

# LEGAL REGULATIONS ON OCCUPATIONAL HEALTH SYSTEM IN POLAND

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**Abstract.** Occupational health care has a long tradition in Poland. It has evolved from the industrial health care system established in the post-war period to a modern system defined in the Occupational Health Services Act of 1997.

When the process of political and economic transformation began in Poland in 1989, the reforms of the workers' health care became inevitable. The process of introducing and implementing new legal regulations comprised three phases:

1. Introduction of amendments to the Polish Labor Code, according to which employers are now committed to provide their workers with occupational health services (OHS) appropriate to given working conditions.
2. Incorporation into the 1991 Health Care Institutions Act the provisions which allow for the establishment of alternative non-public structures responsible for the health care of the working population.
3. Adoption of the Occupational Health Services Act in 1997, the most important law providing grounds for establishing a most comprehensive system of occupational health services.

The Occupational Health Services Act introduces, for the first time, the concept of the OHS system that encompasses the whole working population. The Act outlines a broad range of OHS competences; defines individual tasks; and provides the up-to-date definition of the OHS structure with its two organizational levels, consisting of primary and regional occupational health centers. In addition, the Act specifies the sources of finance for the accomplishment of the defined tasks. Pursuant to the provisions of the Act, OHS units co-operate with employers and employees, bodies supervising working conditions and other organizations involved in occupational health that become their partners in activities aimed at protecting and promoting health of workers.

In order to further develop the workers' health care system its constant adaptation to changing conditions is absolutely necessary through:

- developing modern training for specialists in the field of occupational medicine;
- establishing an efficient system for controlling the quality of services provided by the occupational health care centers; and
- implementing more effective forms of health protection and promotion at workplace, especially for those self-employed.

**Key words:**

**Occupational health, Occupational medicine, Occupational health system**

## LEGAL REGULATIONS ON OCCUPATIONAL HEALTH CARE IN POLAND

Occupational health care represents medical aspects of a general, interdisciplinary system for protecting the health of the working population. A large number of elements contained in the employer-employee relationship play a significant role in strengthening or maintaining workers' health, these include: standard working hours, the guar-

antee of adequate rest, technical safety conditions, and occupational hygiene standards. Initiatives aimed at identifying health risks associated with particular working conditions and job performance; possible modifications and improvements of these conditions to reduce the health risk; efforts to combine these initiatives with the assessment of the employees' state of health and the development of preventive programs, and if necessary, medical

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interventions are of paramount importance [1]. All these activities require specific professional qualifications of the personnel involved, which justifies the establishment of separate organizational structures.

Occupational health care has a long tradition in Poland whose origin dates from the initial forms of organized medical care for employees developed in parallel with the appearance of first large factories. At that time, not much was yet known about the issues known now as “occupational pathology”, although the experience of both physicians and factory owners implied the necessity to provide certain forms of health care for those with work-related health impairments or injured due to accidents at work. The more concentrated industry in certain areas of the country and growing competition, including the competition between employees for attracting better qualified workers, the better it was understood that acting for the worker’s health protection increases both the production capacity and the quality of work.

The organizational principles of the workers’ health care [2] set in the aftermath of the war and implemented by industrial health care centers provided for:

- obligatory establishing of clinics at large (more than 1500 employees) enterprises of the public sector, practically a governmental monopoly in the branches of the national economy identified by political propaganda as leading ones, like the construction and transport industries. The workplaces were made responsible for ensuring the infrastructure necessary for the industrial health care system, and the health care sector for providing the indispensable medical personnel;
- ensuring that employees of small enterprises had access to consultations provided by occupational medicine centers to be organized within each district out-patient clinic (later in the integrated health care center) for the general public use;
- combining preventive and curative medicine.

It should be stressed that these provisions have in fact never been fully implemented. Of all workers employed, only one-third of them were covered by the system, and in over 50% of integrated health care centers occupation health units were not organized so workers not covered by

the industrial health care were deprived of professional preventive care.

In the 1970’s and 1980’s, that is during the period of its greatest development, the industrial health care covered almost 6.3 million individuals (including workers currently employed and those retired or on the disability pension) of a total of near 12 million urban workers and 6 million individual farmers. About half of those covered by the industrial care satisfied all their primary health care needs within this sub-system. This fact illustrates the extent to which the industrial health care system relieved other primary health centers from the burden of providing primary care.

When the process of political and economic transformations began in Poland in 1989, the national health care system faced a dilemma as to the direction of fundamental reforms. The transformation meant that the existing sub-system was not able to keep up with new problems and challenges. It soon became clear that the model developed for the needs of a centrally planned economy, and controlled by the state administration could not be adapted to market economies.

Planning occupational health care reform, a double challenge had to be met. On the one hand, it was necessary to formulate answers to problems adequate to a new economic situation, characterized by unrestrained initiatives and freely chosen solutions, independent of economic entities, and governed by free-market rules of the game. On the other, there was an urgent need to convince the Polish medical profession that new ideas defined by the profession itself and oriented exclusively towards prevention to protect the health of employees, and not simply devoted to curative medicine are required.

