Prevention in Poland: Health Care System Reform

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Synopsis

Despite the political and economic reforms that have swept Eastern Europe in the past 5 years, there has been little change in Poland's health care system. The Ministry of Health and Social Welfare has targeted preventive care as a priority, yet the enactment of legislation to meet this goal has been slow. The process of reform has been hindered by political stagnation, economic crisis, and a lack of delineation of responsibility for implementing the reforms.

Despite the delays in reform, recent developments indicate that a realistic, sustainable restructuring of the health care system is possible, with a focus on preventive services. Recent proposals for change have centered on applying national goals to limited geographic areas, with both local and international support. Regional pilot projects to restructure health care delivery at a community level, local health education and disease prevention initiatives, and a national training program for primary care and family physicians and nurses are being planned.

Through regionalization, an increase in responsibility for both the physician and the patient, and redefinition of primary health care and the role of family physicians, isolated local movements and pilot projects have shown promise in achieving these goals, even under the current budgetary constraints.

HEALTH STATUS INDICATORS in Poland are among the worst in Europe, with increasing morbidity and mortality rates and decreasing life expectancy for middle-aged men and women (*1*). Although to some extent, the deteriorating health status of the Polish population can be attributed to a poorly run, inefficient medical system, much of the problem stems from a lack of sufficient health education to increase the population's understanding of good health practices and healthy lifestyle choices.

The need for a shift in focus from curative services to preventive care and health education was recognized as early as 1980, when political and social pressure forced debate on reforming the health care sector. Under the socialist system, however, no real change was achieved, and attention continued to be placed on curative services by teams of planners dominated by physicians (*2*). After the collapse of Communist regimes across Eastern Europe in 1989, Poland took the lead in proposing widespread political reforms. It was assumed that health services would be addressed as part of a broad restructuring of the Polish government system, and many looked to the Ministry of Health and Social Welfare to design, develop, and implement these reforms.

Although the new political structure would appear to make such changes possible, little progress has been made in the ensuing 4 years. Much of the stagnation hindering efforts at reform is a result of the Communist system's penchant for state planning that had been characterized by a high level of centralization, political dominance over health and social services, and a top-down approach to change.

Health care reform plans have been proposed both to redefine a set of goals for the people's health status and for health practices at the national level and to implement some of the proposals in limited regional and local areas. While legislation at the national level has not resulted in major improvements in health care delivery, several of the pilot programs and national and regional efforts have begun to address these problems. By focusing on primary care and health education, these projects address the historical lack of interest in preventive care and show the potential to make real progress in improving the level of health in Poland.

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Medical Care Under Socialism

Under the constitution of 1952, Polish workers were granted the right to free medical care (*3*). Because of administrative difficulties in excluding those outside the work force, almost the entire population was covered (*4*). The principle of health care as a basic right was used as a political tool to promote the benefits of the socialist model, but many key issues in health service planning and delivery were ignored. Heavy use of health services was encouraged, despite the government's lack of resources, and patients learned to demand highly specialized care, even in situations when the services of a general practitioner would have been more appropriate. Extensive plans and programs for health promotion and health education were never realized because of financial constraints and a strong focus on curative services by the medical profession. The highly centralized, politicized health system was ineffective in responding to the high expectations and real needs of the population.

To address the issue of centralization, the regional health services were restructured in the years 1973-75. Organized into 49 voivodships (provinces), the 380 locally integrated health services were to provide primary health care with referral services to regional hospitals and specialized medical university centers. The structure was designed to integrate previously independent hospitals, clinics, and emergency and long-term care services, with an emphasis on modernization of management methods and increased accessibility to services (*3*).

The political motivation for this reorganization was to demonstrate the socialist system's commitment to primary health care and action at a conununity level. In reality, however, the services were inefficient, poorly managed, underfunded, and inadequate for the needs of the local population. By creating an artificially high demand for services at no cost to the patient, the government found itself in a situation where it could not provide an adequate supply of medical resources (*5*). This discrepancy between the proclaimed benefits of a socialist health care model and its actual reality led to dissatisfaction in both the provider and patient communities and reinforced the assumption that proclaimed political goals would not be met.

Problems in implementing programs. Among the political aims for the health sector in socialist Poland was improvement in the population's health status based on a program of preventive care and health education. Preventive services were highlighted as one of the strengths of the reorganized locally integrated system. Based on the primary health care principles set forth in the international Alma Ata Declaration in 1978, Polish preventive and curative health services would be improved (*6*).

