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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-

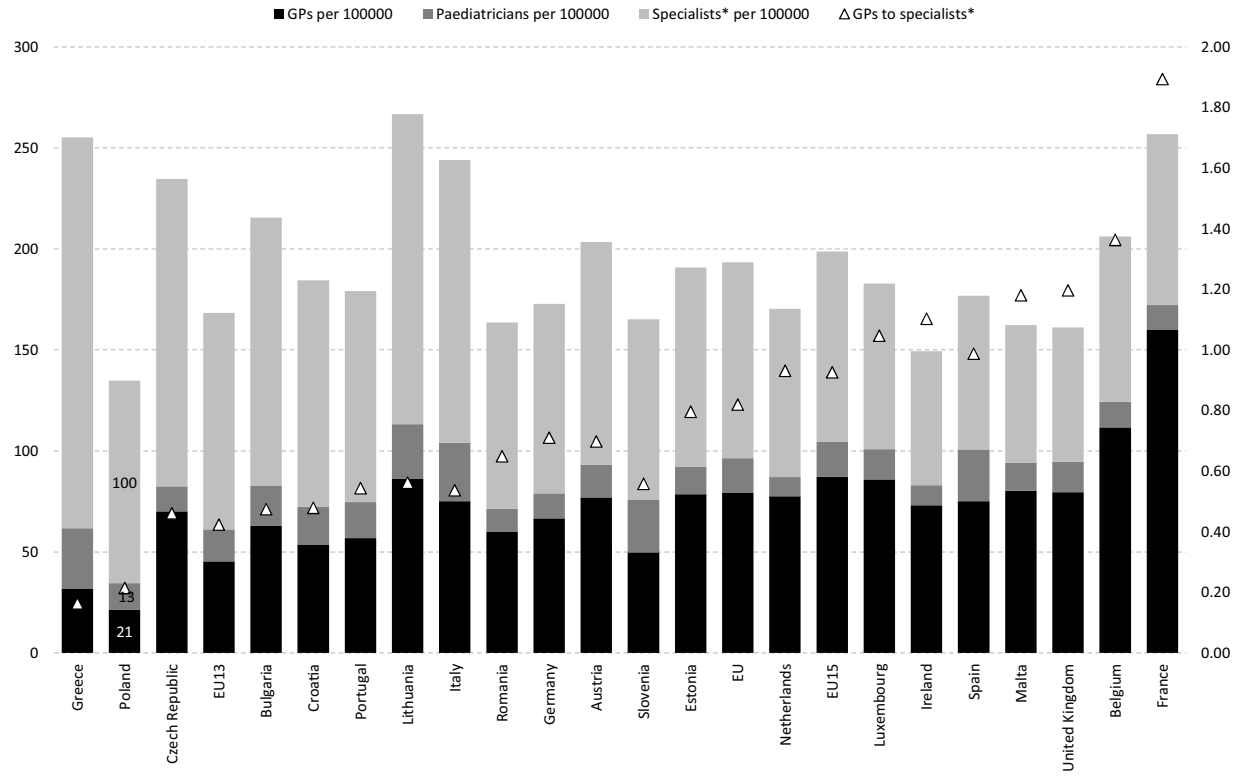

Fig. 1. Number of GPs, paediatricians and other medical specialists* in EU member states, 2013.
Notes: *Excluding surgery, gynaecology and obstetrics, paediatrics, psychiatry and general practice; i.e. GPs = family medicine specialists in Poland. EU15 = EU member states before May 2004; EU13 = EU member states since May 2004. No data for Cyprus, Denmark, Hungary, Slovakia and Sweden; no data on the number of GPs for Finland and Latvia. Countries were sorted from lowest to highest ratio of GPs to specialists.
Source: WHO Regional Office for Europe[27].

