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Country Case Study: Primary care in Poland

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Table of Contents

1. Summary information

1.1 Governance in primary care

Basically primary care consists of i) medical care (family physicians/primary care doctors); ii) district care (district nurses and midwives); and iii) social care (social workers). Medical care and district care together are primary health care (PHC). Social care is organized, managed and financed by local communities and since the beginning of the 90-ties is separated from health care. Social care tasks are focusing on support of inhabitants of local communities in case of poverty and are to prevent exclusion. Social care includes activities such as analyses of the local environment, the economical status of community members and making decisions on financing or co-financing of help measures requested by individuals. The social care budget is also playing a role in financing health services for the unemployed (from the central budget) and the homeless/uninsured (from the local community budget). From the central social care budget money flows to the National Health Fund (NFZ), which is the central insurance institution in Poland, and is further disseminated among the 16 regions of Poland in which branches of NFZ are located. From the local community budget, moneys are paid directly to selected health care units.

Due to the yet unfinished implementation of family medicine, primary health care in Poland consists of two dimensions or care models: the old Semashko model with its group out-patient units and the family medicine model. Nowadays both dimensions have equal representation in the health care system:

First, part of primary health care – the remaining Semashko model – is organized based on out-patient units. Traditionally, these units consisted of different parts: general-internal medicine; pediatrics; surgery; OBGYN; district nursing care and in many cases dental care. Care in each of these parts was provided by specialists of each particular medical discipline. In bigger cities such out-patient clinics included also many ambulatory working specialists like cardiologists, rheumatologists, neurologists, otorhinolaryngologists, ophthalmologists a.s.o.

Nowadays these units consist of group practices usually comprising internists and pediatricians who create unified lists of patients. In many cases, they are supported by ambulatory care specialists, who are located at the same building, but are separated in an organizational meaning. Dental care shifted from this organization firstly and nowadays is running independently. In many cases due to conflicts of interest district nurses also moved out of these out-patient units, created their own patient lists and acted independently. Many of these units remain public, owned by local government. Those that are private usually split up primary health care (also medical and nursing) and specialist care.

The costs of the old Semashko-style outpatient units were high and outcomes didn't meet patients' expectations. Especially access to doctors was not sufficient. Continuity of care was rather limited. Care was not family oriented – mothers, fathers and children had different doctors. General opinion was that this system was not effective – too many patients were referred to specialists and hospitals. When the concept of family medicine was introduced, decision makers pointed out the possible improvements that the new concept could produce in the above mentioned areas (patient satisfaction, access, patient orientation, care continuity, etc.) and also in expanding preventive care.

The second model of primary health care arises from the strategy of implementing family medicine in the Polish health care system. It is based on family physician practices that are run as solo or group practices. Family physicians create lists of patients (the patient has the

right to choose their own primary care doctor and district nurse) and perform the provision of primary health care in a general understanding and dependent on the contract for care provision with the National Health Fund. District nurses are employed by the practice. Most of these practices are privately owned by physicians. Solo practices are found mainly in rural areas of Poland and small cities. Group practices are mainly settled in big cities.

1.2 Financing/remuneration in primary care in Poland

The financing of primary health care is based on capitation fees. Family physicians/PHC doctors are obliged to create patient lists on the basis of which they receive a monthly payment, that is 1/12 of the calculated annual budget, for taking care of the listed individuals. There are possibilities for physicians to increase this budget when they are engaging in preventive programs paid usually for service or for performance and when they secure 24-hour service. District nurses and midwives, in Poland called family nurses/midwives are acting in connection with family doctor practices or independently. Family nurses also have their own patient lists. They are paid upon capitation rules and engaged in some preventive programs. Midwives are paid according to the number of women listed in a family physician's or nurse's practice and engaging in preventive program's activities.

1.3 Human resources in primary care

Primary care is provided by:

