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The 2014 primary health care reform in Poland: Short-term fixes instead of a long-term strategy☆

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ABSTRACT

At the end of 2013, the Minister of Health started legislative changes directly and indirectly affecting primary health care (PHC). The reforms were widely criticised among certain groups of medical professionals, including family medicine physicians. The latter mainly criticised the formal inclusion of specialists in internal diseases and paediatrics into PHC within the statutory health care system, which in practice meant that these two groups of specialists were no longer required to specialize in family medicine from 2017 in order to enter into contracts with the public payer and would be able to set up solo PHC practices—something over which family medicine physicians used to have a monopoly. They argued that paediatricians and internists did not have the necessary professional competencies to work as PHC physicians and thus assure provision of a comprehensive and coordinated PHC. The government's stance was that the proposed measure was necessary to assure the future provision of PHC, given the shortage of specialists in family medicine. Certain groups of medical professionals were also supportive of the proposed change. The key argument in favour was that it could improve access to PHC, especially for children. However, while this was not the subject of the critique or even a policy debate, the proposal ignored the increasing health care needs of older patients—the key recipients of PHC services. The policy was passed in the Parliament in March–April 2014 without a dialogue with the key stakeholders, which is typical of health care (and other) reforms in Poland. The strong opposition against the reform from the family medicine specialists, represented by two strong organisations, may jeopardise the policy implementation in the future.

1. Purpose and content of the policy

In 2007, the 2004 Act on Health Care Services Financed from Public Sources was adapted to the provisions of Directive 2005/36/EC of the European Parliament and of the Council on the recognition of professional qualifications. According to Article 29 of this Directive, which regulates the pursuit of professional activities by general practitioners (GPs), each member state shall, subject to the provisions relating to acquired rights, make the pursuit of such activities in the framework of its national social security system contingent upon possession of evidence of formal qualifications referred to in Annex V of the Directive. In Poland, the evidence of such formal qualifications is the diploma in family medicine. The adoption of the Directive made the provision of PHC services within the Polish social health insurance system, i.e. under contracts with the National

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Health Fund (NHF), conditional on the possession of such diploma. PHC physicians who do not have a diploma in family medicine but who have worked as PHC physicians for at least ten years prior to the adoption of the Directive have been exempted on the basis of the above mentioned provisions relating to the acquired rights. All other PHC physicians without such a diploma who wish to continue to work as PHC physicians within the social health insurance system were required to obtain a specialization in family medicine until 2017 [3,26].

Given the low number of family medicine physicians in Poland (one per 3500 people, compared to one per 2500 recommended by the experts [16]; see also Fig. 1) and the short time left for completing specialization in family medicine (until 2017) it was evident that a shortage of family physicians was looming in 2017, posing a threat to the provision of PHC. Faced with this threat and also taking into account the fact that the declining demand for paediatricians caused by the ageing of the population could have an unfavourable impact on the employment opportunities for this group of specialists in the future, at the end of 2013, the Minister of Health proposed to legally allow all specialists in internal diseases and paediatrics to work in the statutory health care system as PHC physicians and to set up their own (solo) PHC practices. Apart from averting the inevitable shortage of PHC doctors and ensuring employment opportunities for paediatricians, another goal of the policy was to increase the number of PHC doctors – it was hoped that the policy would encourage privately-practicing paediatricians and internists to move to public PHC – and thereby improve access to PHC in general, and to paediatric care for children. The policy was passed in March–April 2014 and came into force in June of the same year.

Previously, paediatricians and internists, with the exemption of physicians with at least ten years of PHC experience prior to the adoption of Directive 2005/36/EC, while being allowed to work as PHC doctors under contracts with the NHF, were not allowed to set up solo PHC practices (in both public and private health care sectors) and could only work in PHC practices as employees. Moreover, from 2017, young paediatricians and internists (with less than ten years of experience in PHC at the time Directive 2005/36/EC was adopted) would no longer be allowed to work as PHC physicians under contracts with the NHF, unless they specialized in family medicine.

The policy that came into force in June 2014 included the following measures:

(1) The legal requirement on primary care doctors with less than ten years of experience in PHC prior to the adoption of Directive 2005/36/EC to specialize in family medicine by 2017 was expunged; and
(2) All paediatricians and internists, not only those who had at least ten years of experience in PHC prior to the adoption of Directive 2005/36/EC, were formally allowed to work as PHC doctors within the statutory health care system and to set up solo PHC practices.

The policy placed all paediatricians and internists at equal footing with family medicine specialists, without requiring from them any changes in professional competencies. This means, for example, that paediatricians are allowed to register and treat adults and can receive capitation payment from the PHC budget, under contracts with the NHF.

These measures were part of the general effort to improve the functioning of PHC by improving the availability of primary care doctors, shifting patients to the lowest possible level of care, shortening waiting times for diagnosis and further treatment, and introducing new care pathways for certain types of patients (mainly oncological patients). Other key measures within these efforts included the "waiting lists" and the "oncology" reform packages proposed in March 2014 and passed in the Parliament in July of the same year [9,8].

2. Political and economic background

Poland, like many other former eastern bloc countries, inherited a poorly arranged PHC system, with too much focus on treatment of common conditions and relatively low importance given to prophylactic activities. After the collapse of the communist regime, efforts had been made to improve the role and quality of PHC that at that time was a trend visible in many other central and eastern European countries [10]. In 1993 specialisation in family medicine was introduced and, around this time, several attempts were made to elaborate a policy document describing the desired development of PHC, including a proposal to make it the main driver of health sector transformation. The attempts to work out a comprehensive strategy document had been unsuccessful due to frequent changes of government and, to date, there is no clear governmental strategy for PHC [26]. This applies to many aspects of PHC services, including health promotion as one of the main areas of PHC activities (emphasised as such in the Alma Ata and Ottawa Declarations) and to older patients as one of the key recipients of PHC services (see below).

Family medicine is not a very popular specialization among medical students in Poland [21]. The reasons behind this include: broad scope of required knowledge; relatively poor working conditions, wages, and professional status compared to other medical specializations; and limited career options, with better professional development opportunities available in hospital settings (see for example Ref. [7]). According to the most recent international data, in 2013 Poland had the lowest number of GPs per 100 000 people in the EU (21 compared to the average of 79 in the EU member states), while the number of specialists per 100 000 was higher that the EU average (100 in Poland compared to 97 in the EU) (Fig. 1). This is reflected in the ratio of GPs to specialists, which in Poland is the second lowest (after Greece) among EU member states. In 2013, this ratio was 0.2 for Poland compared to 0.8 for EU countries. When paediatricians are included into the number of primary care doctors (no data on the number of internists was available), the ratio goes up to 0.3, which is still very low by European standards (it is 1.0 for EU member states on average).

The 2004 Act on Health Care Services Financed from Public Sources amended in 2007 defines PHC as pro-