phylactic health services, diagnostics, treatment, and rehabilitation and nursing services in the area of general medicine, family medicine and paediatrics that are provided within ambulatory care settings by specialists in family medicine (including physicians undergoing such specialisation) and (second grade) specialists in general medicine. The Executive Regulation of the Minister of Health of 20 October 2005 on the scope of tasks of doctors, nurses and midwives working in PHC (Journal of Laws, 2005, No 2014, item 1816) sets out activities in the area of health promotion and prophylaxis that are to be performed within PHC within the statutory health care system but with no indication on who, i.e. type of provider, is to provide the particular services. This Regulation explicitly lists a number of health promotion and prophylactic services that are to be provided within PHC; these include: indication and diagnosis of health risk, health education, provision of mentoring in healthy lifestyle, education in hygienic nursing of new-borns, education in prevention of gynaecological diseases. Despite the existence of these very clear legal obligations, preventive activities are often neglected and medical treatment of diseases is prioritized. This specifically concerns activities such as health education and mentoring in healthy lifestyle and is mainly caused by the lack of resources and the resulting need to prioritize tasks [19]. The list of health promotion services that are included in the guaranteed benefits within the statutory health care system in the area of PHC is shown in Table 1.

Deficiencies in the provision of health promotion services within PHC are particularly visible for older patients. Older patients often represent the most complex cases that PHC has to deal with, as they often suffer from co-morbidities. They may also have long-established unhealthy habits and behaviours that may be difficult to correct and the health effects of these habits and behaviours may be difficult to reverse by health promotion activities. Given the above, prevention of health risks and promotion of healthy lifestyles in this population group is often neglected by health care professionals. The results of a pilot research project carried out within the framework of the European Project PROHEALTH 65+, which included in-depth interviews with PHC experts, showed that there is not enough emphasis on health promotion services at the level of PHC in Poland and this is more pronounced for older patients (this research finding is included in an unpublished report of a pilot study undertaken as part of PROHEALTH65+ project funded within the framework of EU's Health Programme 2008–2013; see Acknowledgements). According to the interviews, lack of time is the main reason why doctors are not able to deliver proper health promotion services to this population group. A PHC physician must see all patients who come to see them in a given day and there is no legally proscribed minimum time that

Table 1
Types of primary care services provided by different types of PHC providers.

Primary care medical doctor	Primary care nurse	Primary care midwife	Nurse school hygienist
- **Medical advice (preventive and curative)** - **Preventive health services (e.g. cardiovascular prevention programme)** - **Periodic health assessment** - **Vaccinations** - **Diagnostic tests** - Referrals to the higher level of health care - Medical advice at night and during holidays	- **Nurse visit** - Patronage visit - **TB preventive health visit (e.g. health education, collection of samples for preventive diagnostics)** - **Screening tests** - Services provided at night and during holidays, including in medical emergencies	- **Midwife visit** - **Patronage visit** - **Preventive health visit (e.g. health education, advice on nutrition)**	- **Planning the screening process** - **Conducting screening tests and interpreting results** - **Active guidance for pupils with health problems** - Paramedical services (in a specified cases) - **Guidance for the school director in common health problems** - **Education in oral health** - **Participation in planning, realization and evaluation of health education**

Source: Executive Regulation of the Minister of Health of 24 September 2013 on the guaranteed benefits in the area of primary care (Journal of Laws, 2013, item 1248).
Note: Preventive health services are marked in bold.

a primary care doctor should spend with each patient. Also the lack of financial incentives in the contracting model with the NHF contributes to the under-provision of such services.

3. Stakeholders' positions

The positions of the key stakeholders during the policy process differed and reflected their particular interests (Fig. 2). It has to be noted that patients lacked a voice in the decision making process. This may be because they were either not aware of the policy change taking place or there was no influential organisation that would represent them (both of these arguments often apply to older patients), even if their opinions were welcomed. For example, the Institute for Patient Rights and Health Education, which is usually very active, with no explanation and understandable reason, did not get involved in the policy process.

The policy was passed with no consultations with the major stakeholders, i.e. family medicine specialists. This is typical of the legislative process in Poland and is not restricted to the health care sector.