Ambitious goals were set in terms of the World Health Organization's (WHO) Global Strategy for Health for All by the Year 2000, but the Polish health sector possessed neither the material resources nor the managerial competencies to design and enact the programs necessary to effect real change in the health status of the population. The primary health services could not bear responsibility for the social, educational, and environmental factors influencing health status. Although this problem was recognized by a government commission, and described in a 1985 review of progress made in Poland's Health for All strategy (*7*), local institutions or initiative planners did not step in to assume the responsibility for improving the population's health status through education or preventive care.

This failure of any group to take responsibility for initiating broad intersectoral action to improve social and environmental conditions and to support a program of health and lifestyle education has been one of the major impediments to improvement in Poland's health status. Under the socialist government, the health system itself was charged with the responsibility to improve Poland's health situation; neither the physicians nor the communities were made to feel accountable for their actions (*2*).

Although preventive care was termed a priority in the health sector, it was emphasized only as one component of the socialist model to affirm the legitimacy of the state system and was not given committed support. Hospitals were often built as monuments and staffed according to defense oriented projections without regard for real needs. Through the neglect of obvious problems and the devolution of responsibility from professionals to the health care

institution, the potential for preventive services to exert a positive effect on health status was not realized.

Within this system, the medical community also contributed to the lack of responsibility for individual cases and for preventing illness. The concept of family physician did not exist in Poland; primary health care workers were either pediatricians, internists, obstetrician-gynecologists, or dentists. Physicians were paid a government salary, without respect to the number of patients seen or treated. The lack of financial motivation and low degree of prestige associated with general practice prevented the primary health care system from functioning effectively. In 1988, there were 21.7 physicians per 10,000 population; however, 72 percent of the physicians were trained specialists (*4a*).

Although Poland's primary health care structure and goals required first contact with a general physician by definition, the goverment-controlled social and economic structure caused the entire medical profession to become dominated by specialists, even at the primary care level, and created a shortage of general practitioners (*8*). Patients were officially required to obtain a referral from a primary care physician before seeing a specialist, but often the referral system was abused.

Underpaid general practitioners, lacking staff, office space, or basic supplies, were not motivated to complete a patient's treatment themselves or to establish a long-term relationship with patients. Patients would often expect to tip the physician for his or her services, although health care was ostensibly funded by the government. Many patients simply would bypass the primary care physicians and go directly to a specialist. The failure of the state-planned primary physician gatekeeper model created an environment in which physicians were generally unable to assume responsibility for the patient's long-term health status or level of health education.

More than for any other reason, preventive programs failed under the socialist model of health care because the patient was not expected to take responsibility for his or her own health. Health care was provided by the state; persons were covered by employers' taxes and did not pay insurance premiums directly. Medical services were seen as free of charge (although the informal voluntary payments became common) (*9*), and patients came to expect specialist referral, rather than treatment by a primary care physician. Patients were not only completely unaware of the costs of medical treatment (as were the medical providers) (*10*), but they "expected their needs to be fully met by professional action with no self-involvement in the healing process" (*11*). Members of the community, unmotivated by the economic threat of illness, were not predisposed to seek health education; the health care providers, lacking a long-term commitment to the patient's health, were not prepared to facilitate a program of preventive health care.

Worsening health status of the population. A former Polish minister of health described Poland's health care policy under socialism as "a combination of ... slogans and promises without any backing by indispensable resources or efficient arrangements" (*2*). Poland's difficult economic situation, which persisted after the destruction of its industrial base in World War II, made the fulfillment of social and health goals impossible, even as they were continually expanded to meet ideological objectives and to counter worsening health indicators. This politicized policy on health failed to include epidemiologic, social, economic, or managerial components and ignored the impact of environment, lifestyle, and education on health status. Because these health policies were incomplete and impractical, the health status of the Polish population worsened.

Morbidity and mortality increased for circulatory system diseases, malignant neoplasms, injuries and poisonings, mental health problems, and neuroses. Morbidity from communicable diseases also rose. The rates of measles, pertussis, meningitis, viral hepatitis, and sexually transmitted diseases increased. There has been no significant decrease in the incidence of tuberculosis; the rate of infection has actually risen in children in recent years (*12*). Although this health crisis had been acknowledged in the past, it was not until the collapse of the socialist system that large-scale reforms were proposed to address these problems in the health care sector.

