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Planning of Polish physician workforce – Systemic inconsistencies, challenges and possible ways forward

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ABSTRACT

Background: Poland has the lowest number of physicians per 1000 population (2.2/1000) in the EU. This is accompanied by a considerable migration rate of Polish physicians to other EU countries (estimated at above 7%). Among other consequences, this results in waiting lists and unmet health needs.
Objective: The aim of this article is an identification of the main challenges for physician workforce planning in Poland.
Methods: The authors analysed national and international documents, reports, official statements, publications and statistical databases.
Main findings: In Poland health workforce planning is inadequate and insufficient. There is no formal structure and no strategy regarding human resource planning or regular forecasts for the health workforce, which results in many negative effects for the healthcare system. Currently the shortage of physicians in some specialties is becoming one of the most important reasons for limited access to care and lengthening the average wait time.
Conclusions: To improve this situation operational and strategic actions should be undertaken without unnecessary delay. Effective and close cooperation between key stakeholders is needed. Health workforce planning needs to become one of the key building blocks of the Polish health system's reforms, strongly connected to the other functions of the health system. It is essential for Poland to follow available good practices in health workforce planning.

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1. Introduction

In autumn 2017, junior physicians in Poland, frustrated with workload, poor working end employment conditions, undertook a strike, demanding reforms. This strike was supported by majority of physician associations and other professional organizations of medical staff. This serious event has brought attention to many inconsistencies and challenges for the Polish health workforce. Due to inadequate policies in respect to medical workforce, the Polish system is facing serious problems like: workload and shortages of medical staff, emigration of health professionals and limited access to health services. In this paper we will examine those challenges.

The quality and quantity of healthcare services available in a country depend to a large extent on the size, knowledge, skills, geographical distribution and attitudes of the health workforce. The role of Human Resources for Health (HRH) is further strengthened because healthcare is comparatively more labour-intensive than other sectors; thus the workforce is an even more important component in terms of its performance [1,2].

Because of this HRH has been promoted to the top of health policy agendas and strategies around the world by the WHO and the EU which are key international stakeholders [3–5]. In 2004, a WHO Report clearly stated the need to elevate HRH's position in the international political agenda while, at the same time, drawing attention to the lack of recent, consistent research on this subject [6]. Another WHO Report, *Human resources for health in the WHO European Region,* was one of the first to address comprehensively many of the key issues facing HRH across Europe [7].

An important initiative of the European Commission, responding to the challenges of the HRH crisis was the development of the *European Commission Green Paper on the European Workforce for Health* [8]. Its goal was to increase the visibility of the issues European HRH was facing, to make a clearer picture of the extent to which local and national health managers face the same challenges and to provide a better basis for considering what should be done at the EU level. A number of the primary challenges facing

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health systems in Europe were identified, like adapting healthcare systems to an ageing population, the introduction of new technology and the related staff training as well as new and re-emerging threats to health. To respond to these challenges, an efficient and effective health workforce of the highest quality should be trained and employed [8].

An important initiative was the development of the WHO *Global Atlas of the Health Workforce* [9]. This electronic platform collects statistical data on medical staff according to geographical distribution as well as age and gender. An equally important WHO initiative was also the development of the *Global Code of Practice on the International Recruitment of Health Personnel* [10].

In 2006, The Global Health Workforce Alliance (GHWA) was created as a common platform for action to address the crisis of HRH [11]. GHWA, a partnership of national governments, professional associations, international agencies, academic, research and financial institutions, is dedicated to identifying, implementing and advocating for solutions to HRH problems and consolidating what is known about HRH and how to attain and accelerate progress on universal health coverage. A new progress report developed by GHWA estimates a global shortage of 7.2 million health workers, with 83 countries facing a health worker crisis [12]. According to the EU internal estimate the gap in the supply of HRH is expected by 2020 to be approximately 1 million health professionals, including 230,000 physicians [13].

Within the framework of HRH an important issue is health workforce planning, especially physician planning.