3.1. Main opponents

Family physicians were the key opponents of the proposed policy. This stakeholder group was represented by two strong organisations: the College of Family Physicians and the Health Care Employer's Federation. The College of Family Physicians made a very emotional appeal to the Members of the Parliament arguing that the proposed changes would lead to a fragmentation of PHC services, prolong waiting times, limit access to comprehensive medical care, increase inequalities in access to care and increase health care costs [3]. They asserted that paediatricians and internists did not have the necessary professional preparation to guarantee comprehensive and coordinated PHC to the patients. They also stated that this measure could lead to more referrals to specialist care since paediatricians and internists are trained in a narrow range of services and do not have competencies in areas such as women's health, mental health, or minor surgery (postgraduate training of paediatricians and internists does not include any practice in a PHC setting). This could negatively affect waiting times for treatment and quality and accessibility of PHC, especially for older patients, who often suffer from chronic conditions and are highly dependent on PHC—the needs of this population group were not taken into account by the legislator. While this not feature in the official debate, opposition of family physicians was probably also driven by their financial interests. Shifting paediatricians and internists into PHC would diminish the bargaining power of family physicians and increased competition of NHF's contracts could also affect their remuneration.

The Health Care Employers' Federation, known for being confrontational in their responses to policy changes (they have previously initiated protests and strikes), was also strongly opposed to the proposal [5]. The Federation stressed the importance of providing PHC by physicians trained in family medicine: unlike paediatricians and internists, family medicine doctors can look after all members of a household in a comprehensive way and allowing paediatricians and internists into PHC would inevitably narrow the scope of PHC services. Neither the College of Family Physicians nor the Health Care Employer's Federation proposed a solution to the looming shortage of PHC physicians.

The strong opposition to the proposed changes of the representatives of family medicine physicians has also been visible since these changes have been passed in the Parliament and may jeopardise their implementation in the future. The College of Family Physicians has claimed that the implemented changes are incompatible with Directive 2005/36/EC [20], which makes provision of statutory PHC services contingent upon possession of evidence of formal qualifications in general medical practice (i.e. family medicine according to the terminology used in Poland). The College has claimed that allowing paediatricians and internists into PHC would reduce the number of family physicians in Poland. This is because medical students

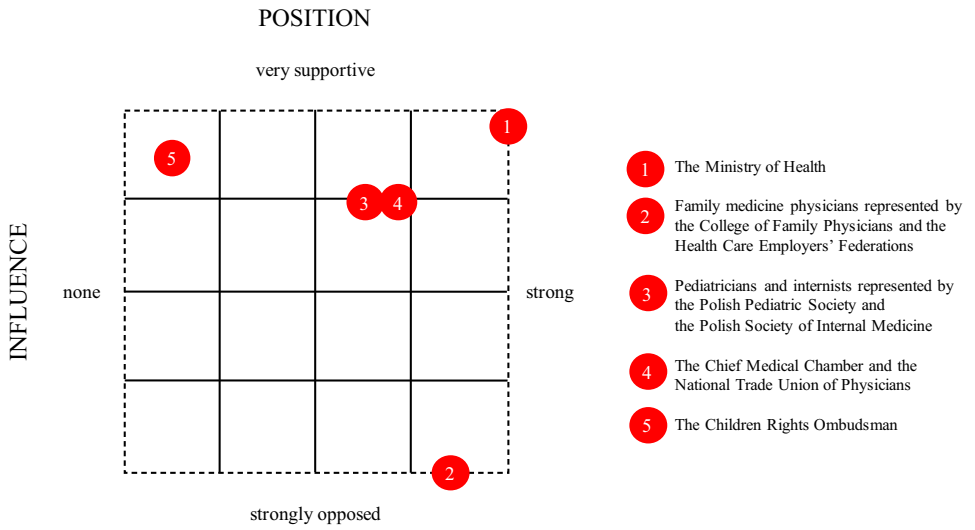

Fig. 2. Positions of the key stakeholders and their influence.

Source: Authors.

are likely to specialize in paediatrics or internal medicine rather than family medicine, because when choosing the latter specialization, they can only work in PHC, while when choosing the former, they can work in both PHC and inpatient and any outpatient settings—not only PHC [11]. In early 2015, many PHC units were inaccessible due to strikes of family physicians. The situation improved towards the end of the year, partly thanks to a slight increase in the PHC capitation rates and partly thanks to the shifting of the focus of public attention to the parliamentary elections that took place at the end of October of that year.