1. Family physicians. These are doctors who are certified for PHC services. A diploma of family physician means that this doctor finalized post-graduate training (nowadays taking 4 years) in an accredited teaching center, passed a national exam (test) and a practical exam in a regional teaching unit. At this moment, over 9 000 physicians have passed the full certification procedure. Around half of this number are physicians who were re-trained from the already existing Semashko PHC model, most of them specialized in internal and pediatric medicine. All retrained physicians worked in PHC for more than 5 years before starting post-graduate training of family medicine. The number of family physicians needed in the Polish health care system is estimated to be 20 000. Family medicine as a strategic direction for the Polish health care system was decided on in 1991. The first full training physicians, around 200, graduated at the end of 1994. The first family practice organized and managed according to the strategy was starting in autumn of 1996. Obligatory creation of patient lists and the decision for the capitation payment mechanism in family medicine for the whole Polish health system was started in 1999 with the implementation of a financial reform and of health insurance.
2. Primary health care physicians. These doctors (around 8 000) are remaining from the previous Semashko health care system. The past primary care structure was based on district out-patient clinics that collaborated with district hospitals. Out-patient clinics consisted of different parts such as: general medicine, pediatrics, OBGYN and surgical dispensaries; district nursing and preventive care units; general dentistry units; and up to beginning of the 90-ties social care units. Physicians working in in these units were specialized in internal medicine, pediatric medicine, OBGYN or surgery. In contrast to family physicians, they are specialized, their scope of services was/still is limited and concentrated on certain patient groups. Nowadays they can attend two to three years of post-graduate training for family medicine, which is shorter than the usual 4 years based on and dependent on their experience. Regular training for physicians just after internship is 4 years.
3. Family (district) nurses. These nurses complete a special graduate course after the regular curriculum. Their role in primary care is supporting patients in obtaining

proper treatment also at home and they assess the influence of living conditions and family status on the health status of the individuals. Family nurses have a right to create their own patient lists and can work independently either solo, in a team of nurses, or they can be employed by family physicians.

4. District midwives called "family midwives" support women after delivery and are taking care of newborns in their first year. They are paid based on the calculation of pregnant women at a particular district. Another part of payment comes from preventive/health programs, especially oncological ones. Family midwives can work individually or in cooperation with teams of district nurses or family physician group practices.
5. Providers of rehabilitation services. Rehabilitation services are connected with primary care structurally in the old out-patient clinics or as a partial duty of family doctors as stipulated in their contract of health care provision. Professionals acting on that level are both group physicians and technicians. They are financed based on a fee for service mechanism, mainly upon contract with the National Health Fund, and in a much smaller part their services are paid directly by patients or other providers.
6. Dentists. Dental care was strongly connected with primary care during the system based on the Semashko model. Nowadays the structure of dental care is based on private, independent providers. Payment for these services is divided into two parts: basic services are paid for on a fee for service model according to the contract with the National Health Fund; so called over-standard services are paid for directly by patients.

1.4 Main drivers for reform in primary care:

1) The College of Family Physicians in Poland. This is a voluntary society-like organization of family physicians which was already established in 1992 – the same year when the strategy for implementing family medicine in the Polish health care system was decided on. The main objectives of the College are: i) supporting professional development of family physicians; ii) supporting development of family medicine as an academic discipline; iii) strengthening the role of family medicine within primary health care and the whole health care system. The influence of the College can be observed mainly in areas such as:

i) Structure of PHC. Since the beginning, the concept of the "complete" family physician consisted of three aspects due to the support and the strong promotion of this concept by the College: 1) the family doctor acts as an independent provider; 2) works with a list of patients, and 3) is particularly trained for primary care needs (ie. patient responsiveness, provision of a comprehensive scope of services including preventive services, family orientation, advocacy, etc.). Also first contracts for primary care provisions were developed by the College based on its job description of family physicians.
ii) Training of family physicians. Based on international collaboration and the experience of different activities undertaken by the EU, WHO and WONCA, curricula for family medicine training were developed for the different training levels: basic training for medicine students – minimum 100 hours during the study period; an internship – one third of the whole time, currently 6 months; post-graduate training – four years and half of that time in a specially selected family practice; continuous training - based on personal needs with recognition of such activities as peer-review groups, practice visits a.s.o.
iii) Quality assessment activities. Initiatives like the "School of Tutors", development of guidelines, practice accreditation

2) The labor union of ambulatory care physicians. This organization was established in 2004 as a movement for the protection of private ambulatory providers (mainly family physicians) of the National Health Fund. The main activities of this organization are focusing on social benefits for family doctors including the level of capitation fee.
3) Individual doctors. They influence local communities who are in charge of confirming the needs of inhabitants in Poland and they promote the importance and the potential of modern family medicine for increasing the health of the population.

