CHALLENGES

Poland

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This is the seventh paper in a series showing the problems facing the medical services for children in different countries.

The time of the second world war was marked by the most gruesome cruelties perpetrated on children, and also by the most heroic self sacrifices made not only for saving their lives but also for alleviating their pain and fear of death. The memory should be cherished of Henryk Goldszmidt, who was also known as Janusz Korczak (1878-1942), the teacher and paediatrician who of his own free will went to his death in a crematorium for accompanying the Jewish children led there.

Social and economic changes after the second world war

After the second world war the devastation of our country was formidable. The outstanding professors of our universities had been murdered, many doctors died or remained abroad, and most hospitals were ruined. From the end of the war up to 1951 infant mortality kept rising, reaching 117.8 per 1000 live births in 1951. This was due not only to the shortage of doctors and drugs, but also to the extremely difficult conditions of life in the devastated country. Some slight improvement was noted from 1952 on when the first postwar graduates left the eight medical university schools organised after the war. Presently there are 11 such university medical schools. The first postwar groups of students were given work allocations—that is, immediately after graduating they were sent to areas of the country with the greatest needs for health services. This policy of staff allocations solved in part the urgent problems but also had obvious long term unfavourable consequences. The enthusiasm of that generation of young physicians allowed the ablest and most persevering of them to attain a high level of qualification under difficult circumstances.

The everyday work of the physicians caring for children was hampered by the low level of hygiene and health education in the lower socioeconomic classes. They shunned prophylactic vaccinations and the heavy work done by women in the rapidly industrialised parts of the country contributed to an increasing frequency of premature births. Also the birth rate was rising with every year.

Mother and child health care system

A significant, although still unsatisfactory, improvement of the mortality and morbidity of infants appeared after 1965. It was attained mainly by providing better medical care for pregnant women and some stabilisation in economy. In 1981 infant mortality fell to 20.5

per 1000 live births. It is difficult, however, to compare these data with those reported in other countries due to the definition of live born neonate accepted in Poland: this is a newborn infant who after delivery shows at least one such vital function and sign as heart action, respiratory movements, umbilical cord pulsation, contractions of skeletal muscles, weight at least 1001 g, or survives at least 24 hours with a birth weight between 601 g and 1001 g. A comparison of the infant mortality per 1000 live births including newborns unable to survive but showing some vital signs according to World Health Organisation (WHO) criteria with the rate calculated according to the Polish criteria has been possible only since 1986 and is shown in the table.

Since 1975 the higher infant death rate in the rural areas in relation to the urban areas has disappeared gradually, which was connected with improving conditions of life in villages, better health education and hygiene, and greater availability of medical care to pregnant women and children in the population of farmers. Another cause of this disappearing difference was the poor working conditions of women in industrialised towns and the disastrous deterioration of the natural environment there.

The Code of Labour provides maternity leave for 16 weeks after the first child, 18 weeks after any subsequent child, and 25 weeks after giving birth to more than one child at a time. Two weeks of maternity leave should be given to the woman before birth; however, this suggestion was disregarded by many, who added their normal leave due to maternity leave to prolong the time spent with the infant and so they worked to the last day before labour. Since 1975 women have been given a three year leave after birth to give them time for child raising. During that leave they receive allowances amounting to about one third of the average salary and have a guaranteed return to their previous work after the leave. Many women take advantage of this, which lowers the expenses of the state on creches, improves the conditions for raising small children etc, but also causes great problems in institutions and occupations where women prevail, such as nursing, teaching, paediatrics, etc.

The care of pregnant women is provided by special regional clinics that should be visited 10 times by women with a normal pregnancy but

	1986	1987	1988	1989	1990
WHO criteria	21.3	21.2	19.9	19.3	19.4
Polish criteria	17.3	17.4	16.1	15.9	15.9

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15 times by those with a high risk pregnancy according to Ministry of Health regulations. However, according to statistical data the average number of such visits during pregnancy is 6.5 in towns and 4.1 in rural areas. Only one third of women in rural areas and slightly over one half of those in towns receive early health care during pregnancy. This is due to the low health education and difficult conditions of life. In the case of an at risk pregnancy, and particularly in high risk pregnancy, patients are referred to consultation clinics and to obstetric hospital departments usually in a university hospital. The great majority of births take place in regional hospitals or village labour wards. Because of the overcrowding of obstetric wards mother and children are discharged home, if no contraindications are present, as soon as possible and during the next few days they are visited by the regional paediatrician and midwife. Further supervision of the child is provided by the paediatric clinic for healthy children, which is in the same accommodation unit and has the same staff as the clinic for ill children. If necessary the doctor from the clinic is called out to visit the children in their own homes. The clinic for healthy children provides periodic medical examinations and prophylactic vaccinations. According to statistics the mean number of visits to the clinic for healthy children is 6.5 in towns and 4.5 in villages in the first year of life. The children in villages are brought to the clinic mainly for prophylactic vaccinations.