3.2. Main proponents

The main proponent of the policy throughout the entire policy process was its initiator—the Ministry of Health [24,23,12]. According to the Ministry of Health, inclusion of paediatricians and internists in PHC would not only assure the provision of PHC (given the looming shortage of family medicine specialists) and improve access to PHC services to the population but also improve access to paediatric care for children[1] [24]: assuming that 15% of paediatricians who currently work outside public PHC move to public PHC, the ratio of paediatricians to children would increase from one paediatrician per 1150 children to one paediatrician per 980 children [24]. With regards to the claims made by the College of Family Physicians on the potential incompatibility of the policy with Directive 2005/36/EC the Ministry formally confirmed that the policy was compatible with EU law [22]. This official stance was based on the legal opinion of the Office of Parliamentary Analyses. The Ministry clarified that the organisation of national health care systems, including the PHC system, lies within the competences of the member states. It claimed that the inclusion of physicians other than family physicians in PHC, namely paediatricians and internists, was possible, as long as the latter provided health care services within the scope of their professional qualifications, i.e. paediatrics and internal medicine. This interpretation has been confirmed by the Ministry of Foreign Affairs [22]. This means that paediatricians and internists will not obtain the same competencies as family physicians and will only be able to provide PHC services within the scope of their specializations.

The following other stakeholders were also supportive of the proposed changes: the Polish Society of Internal Medicine, the Polish Paediatric Society, the Polish Chamber of Physicians, and the National Trade Union of Physicians. Paediatricians and internists (and the organisations representing their interests) were in favour of the policy. The proposed changes improved their employment perspectives, especially given the lower demand for paediatricians due to population ageing, and formally allowing them into PHC without imposing additional requirements with regards to their professional qualifications and performed tasks. Moving to PHC may also be financially attractive to many paediatricians and internists: for paediatricians and internists working in the private sector this is because moving to the public system means receiving capitation payments under contracts with the NHF and for paediatricians and internists working in the statutory sector—because salaries they receive in hospitals are relatively low. In the document signed by the representatives of the Polish Society of Internal Medicine, the Polish Paediatric Society and the Polish Chamber of Physicians *before* the Ministry initiated the policy, the three organisations actually argued that PHC would benefit from the specific competencies of paediatricians and internists [18]. Similar arguments were made during the legislative process in 2013 [17]. The Chief Medical Chamber, whilst being in

[1] Access to paediatricians working outside PHC within the statutory system (i.e. in the private sector) can be regarded as more difficult because one needs to pay out of pocket to see a private paediatrician.

favour of formally including paediatricians and internists into PHC, recognised that the proposal did not address the many problems faced by PHC, such as underfunding, financing model (exclusively based on capitation), lack of incentives to undertake specialisation in family medicine and a very narrow catalogue of diagnostic services provided within PHC [1]. The National Trade Union of Physicians, which was supportive of allowing paediatricians and internists to practice as PHC physicians, also recognised some of the shortcomings of the proposed changes: the changes were not sufficient to strengthen the role of PHC in the system and reduce the burden on specialist ambulatory care. According to the Trade Union, PHC doctors should be allowed to perform services that lie within the scope of their professional competences and within the (narrower) scope determined by the administrative rules [14].

While the positions adopted by the physicians affected by the proposed changes, family medicine physicians, paediatricians and internists, were rather self-evident, it was less obvious why the Chief Medical Chamber and the National Trade Union of Physicians were supportive of the policy. One possible explanation is that it was a sign of concern about the accessibility of PHC services to the population, both for children (a position shared by the Children Rights Ombudsman [2]; and adults. The proposed changes may also have been regarded as an opportunity to improve employment opportunities for physicians in general (without focusing on any specific group of specialists).

