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Health Reform Monitor

The first attempt to create a national strategy for reducing waiting times in Poland: Will it succeed?☆

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ABSTRACT

The waiting lists package, proposed in March 2014, is the first attempt to create a national strategy to reduce waiting times for specialist care in Poland. The policy proposes a number of measures directed at primary, specialist ambulatory and hospital care with the goal of shifting patients to the lowest possible level of care. Initially, it has been welcomed by the patients and there has been, so far, no strong opposition against the reform from other stakeholders. However, this may be because there is some disbelief that the policy would actually be implemented (due to limited funding available for its implementation) and because some of the proposed changes are vague and have yet to be clarified. One stakeholder group that may obstruct the implementation of the reform, if they are not satisfied with the final shape of the proposed measures, is the primary care doctors. They are directly affected by the reform and enjoy a relatively strong bargaining position compared to other groups of medical professionals. Thus, the future of the reform remains uncertain.

1. Purpose of the policy idea

Waiting times for elective procedures are a major health policy concern in the majority of OECD countries [1]. They may constitute a means of rationing health care services based on clinical need and may thus help reduce abuse and the costly times of idle capacity, but they may also be a symptom of underfunding and/or inefficiency in the system [2]. In both cases they generate dissatisfaction among patients and general public and policy makers in many countries introduced a wide range of policies aimed at reducing them [1].

Also in Poland, where waiting times are more the result of underfunding and inefficiencies (such as poor coordination of patients' treatment) rather than the need to ration care based on clinical need, a number of measures aimed at reducing waiting times (and also at the related problems of inequities in access, informal payments and other queue-jumping mechanisms; [3,4]) has been introduced since the early 2000s. While some countries, such as the UK, achieved reductions in waiting times in the first decade of the 2000s [21] the measures implemented to date in Poland seem to have had a limited success.

At the National Council of the Civic Platform political party in December 2013, the Prime Minister asked the Minister of Health to develop, within the next 3 months, a policy aimed at reducing queues to doctors. This request was motivated by the political and popular pressure mounting on the government to take action on waiting times: waiting times saw significant increases in

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2012–2013 [5] and the Minister of Health faced growing criticism for not doing enough to halt this trend [5,6].

In response to this request, in March 2014, the Minister of Health presented two reform "packages" aimed at reducing long waiting times, the so-called "waiting lists package" and the "oncology package" [7] (although the two packages were later merged into one package we refer to them separately and focus only on the measures that concern waiting times; measures concerning oncology are not the focus of this article). In June these two packages were adopted by the Council of Ministers and presented to the Parliament in the form of amendments to three important acts: the Act on Health Care Consultants; the Act on Nurses and Midwifes; and the Act on Health Care Services Financed from Public Sources [8]. The package was passed by the Parliament in July [9,10] and signed by the President and promulgated in August [11]. While some of the provisions came into force within 14 days from the promulgation, most of them will not come into force until 1 January 2015 [12].

The expected direct outcome of the packages is the shortening of waiting times for specialist care, i.e. improved access to care. Indirectly, the packages are also expected to contribute to strengthening of primary care, e.g. through widening the competences of GPs, i.e. to improve the quality of care. Finally, one may also speculate that another indirect goal of the packages was to achieve popular support for the ruling coalition in the local elections in November 2014. However, this is more likely to have influenced the timing of the policy rather than its content.

2. Political and economic background

2.1. Problem of waiting lists in Poland: a short overview

Waiting lists are applied to outpatient specialist consultations and treatment procedures, elective inpatient care, rehabilitation, and certain diagnostic procedures (ultrasound scanning, CT, MRI). The main reason for their existence is the underfunding of the public health care system (see above) but also the poor coordination of patient's treatment, especially in the area of orthodontics and oncology (hence the oncology package, see purpose of the policy idea).

Waiting times may vary significantly depending on the area of care, region and provider. In June and July 2013, the longest waiting times were noted in the area of orthopaedics and traumatology of the locomotor system (11.5 months), ophthalmology (7.8) and angiology (7.2) [5]. The regional variation in waiting times is not only the effect of the unequal distribution of specialists, medical facilities and equipment [3], but also reflects the imperfect allocation of statutory health care funds between the 16 voivodeships that fails to capture the differences in health care needs among the regional populations (the allocation takes into account age and sex and financing requirements from the previous years).

Waiting lists constitute a major policy concern in Poland and the perception of unmet medical need due to waiting lists in Poland is one of the highest among EU member states (in 2012 it was only higher in Estonia) and has been increasing over the years [16]. Incomplete information on the actual waiting times at various providers available to patients (the NHF's website only has information on the average waiting times for all providers) is generally perceived as one of the most serious shortcomings of the system. While some short-term improvements can be observed (Fig. 1), the overall trend in the length of the average waiting times seems to be increasing.

