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OCCUPATIONAL AND ENVIRONMENTAL HEALTH POLICY

POLISH APPROACH TO THE QUALITY ASSURANCE SYSTEM IN OCCUPATIONAL HEALTH SERVICES

JANUSZ A. INDULSKI, LECH T. DAWYDZIK and JACEK MICHALAK

The Nofer Institute of Occupational Medicine
Łódź, Poland

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Abstract. The most important factors which influence the quality of Occupational Health Services in Poland are discussed. The legal regulations, the system of specialists education, guidelines and standards in occupational medicine, and the role of regional specialists supervision system are presented. The audit of medical documentation revealed the 'sub-populations' of doctors who are concerned about the quality and those who are not. Keeping relatively moderate prices of services by some OHS units, even at the cost of their quality, has become a side-effect of competition. The establishment of an accreditation system in OHS is postulated, basing on the existing elements of such a system.

INTRODUCTION

The quality of occupational health services has become in Poland a very important issue, especially during the last few years. The belief that competition is a sufficient mechanism to improve quality in health care, is now replaced by different opinions and activities. A brief overview of such an approach is the aim of this paper.

BACKGROUND

The transition of the socio-economic system in Poland has lasted over 9 years. It is a continuous process, which has been taking place at different levels and in different fields, so one may observe at the same time both, old and new, mechanisms and regulations. Occupational health services (OHS) in Poland consist a sub-system of the national health care system (NHCS). However, there are significant differences

Address reprint requests to Prof. J. Indulski M.D., Ph.D, The Nofer Institute of Occupational Medicine, P.P. Box 199, 90-950 Łódź, Poland.

between them, as the national health care system was built in the 1950s and the 1970s, and occupational health services are being now reconstructed from the industrial health care, on the ground of market economy. The present state of OHS in Poland was described elsewhere (4).

On the other hand, a kind of co-habitation is observed between OHS and NHCS, as both are regulated by common legal acts. The Occupational Health Services Act, that came into force on January 1, 1998, is an additional regulation governing OHS only.

It should be mentioned here that according to the Labour Code each employee must undergo the prophylactic examinations performed by an authorised doctor. Costs of examinations are covered by the employer.

LEGAL REGULATIONS

The issues on health care organisation and health-related problems are placed in almost 150 different legal regulations, including parliamentary bills and orders issued by the Minister of Health and Social Welfare. Different acts have been adopted in varied times, in different political and economical systems, but all these acts are still in force. Sometimes, the regulations are even in conflict one with another, mainly due to long lasting procedure required for passing a new act through Parliament. However, it puts an individual OHS unit in a very complex situation. The most important acts are mentioned here, but one should remember that many other regulations may have an indirect impact on the activities and the quality of OHS.

The legal base on which all health care institutions (HCIs) rest is the Health Care Facilities Act (1991). According to its provisions a health care institution may be public (established and run by the government or local authorities) and non-public (owned by foundations or private sector). The costs of services in the former are covered from the state budget, while a non-public HCI may contract its services with different clients at their own cost. So the competition exists mainly among non-public HCIs.

OHS consist of two levels, at the primary level different forms of organisation and practices may function if the authorised doctors are performing the examinations. At the regional (voivodship) level there are only public HCIs one in each region, named Voivodship Occupational Medicine Centres (VOMC), equipped with the power to control all primary level units. Regional HCIs are also responsible for consulting doctors at the primary level, as well for the education of medical personnel in the region.

The Health Insurance Act, regulating mainly economic issues and organisation of the health insurance system, will come into force on January 1, 1999. This act assumes that all health care institutions will compete one with another for the contracts with the health insurance.

The Health Care Facilities Act commits the Minister of Health and Social Welfare to establish the quality standards and requirements for health care institutions. The Minister of Health and Social Welfare is obliged:

1. to lay down medical procedures and standards,
2. to define minimum number of personnel in different kinds of HCIs and different hospital departments,

3. to establish the Accreditation Council,
4. to set quality standards for medical equipment,
5. to establish methods for controlling health care institutions.

To date only the anesthesiological standards have been regulated by the Minister of Health and Social Welfare. In other medical disciplines the discussion on medical standards has not as yet been completed.

The exception in this respect are OHS, but their standards do not result from the Health Care Facilities Act. The OHS are also an exception in the Polish health care system regarding the extent and rate of the reforms. They have been gradually transformed since 1991 and step by step significant changes have been implemented along with the development of relevant legal regulations:

1. Health Care Facilities Act (1991),
2. Amendments to the Labour Code (1991, 1996),
3. Medical Professions Acts (1995, and 1996),
4. Profession of Physician Act (1997),
5. Health Insurance Act (1996),
6. Occupational Health Services Act (1997),
7. Economic Activity Act (1988),
8. Instruction of the Minister of Health and Social Welfare on the specialist supervision system (1982),
9. Instruction of the Minister of Health and Social Welfare on the prophylactic examinations (1997).