4. Discussion

Some policy analysts have argued that the new policy means a de facto return to the pre-1990s (i.e. communist) arrangements, under which other medical specialties, including paediatricians and internists, were allowed into PHC, and it was suggested that the described policy was not based on evidence [25]. However, while it is unlikely that the reform is based on any rigorous analyses, paediatricians and internists (and other medical specialists) are involved in the provision of PHC in many European countries (see for example Refs. [10,15]) and many of these countries score high in the area of PHC delivery (in terms of its accessibility, continuity and coordination) (see Ref. [10]). Also, paediatricians and internists were formally included in the provision of PHC not only in the communist times but as late as until 2007, which is when the amendment of the 2004 Act on Health Care Services Financed from Public Sources required that they obtain a diploma in family medicine until 2017. This means that some of them may have a longstanding experience of working in PHC settings and should be able to provide quality PHC to patients. In addition, the formal inclusion of paediatricians into PHC is likely to improve the quality of such care for children and adolescents: if there are more paediatricians in PHC, then it may be more likely that a child accessing PHC is seen by one and the quality of care for this patient group may improve. However, since pediatricians and internists are only allowed to perform health care services within the scope of their respective specializations (see the position of the Ministry of Health in Section 3), their inclusion into PHC will not improve access to family medicine in general.

The success of the reform remains uncertain. Because of the lack of relevant data, it is still not clear how many paediatricians and internists decided to move to public PHC. The Polish Paediatric Society has signalled that there is an outflow of paediatricians from paediatric hospital wards to PHC, due to low salaries in hospital settings [6]; however, there is no official data allowing to quantify this 'outflow'. There is also no data on whether the change led to any efficiency losses or gains (e.g. an increase in health care costs predicted by the College of Family Physicians; see Stakeholders' positions). A special study would need to be undertaken to obtain such data. However, it may still be too early for any significant changes to be detected. It also remains to be seen whether the compatibiliy of the reform with Directive 2005/36/EC will not be questioned by the European Commission in the future.

5. Conclusions

While this reform was necessary to assure access to PHC for the population as a whole by averting the shortage of PHC physicians looming in 2017, as all recent health care reforms in the area of PHC the implemented measure was another ad-hoc solution and a long-term strategy is still missing, especially one that would take into account the changing demographic trends. Population forecasts for Poland show that by 2035 the number of people aged 85 and over will increase by over 158% compared to 2007. Poland also has one of the lowest fertility rates among the EU Member States and the effective old age dependency ratio (for people aged 65+) is projected to peak in 2060 [4]. This would constitute a dramatic change in the structure of health care needs of the populations as a whole and a huge strain on health care financing (demographic changes alone are projected to increase public health care speeding by 0.9% of GDP between 2005 and 2050 and by 1.3% of GDP between 2007 and 2060 [4]. It also means that the structure of human resources, especially at the level of PHC, should be adapted to these changing health care needs: more emphasis should be put on the prevention of geriatric problems and provision of LTC and community nursing. The Health Needs Maps that are currently under preparation by the public administration at the voievodship (region) level [13] are bound to flag up the problems described above. The attempt to shift paediatricians to PHC, while assuring employment for this group of medical specialists, does not address health care needs of the key recipients of such care—older patients. The fundamental question on how PHC should be organised to meet the changing patient needs remains open. The new government elected at the end of October 2015 has yet to present its vision for PHC and the health care system as a whole.

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References

[1] Chief Medical Chamber. Stanowisko Naczelnej Rady Lekarskiej (NRL) nr 7/13/YI z dnia 24 maja 2013 [The Position of the Chief Medical Chamber of 24 May 2013]; 2013. Available at: http://www.nil.org.pl/_data/assets/pdf_file/0003/87609/rs007-13-VI.pdf.

[2] Children Rights Ombudsman. Rzecznik Praw Dziecka popiera "Memorandum w sprawie miejsca specjalistów chorób wewnętrznych i pediatrów w systemie opieki zdrowotnej w Polsce" [The Children Rights Ombudsman supports the "Memorandum on the place of internal medicine specialists and pediatricians in the health-care system in Poland"]. Published on 23 June; 2013. Available at: http://brpd.2012korczak.pl/aktualnosci-wystapienia-generalne/rzecznik-praw-dziecka-popiera-memorandum-w-sprawie-miejsca.