3. Content of the new policy

Changes proposed in the packages concern primary, specialist ambulatory and hospital care. The proposed policy bears some resemblance to the measures implemented in the English NHS, for example, in its orientation on incentives and the use of waiting-time targets and heavy sanctions for hospitals that do not meet them [21]. However, there is no evidence that the policy was directly influenced by the English experience.

The packages introduce a number of financial and other measures aimed at strengthening of primary care and shifting patients from specialist care to primary care (Fig. 2). This includes the introduction of a "prescription visit" so that patients who previously had to see a specialist just to get a prescription can get it from the primary care doctor and giving nurses the authority to prescribe certain medicines and diagnostic procedures. At the same time, specialists who are quick to diagnose, treat and transfer the patient back to the primary care doctor will be financially rewarded. Financial incentives were also put in place to encourage day surgery and shorter hospitalization times. Moreover, e-waiting lists are to be centralized in order to make list management easier and more transparent (e.g. to prevent situations where one patient is on a waiting list of several providers for the same procedure). Centralized lists will also indicate the first available date rather than the average waiting time, which should give patients and health care professionals more accurate information on the expected time of treatment.

The policy also constraints the influence of the NHF on health policy: the NHF should focus on its core role of the public payer [22]. The NHF contracting is to be based on health needs mapping according to uniform guidelines (currently this is done by the regional self-governments on a voluntary basis) in order to reduce regional inequalities in access to health care, the pricing of services is to be transferred to the Agency for Health Technology Assessment in order to achieve a more realistic valuation of services and the duration of contracts with primary care doctors is to be extended to give more stability in the market of health care provision.

4. Stakeholders positions

Initially, patients were supportive of the new proposals (Fig. 3) [13], while the organizations representing health care providers were on the whole rather skeptical about it but had not opposed it strongly either. The main reason for this was the disbelief that the policy would actually be implemented due to the limited funding available for

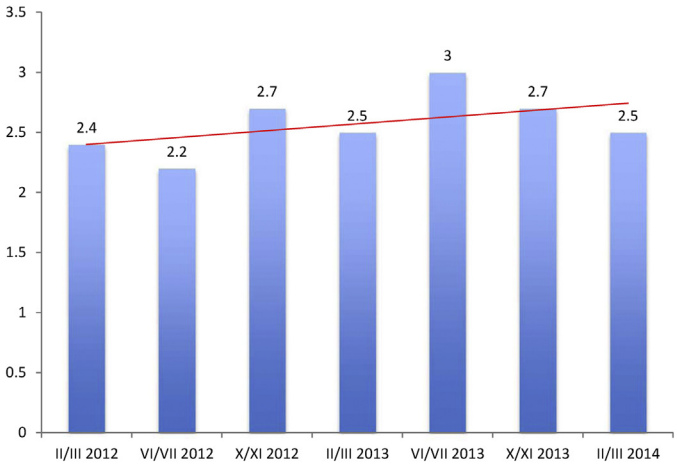

Fig. 1. Average waiting times for guaranteed services in Poland, in months, 2012–2014. Source: [14]. Notes: The average waiting times shown in this figure are based on the register of patients' problems maintained by the WHC Foundation and on the opinions of medical specialists. The Foundation monitors access to 43 areas of medicine and monitoring is carried out three times a year. It has to be kept in mind that the official reporting of waiting times by the providers is inaccurate: providers only report average waiting times of new patients and patients who are already undergoing treatment are not included; moreover, providers (especially hospitals) often do not report the actual number of patients waiting for treatment – some report higher numbers of patients on the waiting lists in order to get a better contract with the NHF. The average waiting times calculated by the WHC Foundation are likely to be more accurate than the official reporting by the providers as they are based on telephone interviews with the patients and thus take into account the barriers they encounter when accessing care.