The Impact of the New Order

In 1989, large-scale political and economic reforms enabled Poland to elect a non-Communist prime minister and to abolish the socialist government and political structure (*2a*). Sweeping reforms in the health care sector were discussed; it was assumed that for the first time, national policies would be reviewed and adapted to social needs rather than fitted to political goals. The first proposals dealt with developing a system of national health coverage. These plans provided for care by a primary physician and basic insurance for standard medical services.

Two different sets of proposals were produced in November 1989, both of which called for major

changes in the health care system. Because of the nation's economic instability, neither of these plans could be adopted; instead, a set of proposals was developed at a February 1990 conference organized by the Ministry of Health and Social Welfare and cosponsored by WHO's Regional Office for Europe, the World Bank, and Project Hope. With support from the World Bank, task forces were established to focus on the specific areas of health promotion, primary health care, infrastructure, and regional systems of health care services (consortia). Some of the basic concepts outlined at this early stage provided the framework for developing various proposals for pilot programs that are now beginning to be implemented in three different regions of Poland.

National standards and goals for the improvement of health also were defined at an early stage. Proposals to target health promotion included the creation of a national health promotion center to coordinate public information and the training of health educators, plans for the development of programs in public health at the universities of Warsaw, Krakow,and Lodz, reviews of standards and regulations in the field of occupational health, and the development of a primary care physician training program (*11a*). These programs were conceived to focus on specific targets—limiting tobacco smoking and alcohol consumption, promoting healthier lifestyles, and eliminating occupational risks.

To achieve these goals, reform planners realized that the role of the family physician would have to be redefined. Rather than just providing curative services and referring patients to more highly trained specialists, primary health care physicians would be charged with "the main role in disease prevention and medical treatment of all inhabitants of our country" (*11b*). Health care centers were envisioned that would sponsor traditional preventive services and prophylactic efforts such as immunization, hypertension screening and control, and cancer screenings. In addition, media campaigns and community education would be sponsored (*4b*). Overall, these changes were representative of a shift in focus from curative medicine to health promotion and prevention and from overspecialized services to general family medicine.

National goals and programs. Over the past 2 years, certain phases of the proposed projects have been implemented, particularly in the areas of decentralization and reorientation to family and preventive medicine. Although many of the reforms deal with cost accounting, medical insurance, and health care management, it has been recognized that even the most complete restructuring of the Polish health care system cannot, in itself, improve the health care status of the population (*13*). For this reason, reforms must focus on changing the community's attitude towards health services and increasing the population's level of health awareness.

The program to educate family physicians has focused on a comprehensive scope of health promotion and preventive services along with basic curative services. In cooperation with the World Bank and the European Community, family physicians and local activists have made progress in developing preliminary activities to support the concept of primary and preventive care through the regional pilot programs and physician education initiatives.

The European Community funded a program in 1992 to develop the specialty of family medicine in Poland to meet primary health care needs (*14*). This project has involved 6-month exchanges of Polish physicians to European Community medical schools, and trips by professors of family medicine to Poland. In seminars, visits, and conferences, European Community experts in family medicine have helped a committee of Polish physicians develop a curriculum for family practitioners. A list of competencies and examination requirements for family physicians has been written, and a 3-year plan for specialization in family medicine has been developed. In addition, the College of Family Physicians was created in Warsaw in 1992 to support this model of primary health care.

With a newly created structure for comprehensive medical care by family practitioners, the health care sector in Poland has the potential to meet some of the preventive health goals that were not achieved under socialism. By decentralizing the health system and devolving responsibility to the regional health centers, the physicians, and the patients themselves, health promotion can become an effective tool in improving Poland's poor health indicators.

Pilot programs. In 1991, the World Bank sponsored a competition to develop plans for integrated services, and awarded three regions the technical and financial assistance necessary to begin this regionalization process. The areas selected for these pilot projects cover 23 percent of the territory of the country, with 6.2 million inhabitants (16.2 percent of Poland's population) (*15*). They are Ciechanów, Wielkopolska, and Pomerania, three regions that differ greatly in size and in their existing medical services.