These acts enabled the incorporation of the elements of free market economy into the health care system. The provisions of the Economic Activity Act allowed the establishment of private health care units, the Health Care Facilities Act introduced non-public health care units, the Labour Code Amendments committed employers to cover the costs of the prophylactic examinations, and it introduced the post of an authorised physician into OHS (2,7).

SPECIALISATION IN OCCUPATIONAL MEDICINE

Education is one of the factors which make a tremendous impact on the quality of health services. At present the post of an authorised physician may be obtained by a doctor only through the specialisation in occupational medicine. There are two degrees of specialisation in occupational medicine in Poland. The first degree can be completed after at least two years of postgraduate education. This includes a 300-hour course of lectures and seminars on: occupational hygiene, physiology of work, occupational clinical pathology, toxicology, occupational diseases, health care organisation etc. The rest of time is spent by a doctor on practical training in outpatient clinics, occupational medicine departments or wards. Each candidate applying for specialisation must pass a foreign language examination and prepare a dissertation on a selected topic. The postgraduate training is conducted individually by a specialist supervisor. The specialisation examination consists of practical and theoretical components.

The scope of the second degree postgraduate education is basically similar, but the extend of seminars and practical training is broader. The main difference, from a practical point of view, is a three-year period of different practical training. In Poland specialists in occupational medicine total about 3 000 persons and the number of

physicians who are willing to get this specialisation rises systematically every year. It should be remembered that in 1997 the total number of authorised doctors was around 8 000, including 5 000 physicians who had received authorisation before 1996 on the basis of their at least 6 years of experience in occupational medicine. Letting the physicians without specialisation enter the system was recognised as a temporary price for the transition from industrial health services to OHS.

GUIDELINES AND STANDARDS IN OCCUPATIONAL MEDICINE

Guidelines for occupational medicine have been published in the Instruction of the Minister of Health and Social Welfare on the prophylactic examinations. Standards for the prophylactic examinations depend on the kind of hazardous agents at the workplace.

The prophylactic examination (pre-employment or periodic one) cannot be performed by any authorised doctor unless the employer provides him/her with full information on the working condition of a given employee at a given workpost. If any kind of hazardous factor is present at the work post, the employer is obliged to get the current results of measurements of this factor. Measurements can be done by any of the occupational hygiene laboratories which are under supervision of the State Sanitary Inspection. These laboratories must fulfil the standards established also by the Minister of Health and Social Welfare. The validation of these laboratories is performed periodically. The majority of the occupational hygiene laboratories are placed in Departments of Occupational Hygiene at the State Sanitary-Epidemiological Stations. The costs of measurements are covered by the employer.

The list of harmful factors contains the following groups:

A. 14 groups of physical factors (noise, ultrasounds, vibration etc.),
B. 9 groups of industrial dusts (silica, asbestos, etc.),
C. 53 groups of toxic compounds (chemical substances),
D. 6 groups of biological factors (HBV, bacteria, fungi etc.),
E. 8 groups of other factors (psychosocial factors, stress, shift work etc.).

Also the following factors may be placed in the above mentioned groups:

A. carcinogenic agents,
B. probably carcinogenic agents,
C. allergic substances,
D. enotoxic/teratogenic agents.

Depending on the factor(s), the guidelines indicate the kind of examination (general, general with special reference to an organ/system, specialist consultation required) and laboratory tests to be performed in a given case. In some conditions also exposure test should be performed. This is usually done in patients exposed to lead.

The standards for prophylactic examination define the minimum range of medical examinations performed by an authorised doctor and the kind of consultations which have to be performed by an appropriate specialist. This can be extended by a doctor, depending on his/her assessment of the patient's health status.

The minimum frequency of prophylactic examinations is also established in the Instruction of the Minister of Health and Welfare. As a rule, in regard to the majority of factors examinations should be performed every 2–3 years, in some

cases (CS_4 or asbestos) even every year. Minimum frequency means that the doctor is not allowed to prolong this interval, but depending on the health status of an employee, the inter-examination period may be shortened. The selected examples of guidelines are presented in Table 1.

Table 1. The selected examples of guidelines

Factor	Pre-employment examination		Periodic examination		Frequency of examinations
	medical	laboratory	medical	laboratory	
Low frequency ultrasounds	general laryngological	audiometry (125–8000 Hz),	general laryngological	audiometry (125–8000 Hz),	every 2 years
CS_4	general neurological	cholesterol triglycerides glucose ECG	general neurological ophtalmological	cholesterol, triglycerides, glucose ECG, EEG, peripheral nerves conductance psychological consultation	every 2–3 years

THE ROLE OF REGIONAL SPECIALISTS

It must be forgotten that the problem of quality of the Polish medical services has been invented over a period of the last few years. The tradition of different forms of quality assessment reaches over 40 years in Polish laboratory medicine. Also the supervision system had been implemented in Poland under the former political system. However, one should recognise the differences between 'anatomy' (i.e. the structure of specialist supervision system) and 'physiology' (i.e. a real function of such a system).