1.5 Barriers to primary care reform

- Insufficient number of family physicians. The training period for being a family physician is relatively long but it's a price for quality. There are 12 regional teaching units connected to medical universities and more than 60 certified teaching centers. Twice a year a national exam for family physicians is organized. Each year around 600 physicians successfully pass this exam. Based on these facts, complete implementation of family medicine, that is the ability of Polish inhabitants to choose their own family physician, will take more than 10 years. Another problem that further aggravates the lack of family physicians is brain drain. Family physicians come second after anesthesiologists with regard to emigration to other EU countries after Polish accession to the EU.
- Lack of an integrative IT system. Medical record keeping does not meet the criteria for modern recording of patient problems. In many cases, family practices are keeping paper patient records. There are at least 6 types of software available for the practices but no one is fulfilling physician and practice needs. Reporting to the National Health Fund and public statistic offices doesn't help in everyday practice, ie. there is no feedback from the NHF regarding the submitted data and thus it is not possible to analyze the data and improve services based on the results.
- Lack of support – since the development of the strategy for implementation of family medicine into the Polish health care system in 1992, there has been no other legal act that covers the already implemented changes and provides direction for further development.
- Misunderstandings on the side of public payer, local authorities and other actors in the health care system concerning the role, responsibility and scope of services provided by family physicians.

2. Macro level
2.1 The health system

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Cooperation and coordination between providers of health and social care.
Support for better cooperation between providers was only given at the stage of implementation of family medicine in Poland in 1992. At this time, a legal frame and a strategy for implementing family medicine into the Polish health care system was developed. The basic job descriptions for family physicians and district nurses were described. Family doctors are to act as gatekeepers and they are playing a coordinative role for their patients. These roles are explicitly written down in the family physicians' contract with the NHF.
The strategy of implementation provided directions for the structure of practices (dispensaries) and it allowed for settlement of solo and group practices. Also, from this document, the first content of training programs was driven. The legal frame stipulated the

structure of contracts with family physicians for primary care provisions – this was an important step because of sharing public finance with private, independent contractors.

Social care was separated from health care at the beginning of the 90-ties. There are no rules at the macro level for cooperation with primary and secondary care. Social care responsibilities are in the hands of local governments and at this level initiatives for collaboration based on local needs are developed.

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Chronic patients, primary and specialist care policies

At the macro level there are some activities concerning the preparation of guidelines for the management of some chronic diseases. These guidelines are worked out by professional societies of physicians involved in the care and treatment process. The guidelines include descriptions of the role of primary and secondary care as well as areas and needs for cooperation. There are also some protocols for the management of chronic diseases that are prepared at the specialist care level and do not have an influence on primary care performance due to a lack of understanding of this care level and without recommendations for implementation of these guidelines.

Chronically ill elderly patients have access to long-term care services at hospital-like organizations like nursing units or, in the terminal stages of diseases, at hospices. These services are partially paid by the National Health Fund and partially by social funds of local communities or by patients (40-70% of their pension). Elderly inhabitants have the possibility to stay at “elderly houses”.

There are efforts to provide care for chronic patients at their homes – so called home hospitalization. The idea behind this model is to better coordinate social and health care services. The curative role in this model is played by family physicians (with each family physician treating those patients that are on their patient list) with support by social care providers, nurses and the possibility for easy access to specialist consultations. This model still needs more development concerning proper coordination between family physicians, district nurses, rehabilitation service providers and specialists providing care at hospitals.

Recently, the National Health Fund started to organize new payment programs in which the whole disease is treated as a case. That means that providers will receive payments for specific activities described in the respective programs. This idea derived from the success of preventive programs performed that way.

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Remuneration system for primary care providers and incentives for prevention, follow-up care and continuous patient support.

Remuneration for primary care is based on a capitation system. Around 80-90% of the annual budget of family physicians’ practices comes from capitation fees. Family physician can apply for preventive programs financed by the National Health Fund, local or central governments. The remuneration scheme for preventive services differs depending on the respective payer – it can be fee for service but also capitation or other payment modes. Usually practices can perform such programs independently only at the community level; those programs that are financed by a higher level (county, region or central government) need collaboration with specialists including hospital care. In most of these activities, family

physician practices are invited to cooperate with bigger units who apply for the financial sources.

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Measuring the structure, process and outcomes of primary care.

The structure of primary care is measured at the time of registration for allowance to enter the "medical market". This comprises controls of the qualification of personnel, facilities, buildings, rooms and equipment. During performance of services, external sanitary inspections are scheduled irregularly but quite often.

The care process is assessed by the National Health Fund but because of a lack of an IT system, external control also has a meaning. There are controls of procedures like record keeping of access to different professionals - basically, process measurement is the control of activities according to contract descriptions.

The outcomes are measured by the National Health Fund, public statistics and in some cases by local government authorities. Areas such as patient satisfaction, amount of referrals, and rarely health status are being controlled.