Although the regional health networks vary slightly in their priorities and needs, each has focused on health promotion as one of its main objectives. Because of their work at the primary care level, the

regional health care consortia are expected to play a vital role in the nationwide transfer of responsibility for health from the state to the individual citizen (*16*). The consortia developed specific plans for implementation of health promotion and preventive activities, integrating local hospitals, clinics, physicians' services, medical schools, and industrial health services to target the communiry's needs. Despite a temporary lack of funding because of political disagreement, the preliminary programs have proceeded on a voluntary basis, particularly in the field of preventive medicine.

In Ciechanów, a rural area in central Poland, the consortium involved integrating neighboring voivodships and coordinating public clinics, health care centers, and government facilities. The Ciechanów region is small, with 2 percent of Poland's land, and 1.2 percent of the population. Although initial accomplishments in preventive care focused mainly on educating school nurses and retraining them to teach principles of health promotion, more recent programs have been directed at specific illnesses and behavior patterns. A program to encourage breastfeeding by new mothers involved starting a course for expectant parents, writing a book of instructions on breastfeeding, giving television and newspaper interviews, and running workshops for obstetric and neonatal department workers.

The Pomeranian Health Consortium is larger, comprising 9.6 percent of Poland's land and 5.2 percent of the population. Its initial programs in health promotion have emphasized the importance of shifting the focus of medical care from actual therapeutics to preventive care and including people who are not professionally connected with medical care in the healing process (*16*). To make the patients feel responsible for their own health before becoming ill, the consortium has proposed open meetings and lectures, articles and programs in the mass media, improving exercise facilities, and targeting environmental hazards.

The Wielkopolska Health Care Union is the largest region involved in the pilot project, with an area comprising 10.3 percent of Polish territory and 8.9 percent of the population. Its Regional Center for Health Promotion has targeted influencing lifestyle changes as its primary objective, along with programs in cardiology, maternal and child health, school health promotion, and smoking cessation programs. Focusing on the high rate of malignant neoplasms, the consortium has proposed campaigns to promote proper dietary habits, a reduction in environmental and occupational toxins, instruction on systematic self-examination, and regular prophylactic examination by primary care physicians.

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The Wielkopolska consortium has also highlighted the importance of anti-drunk driving campaigns, recognizing the role of alcohol abuse in Poland's increasing rate of mortality from automobile accidents.

One benefit of the regionalization effort has been cooperation between districts and provinces, as well as international support. The Wielkopolska consortium combined five districts, the Pomeranian consortium three districts, and the Ciechanów consortium two formerly independent districts. This cooperation is an effort to eliminate duplication of services and combine efforts to improve health indicators at a local level.

Health promotion programs have been created using the recommendations of the Polish National Health Program, the WHO goals of "Health for All by the Year 2000," World Bank recommendations, and local health statistics.

A program was developed in Ciechanów to focus on the high rate of cardiovascular system disease. The local initiative adapted the WHO slogan "Health in Heart Rhythm," and based its program on Welsh and Finnish experiences in reducing heart disease at the local level. The working group collected demographic and epidemiologic data and developed an educational curriculum on the prevention of cardiovascular diseases, then prepared leaflets, brochures, and posters for health care institutions, gave lectures and interviews on healthier lifestyles, created a program to promote physical exercises, and established rules to prohibit cigarette smoking in local health care facilities and offices.

The consortia also have become involved in the program to strengthen primary health care and support the establishment of a family practice specialty. Recognizing the contribution family nurses could make to health promotion, especially in medically underserved rural areas, the Ciechanów

consortium has developed competency requirements for the training of community health nurses. The structure of the consortia health centers, with their comprehensive approach, supports health education and health promotion by family practitioners, both nurses and physicians.

Conclusion

Recent efforts to reform Poland's health care system have focused on emphasizing health education and preventive care. A devolvement of responsibility from the national health system to the local and regional level and to individual family physicians has led to the development of new programs and initiatives. The redefinition of national health objectives, supported by the introduction of international financial and technical assistance to develop practical steps toward achieving these goals, has created an environment in which there is more realistic hope for improvement in the health status of the Polish population.

The introduction of new national initiatives and regional pilot programs has demonstrated how community involvement and regional efforts can foster strong projects in preventive care. Even with the limited resources allocated for health care during this phase of transition in Poland, local health workers have designed and implemented novel approaches to involving the community in its own health. Encouraged to develop and institute their own ideas in health promotion and health education, health care workers at the grass roots level can overcome the apathy and lack of responsibility for health fostered by the previous system and take steps toward improving the nation's health.

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