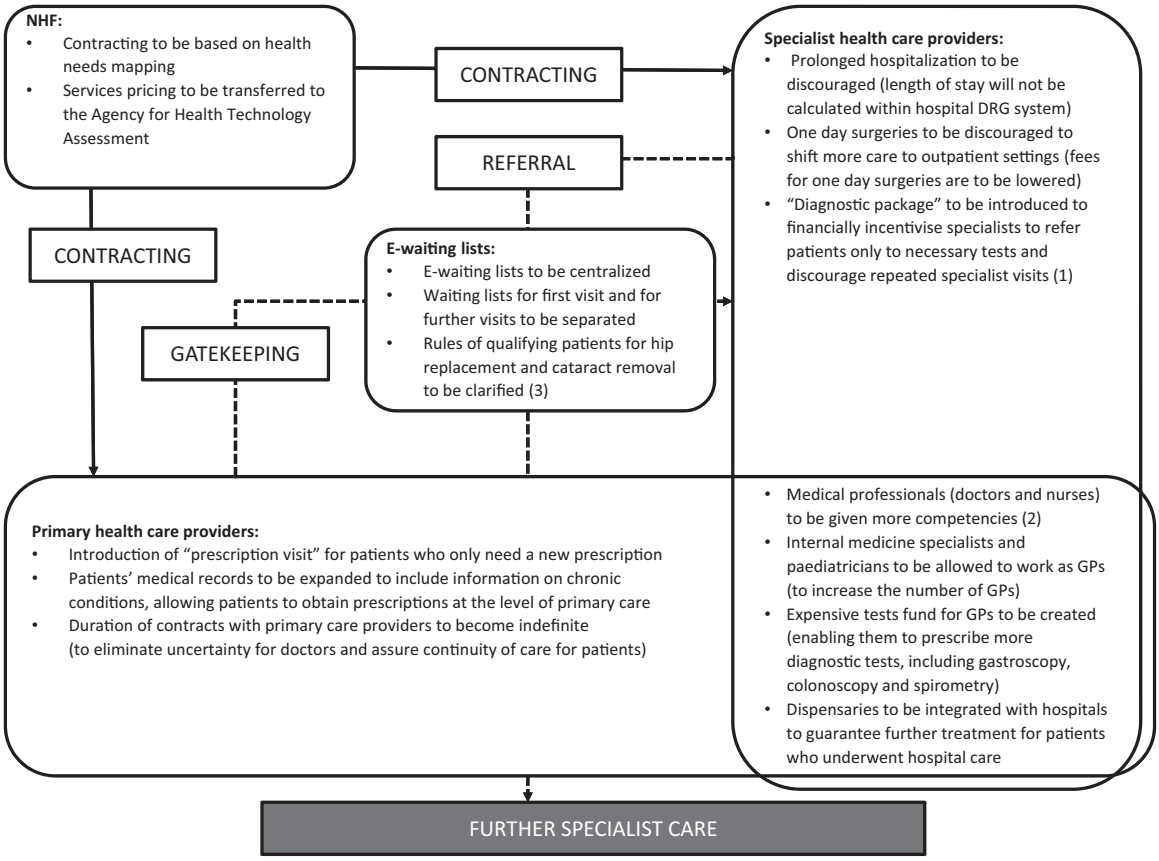

Fig. 2. Measures proposed in the waiting lists package. Source: Authors' own compilation. Notes: (1) Medical specialists will receive increased fee for the first visit if they makes diagnosis, plan treatment and refer the patient back to his/her GP for further care within 6 weeks after the first visit; (2) E.g. nurses will be able to prescribe certain pharmaceuticals and medical devices (since 2016); (3) Currently some patients undergo these procedures as a preventive measure.

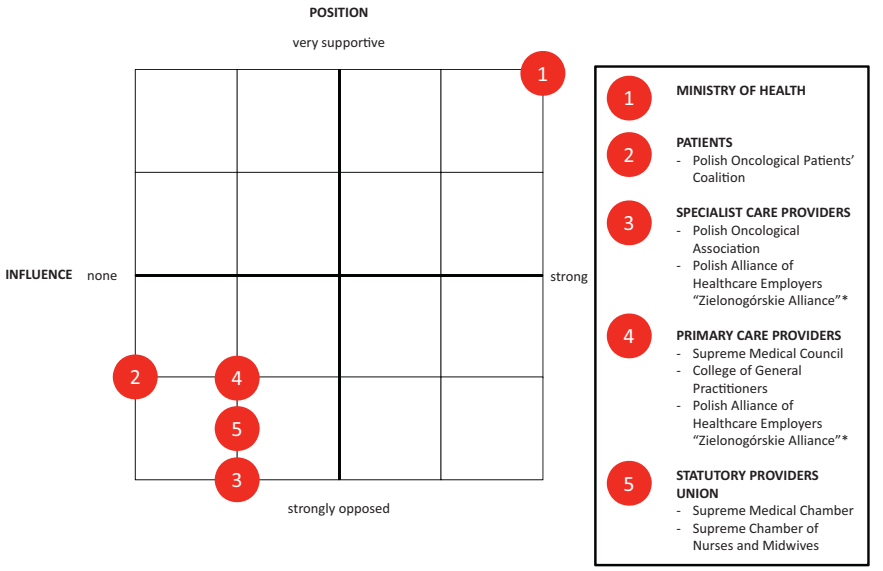

Fig. 3. Position of stakeholders and their influence. Source: Authors' own compilation. Note: *Zielonogórskie Alliance was established in 2003 and mainly represents the interests of primary care physicians. It gives them a relatively strong bargaining power compared to other groups of medical professionals as it has a very wide geographical reach (it represents primary care physicians in most voievodeships) and it has, in the past, successfully negotiated with the government on the terms of contracts with the NHF and on other issues. Zielonogórskie Alliance is listed under primary care providers and also under specialist care providers in Fig. 3. The reason for including it under Specialist care providers is related to the oncology package, as the oncological care begins in the primary care sector and primary care doctors will have much say in this area.

