suggests that the doctor and patient undertake a systematic 'patient's review' to enhance the human quality of clinical care and improve outcomes. The review should address seven dimensions of care: (i) respect for patient's values, preferences, and expressed needs; (ii) communication and education; (iii) coordination and integration of care; (iv) physical comfort; (v) emotional support and alleviation of fears and anxieties; (vi) involvement of family and friends; and (vii) continuity and transition. Incorporating this review into the clinical encounter would serve to encourage both the patient and the doctor to confront individual preferences and values.

Delbanco (1992) carried out 8 focus groups with recently-discharged patients to better understand their concerns. The results of these focus groups suggest that patients were less concerned about the environment in the waiting rooms or with the quality of hospital food. Rather, they worried about issues of clinical significance, such as being able to trust the competence and efficiency of their caregivers, being able to negotiate the health care system effectively and to be treated with dignity and respect. Patients reported wanting to understand how their sickness or treatment would affect their lives, and how to care for themselves away from the clinical setting. Further, patients wanted to discuss the effect of their illness on their family, friends, and finances. In adopting a true patient-centered approach, Poland's health system must therefore create circumstances that "encourage both the patient and the doctor to confront and express individual preferences and values while offering patients a structured opportunity to participate actively in their care." (Delbanco 1992, page 415).

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