[3] College of Family Physicians. Nie pozwólmy dewastować podstawowej opieki zdrowotnej – apel środowiska medycyny rodzinnej [Do not destroy primary health care – an appeal of family medicine circles]. Kolegium Lekarzy Rodzinnych w Polsce [College of Family Physicians]. Published on 17 December; 2013. Available at: https://rodzinni.org/News/Show,286.html.

[4] European Commission. 2009 Ageing Report. Economic and budgetary projections for the EU-27 Member States (2008-2060). Direcorate-General for Economic and Financial Affairs of the European Commission, European Economy 2; 2009. Available at http://ec.europa.eu/economy_finance/publications/publication14992_en.pdf; [accessed on 13.10.15].

[5] Health Care Employers' Federation. Lekarz rodzinny czy pediatra? Czyli, jak skłócić lekarzy i zniszczyć POZ? [The family doctor or the paediatrician? How to antagonize physicians agains eachother and destroy PHC?]. Federacja Związków Pracodawców Ochrony Zdrowia "Porozumienie Zielonogórskie" [Health Care Employers' Federation "Zielonogórskie Alliance"]. Published on 14 November; 2013. Available at: http://www.federacjapz.pl/aktualnosci/font-colorbluelekarz-rodzinny-czy-pediatra–czyli-jak-skci-lekarzy-i-zniszczy-pozfont,187.

[6] Gazeta Lekarska. Zdrowie dzieci naszym wspólnym dobrem [Children's health as our common good]. Gazeta Lekarska, 18 January; 2016. Available at: http://www.gazetalekarska.pl/?p=20926.

[7] Gowin E, Horst-Sikorska W, Michalak M, Avonts D, Buczkowski K, Lukas W, et al. The attractiveness of family medicine among Polish medical students. European Journal of General Practice 2013;20(2):121–4.

[8] Kowalska I, Sagan A, Mokrzycka A, Zabdyr-Jamróz M. The first attempt to create a national strategy for reducing waiting times in Poland: will it succeed? Health Policy 2015;119(March (3)):258–63.

[9] Kowalska-Bobko I, Mokrzycka A, Zabdyr-Jamróz M. The "waiting lists package" and "oncology package" have been passed by Parliament and are to be implemented. Health Systems and Policy Monitor. Published on 8 December; 2014. Available at http://www.hspm.org/countries/poland27012013/countrypage.aspx; [accessed 12.10.15].

[10] Kringos DS, Boerma WGW, Hutchinson A, Saltman RB, editors. Building primary health care in a changing Europe. World Health Organization; 2015 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies).

[11] Mejssner M. Chwiejna reforma zdrowia [Shaky health reform]. Medonet [a medical Internet portal]; 2016. Available at: http://www.medonet.pl/zdrowie/zdrowie-dla-kazdego/chwiejna-reforma-zdrowia,artykul,1707693.html.

[12] Minister of Health. Odpowiedź Ministra Zdrowia (MZ) w Senacie, 31 stycznia 2014 [The Answer of the Minister of Health in the Senate, 31 January 2014]; 2014. Available at: http://www.senat.gov.pl/gfx/senat/userfiles/_public/k8/dokumenty/stenogram/oswiadczenia/person/4701o.pdf.

[13] Mokrzycka A, Kowalska-Bobko I. Health Needs Maps introduced on 1 January 2015. Health Systems and Policy Monitor. Published on 10 February; 2015. Available at http://www.hspm.org/countries/poland27012013/countrypage.aspx; [accessed 12.10.15].

[14] National Trade Union of Physicians. OZZL o definicji lekarza POZ [The National Trade Union of Physicians on the definition of PHC physician]. Published on 29 May; 2013. Available at: http://www.rynekzdrowia.pl/Polityka-zdrowotna/OZZL-o-definicji-lekarza-POZ,130980,14.html.

[15] Pina CS. Re: back to red: allowing specialists to provide primary care would be a step backward for Poland. A response. BMJ 2014;348:g3030.

[16] Polish Chamber of Physicians. Informacje Statystyczne [Statistical information]; 2015. Available at www.nil.org.pl/rejestry/centralny-rejestr-lekarzy/informacje-statystyczne; [accessed 13.10.15].