its implementation [14–17] and the potential opposition from primary care physicians at the implementation stage. It was also due to the fact that, some of the proposed changes were vague. For example, it was not clear whether financial incentives for primary care providers would cover only the additional tasks they have to perform or also the purchase of specialist equipment (i.e. ultrasound scanning devices) that is needed to perform these tasks. Moreover, the nurses were anxious that, given the low ratio of nurses to patients (especially in the area of primary care), with the additional responsibility of prescribing medicines they may not have enough time to perform their core care functions [22].

The real influence of both patients and providers on the final shape of the reform was marginal and the scepticism of the latter did not affect the outcome of the legislative process. This is due to the well-established model of health policy making in Poland, whereby stakeholders are merely consulted (this is a 'token participation' with no real influence on the policy making and is meant to appease potential opposition) and the decision-making up to the legislation stage is limited to the governing party. The policy has been developed by the Ministry of Health upon a direct request from the Prime Minister and had passed the legislative process very quickly, given that the governing coalition controls the majority of seats in the Parliament.

The scepticism of health care providers turned into a strong opposition when the reform was passed in the Parliament, as the suggestions they had made during the consultation process (mainly concerning the lack of funding to implement the reform, the excessive administrative burden faced by the providers and the lack of forecasts on the possible economic outcomes of the reform) were largely ignored. The Alliance of Doctors' Organizations issued a statement in which the reform was harshly criticized as "not only not having a chance to improve the system's performance, but even threatening its proper functioning" [9,19]. The critics argued that, rather than reducing waiting times, the reform merely shifts queues from specialized care to primary care (hence, relatively stronger opposition from the primary health care providers) [18]; gives the Minister of Health more power over establishing contracting rules (through the introduction of contracts of indefinite duration) and the NHF excessive control over providers (additional reporting obligations). It was also argued that the reform lacks sufficient organizational, structural and financial support and would therefore be difficult to implement. Moreover, providers did not approve that the evaluation of doctors' performance was based solely on performance statistics and not on merit [9]. Even the patients' organizations, initially supportive of the reform, took a negative stand after the reform was passed, due to the fact that they lost confidence in the reform's success [20].

Given the strong opposition of health care providers, it is likely that the implementation of the reform will reach a deadlock. Primary care doctors, who are affected by many of the proposed measures, are well organized and enjoy a relatively strong bargaining position compared to other groups of medical professionals. They may thus be able to obstruct the implementation of the reform. Currently, they do not seem to be prepared to take on greater responsibility for more complex care: they are neither well trained nor equipped to receive patients with more specialist health care needs.

As of November 2014, turbulent, on-and-off negotiations between doctors and the Ministry of Health

are in progress. These negotiations concern mainly the level of increased financing for the primary health care. The representatives of the powerful "Zielonogórskie Alliance" (see note under Fig. 3) declared that if they are not satisfied with the outcome of the negotiations its members will refuse to sing contracts with the NHF [23].

5. Conclusions

The reform is the first attempt to create a national strategy to reduce waiting times in Poland. It focuses on improving the coordination of treatment and freeing some capacity of specialist care by channelling more patients to primary care. The pressure stemming from the local elections (November 2014) seems to have increased the government's effort to implement the reform. However, potential opposition from primary care doctors is likely to diminish the success of the proposed measures during the implementation phase. Also, with primary care doctors not prepared to take on patients with more complex health care needs, shifting more patients to primary care may unintentionally lead to an increased use of medical emergency departments. Furthermore, additional systemic changes may be needed to reduce the inappropriate use of specialist care, beyond the measures proposed in the waiting lists package. For example, legal rules are needed to better separate the activities of doctors working in both private and public facilities as they have an incentive to maintain long waiting times for public patients to boost demand for their private practices [3]. Also, focus on one area of care (such as the oncology) may have a negative effect on waiting times in other areas of care (with more funds allocated to oncology the NHF will have less money to contract other services). The success of the enacted reform is therefore largely uncertain.

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