In the Polish health care, the quality of medical services has been attributed mainly to the functioning of the specialistic supervision system which has not been changed since 1982. The following three levels of specialists can be distinguished: national, regional and voivodship. These specialists are appointed by the Minister (at the national and regional levels) or by the voivods (at the voivodship level). There are 33 medical specialties, including occupational medicine, in which the national, regional and voivodship specialists have been appointed. Accordingly, for each specialty there is one national specialist, 10 regional specialists and 49 voivodship specialists. Their responsibilities are extensive, but the resources they have at their disposal are relatively limited. The duties of the national, regional or voivodship specialist are usually highly time consuming and the specialists are already occupied with their main jobs at the university clinics or regional hospitals. Thus in fact, the status of the specialist is something like a part-time job, besides a badly paid one. However, some of the specialists and the managers of several hospitals have come to the conclusion that the quality of services may be of value when applying for contracted work in the health insurance system.

The personality of an individual regional specialist may play, at present, the most important role in different forms of improving the OHS quality. Basing on the preliminary investigations it seems reasonable to assume that the active regional specialist play a crucial role in the quality assurance (5). There are important

activities in the field of organisation, education and control which may contribute to an indepth transformation of OHS in a region. On the other hand, it is impossible to built the system on personalities of single people. The more stable and long-lasting base is needed here.

AUDIT OF DOCUMENTATION

According to the results of our investigation on the quality of OHS the most significant problem is the quality of medical documentation. Poor quality of information obtained from different OHS units prompted us to establish new forms of documentation. Later on, the audit of documentation has been implemented in selected OHS units (7). These activities resulted in a marked improvement of the documentation quality. However, the quality of documentation of individual doctors has been well differentiated. One can find the 'sub-populations' of doctors who are concerned about the quality and those who are not. At present, it is difficult to establish the actual proportion of these 'sub populations' as they are changing and it is too early to obtain the objective results.

FREE MARKET MECHANISMS AND THE QUALITY OF OHS IN POLAND

At present, the OHS personnel consists of authorised physicians (service providers) who render a required scope of prophylactic services, employers (purchasers and clients) covering the costs of examinations, and the employees who are clients of OHS, according to official standards. Thus, almost all the elements which are necessary for the implementation of the quality assurance methods have been developed in the Polish OHS.

The general belief that the competition will improve the quality of services was shared by the majority of physicians and patients in Poland in the mid 1990s (6). And it was true at the beginning. Starting from the low level quality, especially in outpatient clinics, the slightest improvement in the quality of services resulted in enormous increase in the patients' satisfaction rate. For example over 80% of patients in a big city were fully satisfied with newly implemented general practices as compared with 52% of patients who were not satisfied with the previous forms of primary health care (1).

The changes in the structure and financing of the occupational health services in Poland may have an impact on the quality of services. At present, according to the general opinion, shared also by the State Labour Inspectorate, a remarkable proportion of OH services is of a relatively poor quality, it is estimated that as much as 50% of services failed to reach the satisfactory level.

It seems reasonable to suggest, as the current data are not available, that free-market economy in occupational health care exerts divergent effects on the quality of services, but it is hard to establish these effects without long-term investigations. At present only partial data can be obtained (3).

PERSPECTIVES FOR FUTURE

Within the next two years profound changes are expected in Poland: the restructuring of the state administration, the reduction in the number of voivodships,

the development of a two-level self-government (instead of one level), and the implementation of a new social insurance system and the health insurance system. Each of the above changes must influence the health care including OHS.

It is also expected that the competition among OHS units may result in the need for some kind of the OHS accreditation. Also the increasing role of employers and the representatives of employees should be expected in terms of the OHS quality assurance. The knowledge of employers is continuously increasing, and more and more of them know what they should get for their money.

The future role of Voivodship Occupational Medicine Centres is still to be established. At present, more profitable for an authorised doctor is to work at the primary level (and to be paid by the clients – employers) than to work as a consultant in a VOMC. This results in transferring well educated specialists from a higher to a lower level of the occupational health care system. Nevertheless, OHS in Poland seems to be the most active and the most effective part of the health care system.

CONCLUSIONS

1. The quality of occupational health services in Poland has become a more and more important issue for both, public and non-public health care institutions and individual doctors as well.

2. The Polish approach to the quality assurance in occupational health services is based on a well developed legal basis, a relatively good system of education of specialists, and the implementation of different tools for quality improvement. However, the results has not as yet been fully satisfactory. More time is needed for getting tangible results.

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