Since 2002 there exists a trial to implement an accreditation process for family practices. This assessment is also external but, firstly, it is voluntarily and secondly it covers all aspects of family practice activities. This includes practice structure (also legal), documentation and record keeping, the sharing of information among practice staff and patients, usage of guidelines, implementation of patient rights and assessment of their satisfaction.

2.2. Delivery system design

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Primary care is focusing mainly on acute care right now in Poland. Preventive activities are performed basically for children as vaccinations, check-ups for newborns and for children at the age of 1-2-3-6-7-14 and18 years. Other than the above mentioned activities depend on the programs organized by the National Health Fund, the Ministry of Health or local governments and are performed differently in different regions.

The primary care system in Poland is in part suited to provide comprehensive care, especially where care is provided by trained family physicians, but it needs some demand and strong support from central institutions like the Ministry of Health and central insurance. Working at the primary care level requires some specific skills (knowledge of health promotion and preventive activities, family-orientation, local society involvement a.s.o.) and the family medicine program during post-graduate training is organized in such as way as to provide family physicians with these skills. The Polish family physician training program is similar to the British, Dutch or Danish one and allows graduated family physicians to provide similar care like in these countries. In contrast to family physician training programs, trainings for internists and pediatricians (who make up the Semashko-style primary care units) are different and their performance in the primary care setting is different.

The majority of family physicians in Poland work in group practices but in rural areas solo practices are dominating. The remaining primary care units (those that still exist from the Semashko model, approximately half of the PHC structure) are group practices consisting of internists and pediatricians. In this case these practices are often connected with ambulatory specialist care and create policlinics. Most family practices are private and the majority of the remaining Semashko units (policlinics) are publicly owned organizations.

The coordinating role of family physicians is rather limited and reduced to referral of patients to specialists, hospitals and diagnostic procedures. In some cases continuity of care is performed for patients discharged from hospital, especially those with moderate chronic

illnesses. The obligation for coordination is stipulated in the contract of primary care provision. Even though that coordinating role of family physician is an important aspect also during post-graduate training there is no unified mechanism for this action.

Research projects in primary care that are organized and performed by family physicians trained in this area is still premature in Poland. There are a limited number of physicians getting a PhD title and only two fully qualified independent researchers in Poland. Despite this insufficient capacity for undertaking research activities, family physicians in Poland are acting at this field mainly in collaboration with international programs. Also, individual physicians are being connected with regional teaching units and departments of family medicine at the medical universities. These individual research projects are mainly focusing on case studies or quality of care. Results of these projects can be published in a scientific journal, the *Problemy Medycyny Rodzinnej* (Family Medicine Problems) or, what is more popular, presented during annual congresses of family medicine.

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3. Meso level

3.1. The community

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The local community government in Poland is responsible for primary care. In some cases it owns the units serving care. In all cases communities have financial resources for preventive programs for their inhabitants. The role of family physicians can be assessing health needs of inhabitants and selecting effective preventive programs. Still this is not common in Poland.

4. Micro level

4.1. Self-management support

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What kind of patient support strategies and resources exist that help the patient better manage their disease?

Because of the resisting Semashko model and decreasing access to different specialists, support to patients with diagnosed illness is limited to controlling specific examination results.

4.2. Decision support

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Evidence-based guidelines that meet criteria of independent recommendation and are built up according to Delphi methodology or consensus conference with participation of specialists and family physicians are covering the following topics: asthma; asthma in childhood; chronic obstructive lung disease; influenza; hypertension; chronic pain and Helicobacter Pylori infection. There are also other guidelines but their quality is lower or they are not dedicated to primary care directly.

CME is supported and controlled by the Physician Chamber in Poland and organized by different institutions accredited for this purpose. Physicians are obligated to collect 200 educational points within 4 years.

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5. Key findings from the country case study

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Three main barriers to improving primary care in your country:

1) lack of support from central institutions (after development of family physician strategy in 1992, no further strategy plans or laws that further guide and direct development of primary care)
2) lack of proper promotion of role, abilities, importance of family medicine professionals for the system of health care and public health
3) lack of information dissemination system

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Three main success factors for improving primary care that derive from your analysis of your country's primary care system:

1) recognition of family physicians (positively recognized profession among public)
2) self-organized and self-managed societies of family physicians
3) existence of leaders of change and implementation of different activities: accreditation, guidelines, specific trainings, peer-review groups, international cooperation and many others.