BCG vaccination is done in neonatal wards, and the next obligatory vaccination is against pertussis, diphtheria, tetanus, and poliomyelitis, and girls are vaccinated against rubella. In view of the high prevalence of hepatitis B virus (HBV) infection, newborn infants of mothers with this infection are vaccinated against HBV. In certain centres vaccination against HBV is offered children in high risk groups—for example those with haematological diseases, renal failure, malignancies.

Highly specialised paediatric health care is provided by the university hospitals of the 11 medical schools, which serve as referral centres for various regions of the country, two paediatric centres covering the whole country, the National Mother and Child Institute cooperating with the Ministry of Health, and several specialist paediatric district hospitals. These institutions differ among themselves in the degree of care provided in various paediatric specialties, for example cardiac surgery is performed in only some of them. In some others particularly good results are obtained in the treatment of malignancies, dialysis is carried out in eight centres, two carry out continuous ambulatory peritoneal dialysis, and in one renal and liver transplantations in children are performed. In this way there is some concentration of problems.

Problems of nursery care

Despite a well planned system of mother and child health care infant mortality is still high in Poland. It is mainly due to the high death rate of newborn infants, which is related in 70% to the perinatal pathology. Infants with a birth weight

below 2500 g account for 7.8% of all newborn babies. In the industrialised regions this proportion is higher. The obstetric and neonatal wards are usually below the modern standard of requirements, they are overcrowded, and their equipment is inadequate. In most hospital departments and even in certain referral hospitals there are no adequately organised and equipped intensive care units for newborns and the resuscitation facilities are obsolete. Infants with life threatening conditions are referred usually to intensive care units or wards for high risk neonates in paediatric hospitals. Transport is often by ambulance in conditions far from satisfactory. These shortcomings could be removed with considerable financial efforts but this is impossible at the present time. Another problem is training doctors in neonatology and intensive care of the newborn. The low standard of most neonatal hospital departments, their outdated equipment, and limited opportunities for career development discourage the ablest young doctors from specialisation in this field. In only 25% of all neonatal departments in the mid-1980s was the head of department a paediatrician with specialised neonatal knowledge, and 30% of the departments had no heads. In recent years training of physicians in neonatology and intensive neonatal health care has been intensified, and is being conducted in selected clinical research centres and institutes, where instruction courses and symposia are organised.

Of invaluable help for training in neonatology are easier international contacts made possible by certain western medical centres, social organisations and scientific societies providing access to scientific literature, scholarships, and participation in international meetings that are usually too expensive for our doctors.

Academic paediatrics

The basic functions of university hospitals—patient care, teaching, and research—are paid for by medical schools, grant related income is symbolic, and income from patient care does not exist as medical care is free of charge.

Highly specialised paediatric departments are under equipped with respect to diagnostic and therapeutic devices. The economic difficulties are felt particularly adversely in the work of those teaching paediatric hospitals where the cost of treatment is particularly high. The insufficient financial support makes it difficult particularly for the functioning of costly, highly specialised disciplines even though the medical staff have the technical expertise. This decreases the feeling of satisfaction with work, and in view of the low salaries received particularly by young physicians, nurses and technicians, and the low outlay on research, it has an unavoidable influence on the possibility of introduction of new diagnostic methods and on the level of research, which is an integral part of the teaching function.

An additional difficulty is the shortage of international periodicals, new textbooks, monographs, compendia, etc in hospital libraries. Two Polish paediatric periodicals *Pediatrica Polska* (Polish Paediatrics) and *Przegląd Pediatryczny* (Paediatric Review) are the forum

for publications of papers in which young doctors participate. However, the length of time to publication is very long with accepted papers waiting for over two years. Certain possibilities have recently been opened up for improvement of this situation. With support of a public organisation efforts have been made to have a cheap and short translation of *Nelson Textbook of Pediatrics* to give Polish physicians and students a textbook of paediatrics used in other countries. Due to limited contacts with foreign countries the knowledge of foreign languages among medical students and young doctors is insufficient, especially outside the clinical research centres.

The financial situation of paediatric health care is made even worse by the lack of a correctly functioning social health insurance system and the costly system accepted years ago in which the primary health care for the child is provided by the paediatrician. Abandoning this safe and well developed system too fast would be risky, as training of a doctor freshly graduated from a Polish medical school for the role of family doctor and for taking responsibility for the health of children would require a long time. Help from international contacts is priceless from the standpoint of further

development in our country of such paediatric specialties as nephrology with renal replacement therapy, neurology, haematology, oncology, cardiology, gastroenterology, allergology, genetics, psychiatry, surgery, etc. Participation in international meetings, courses and symposia, and in multicentre studies, visits to the foremost research centres, and more uniform principles of specialisation programmes for all countries are as important for decreasing the differences in health care of children between various countries as rational financing of health services. At present, when Polish society is heavily encumbered by the ongoing systematic transformations of national economy, it does not seem fair that children should bear the cost of the ensuing deprivations to the same degree as adults.

Inadequate financing of education and severe cuts in the national health service, which are part and parcel of the currently discussed national budget, would raise legitimate doubts and objections unless some essential amendments in child care were introduced. For it is obvious, and was well understood in the past, the society is responsible for the state of child health. Any default will take a toll of the quality of life in subsequent generations.