Medical workforce planning has been attracting academics' attention for over thirty years [14,15]. Among respective publications one may distinguish those focused on technical issues related to the tools and/or methodological aspects of physician planning [16,17] and those of more a practical/operational focus [18–21]. There were analyses of the supply of physicians by specialty [22,23] as well as gender [24]. While the vast majority of publications were focused on a particular country, Dubois et al. [25] offered a comprehensive picture of the physician labour market in the EU. Such a perspective with an emphasis on the methodology of planning was most recently used by Malgieri et al. [26] which contributes to Ono et al.'s [27] analysis of projection models used in 18 OECD countries. These last two publications constitute the most comprehensive, informative and methodologically advanced sources of information about the current state of physician manpower planning. Unfortunately, Poland is absent from these two corner stone volumes despite the fact that the situation of Polish doctors is the most difficult of all EU countries. Poland has the lowest number of doctors per 1000 population in the group of EU countries (22/1000) [28] and the migration rate of Polish doctors to Western countries is significant (it is estimated at 7%) [29]. Due to the limited numbers of physicians, access to healthcare services in Poland is a cause for serious concern.

Unlike solutions used in other countries, in Poland there are no dedicated departments, governmental agencies or other professional bodies responsible for health workforce development. In Poland, proper health workforce management and planning processes are sadly neglected, in particular for medical doctors. A planning process in respect to HRH ("defining health workforce planning perspectives, based on needs assessment, identification of resources, establishing the priority of realistic and feasible goals, as well as on administrative measure planning to achieve these goals" [26]) is not being used.

The methodology, tools and approaches recommended and commonly used in other countries to plan HRH and to project the future health workforce [27,30] are not being implemented.

Consequently the evidence is that the Polish healthcare system is lacking in a continuous process of medical workforce planning [29,31]. This is accompanied by a failure to gather necessary data and then process it. This in turn results in the absence of proper analyses, prognoses and strategies.

The aim of this article is an identification of the main challenges for physician workforce planning in Poland. Selected factors influencing educational policy in respect to physician supply, as well as current trends in Polish physicians' migration to Western countries are presented. It is argued that due to inadequate policies in respect to health workforce planning, the Polish system is facing serious problems today. Systemic approaches, including institutional change models and tools used in other countries, supported by orchestrated cooperation between key stakeholders are also needed.

2. Material and methods

A desk analysis of the key national and international documents was performed. The main sources used in analysis were Polish and English-language scientific papers and grey literature as well as government reports, strategic documents, legal regulations, available guidelines and official statements published between 2011 and 2016. The cited statistical data come from such sources as: the Ministry of Health, the National Chamber of Physicians, the Polish Supreme Audit Office and OECD. As a result of the desk analysis five main challenges in Polish medical workforce development were identified: 1) lack of health workforce planning and capacity, 2) access to medical studies and specializations, 3) medical workforce composition and ageing 4) emigration of Polish physicians and 5) access to health services. These five challenges are described below and they structure the Results section of this article.

3. Results

3.1. Lack of health workforce planning capacity

There are no dedicated departments, governmental agencies or other professional bodies responsible for health workforce planning in Poland. The key stakeholders of HRH representing the supply side of the labour market of physicians are shown in Fig. 1. These stakeholders are grouped according to their influence and willingness to change (defined as a formal statement of a legal representative of a given organisation concerning their specific proposals and recommendations) based on the analysis of legal regulations, official statements and literature review [32–35], and opinions presented by particular stakeholders and national experts on internet-based professional platforms e.g Termedia [36] and Medycyna Praktyczna [37]. As can be seen in Fig. 1, those institutions with the greatest influence show the lowest willingness to change, whereas stakeholders that demonstrate this willingness have little influence. The dominant role is played by institutions responsible for the education of physicians, i.e. the MoH and the Ministry of Higher Education (MoHE). The MoH is solely responsible for admission quotas (student intake) and the number of medical specializations while MoHE stipulates the academic standards and procedures of medical education in medical universities. Some non-medical universities currently not involved in physicians' education have expressed their willingness to open medical departments and these ambitions have been supported by local governments. While the above institutions cover regular university education, the National Chamber of Physicians (NCP) (membership to which is obligatory for every practicing physician in Poland) and other professional associations are involved in postgraduate physician training. The NCP also aspires to shape the process of the university education of physicians [35]. Anecdotal evidence shows that effective cooperation between these stakeholders is

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