[17] Polish Society of Internal Medicine. List otwarty Zarządu Głównego Towarzystwa Internistów Polskich [Open Letter of the Board of the Polish Society of Internal Medicine]. Published on 17 April; 2013. Available at: http://adst.mp.pl/s/www/tip/list_otwarty.pdf.

[18] Polish Society of Internal Medicine. Memorandum w sprawie miejsca specjalistów chorób wewnętrznych i pediatrów w systemie opieki zdrowotnej w Polsce. [Memorandum on the place of internal medicine specialists and paediatricians in the health care system in Poland]; 2010. Available at: http://tip.org.pl/artykul.html?aid=84363.

[19] Rezner A, Rezner W, Kosecka J. Edukator zdrowia w podstawowej opiece zdrowotnej jako szansa na podniesienie poziomu promocji zdrowia i profilaktyki w Polsce [Health educator in primary health care as a chance to increase the level of health promotion and prophylaxis in Poland]. Problemy Hignieniczno Epidemiologiczne 2013;94(3):403–12.

[20] Rodzinni on-line. Powrót do skompromitowanego modelu – wywiad z prezesem KLRwP dr. med. Tomaszem Tomasikiem [Back to the discredited model – an interview with the president of the College of Family Physicians dr. med. Tomasz Tomasik]. Published on 19 January; 2014. Available at: https://rodzinni.org/News/Show,294.html.

[21] Sagan A, Panteli D, Borkowski W, Dmowski M, Domaniński F, Czyz˙ewski M, et al. Poland: health system review. Health Systems in Transition 2011;13(8):1–193.

[22] Secretary of State at the Ministry of Health. Odpowiedź sekretarza stanu w Ministerstwie Zdrowia - z upoważnienia ministra - na interpelację nr 23391 w sprawie zgodności definicji lekarza podstawowej opieki zdrowotnej zastosowanej w projekcie nowelizacji ustawy o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych z art. 29 dyrektywy 2005/36/WE [Response of the Secretary of State at the Ministry of Health - authorized by the Minister - to the interpellation No. 23391 on the compatibility of the definition of a primary care physician used in the draft amendment to the Act on Health Care Services Financed from Public Sources with Article. 29 Directive 2005/36/EC]. Published on 21 January; 2014. Available at: http://www.sejm.gov.pl/sejm7.nsf/InterpelacjaTresc.xsp?key=70282D5E.

[23] Secretary of State at the Ministry of Health. Odpowiedź sekretarza stanu w Ministerstwie Zdrowia – z upoważnienia ministra – na interpelację nr 23091 w sprawie planów likwidacji instytucji lekarza rodzinnego [Answer of the Secretary of State at the Ministry of Health – authorized by the minister – to the interpellation no. 23091 on the plans to liquidate the institution of a family medicine physician]. Published on 9 January; 2014. Available at: http://www.sejm.gov.pl/Sejm7. nsf/InterpelacjaTresc.xsp?key=5C23E6A1.

[24] Secretary of State at the Ministry of Health. Odpowiedź A sekretarza stanu w Ministerstwie Zdrowia – z upoważnienia ministra – na interpelację nr 22636 w sprawie planowanej nowelizacji ustawy o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych [Answer of the Secretary of State at the Ministry of Health – authorized by the minister – to the interpellation no. 22636 on a proposed amendment to the Act on Healthcare Services Financed from Public Sources]. Published on 23 December; 2013. Available at: http://www.sejm.gov.pl/Sejm7. nsf/InterpelacjaTresc.xsp?key=5A51AB4F.

[25] Tomasik T. Back to red: allowing specialists to provide primary care would be a step backward for Poland. BMJ 2014;348.

[26] Windak A, Oleszczyk M. Poland case study. In: Kringos DS, Boerma WGW, Hutchinson A, Saltman RB, editors. Building primary care in a changing Europe. Case studies. Observatory Studies Series. European Observatory on Health Systems and Policies, a partnership hosted by the WHO Regional Office for Europe; 2015.

[27] WHO Regional Office for Europe. European health for all database (HFA-DB); 2015. Updates September 2015, [accessed on 24.09.15].