Looking chronologically, we can distinguish several phases in the process of occupational health care reform [3]:

1. The first important step was the amendment made to the Polish Labor Code. According to it, the former commitment of employers to establish and maintain health care structures (industrial health centers), was replaced by free market rules, namely by the duty to purchase health care services appropriate to given working conditions. Thus, employers are now responsible for:

- conducting (at their own cost) tests and measurements of harmful agents present in the workplace (in place of the former obligation to create internal laboratories or have these measurements performed by the laboratories of the State Sanitary Inspectorate - at the state cost);
- informing employees about the work-related health risks and the results of the measurements concerning harmful agents (this information is no longer considered confidential);
- permitting only those employees to work in certain working conditions who can present a valid medical certification stating the absence of any contra-indications to perform a given kind of job;
- covering the costs of prophylactic examinations (in place of the former obligation to establish and maintain internal health care units in enterprises that employ more than a certain number of workers).

These innovations took account of the opinions presented by the Polish Occupational Medicine Association and the Nofer Institute of Occupational Medicine in Łódź.

2. The Health Care Institutions Act adopted on 30 August 1991 is regarded as another extremely important event. This Act, among others enabled the employers to play the role of a founding body for health care institutions.

The Act provided the ground for introducing alternative organizational structures with a complete freedom of their choice. It is allowed now to establish an organizational structure serving the founder's own needs. The founder can at the same time sell services to other parties or purchase them "from outside". The new regulations allowed for the privatization of occupational health care centers.

The introduction of a rule that prophylactic examinations of workers can be carried out only by physicians with appropriate professional qualifications, that is by occupational health physicians is of key importance since it enhances the quality of these kind of examinations. At the same time it stresses the rank of occupational health specialization as the only way to become authorized for providing such examinations. A set of transitional (up to 1995) and less rigorous requirements for doctors performing prophylactic examinations were also introduced (at least a

6-year experience in the former industrial health care, completion of a special qualification course, etc.).

The introduction of a "prophylactic certification" evoked certain criticism in some groups of the medical profession, as it was considered as a restriction imposed on physicians not specialized in occupational medicine. This misunderstanding probably results from both a generally low status attributed by the profession to any kind of prophylactic examinations and a lack of awareness that examination of workers (preplacement, periodical, and control) is aimed not only at checking the state of their health, but also at assessing the organic abilities to perform the job under specific conditions. Such an assessment requires professional knowledge and skills in the field of work hygiene and occupational pathology.

The fundamental significance of the provisions of the aforesaid Act lies in the creation of a particular precedent: for the first time in Polish health care legislation a defined range of responsibilities was assigned to an individual, a physician of a defined specialization, regardless of his or her place of employment and kind of practice performed.

3. The restructuring of the occupational health care system was completed by the introduction of the Occupational Health Services Act, adopted almost unanimously by Parliament in June 1997. The provisions of the Act brought to Poland the regulations applied in European Union (EU) member states, primarily through its compliance with the conventions (No. 155 of 1981, and No. 161 of 1985) of the International Labour Organization (ILO) [4] and EU directives (particularly Directive No. 89/391/EEC)[5] Thus far, this is the only such a legislative initiative in this field undertaken in the countries of central and eastern Europe (CCEE).

It is worth drawing attention to the most important concepts adopted in this Act:

**The concept of occupational health services.** The term "occupational health services" (OHS) was adopted in the Act as a name of a new organizational system defined as bringing together doctors, nurses, psychologists, and specialists in other professions "...with the aim to protect workers' health against noxious effects of the work envi-

ronment and the consequences of the way the jobs are performed, and to provide preventive care ...”.

The occupational health services system understood according to this definition is to serve all employees, regardless of the location and nature of their employment, differentiated only in the range and forms of activities determined by the workers’ state of health and occupation-related health risks. It should be stressed that due to such a formulation of the aims, the Act has been extended beyond the provisions of the Labor Code, which applies only to those who perform work on the basis of an labor contract or relevant forms of employment

Thus the OHS system has been formally opened to the “self-employed”, namely small-business owners who run it at their own risk, and according to their own concepts on how a workplace should be arranged (with only very few restrictions). It is an open secret that working conditions and job performance in self-owned business are often very bad, and we mostly learn about unhealthy conditions in case of accidents at work. It may be presumed – as there are no statistical data in this regard – that a large number of accidents occurring “at home”, known as “consumer’s accidents”, occupying the first place on the list of all accidents, may in fact be related to such situations.

**The tasks of occupational health services.** The OHS tasks have been thoroughly defined. First of all they include preventive medicine in the form of prophylactic examinations for employees and specific health care required due to certain working conditions, they also encompass:

- primary prophylaxis to identify and assess working conditions;
- expertise on how to improve working conditions addressed to partners responsible for the work process;
- analysis of changes in the state of health of the population covered by the OHS system.

Unlike the former health services legislation, the tasks specified in the Act are not compulsory, which means that they are not obligatory for all health care providers and those who receive occupational health services. The range of tasks indicates the competence of OHS. To this end, it defines the offer of possible and desirable services. A real

spectrum of services provided should be composed of freely-chosen individual activities in health care settings as a resultant of competences of occupational medicine personnel, their technical and co-operative facilities, and the demand for specific type of services and the choice made by workers (consumers) who carry financial means.

**The structure of occupational health services.** The structure of occupational health services was designed using new ideas. It is now a two-level structure with primary and regional occupational health centers.

Primary occupational health centers are completely free as far as their organizational structure is concerned. This applies firstly to physicians with adequate qualifications (certifications) who decide themselves on how the occupational health tasks are accomplished, either they accept employment in a health care institution whose statute encompasses this kind of activities, or they run their own practice. Health care institutions, public or private, including those established by employers with the aim to provide preventive health care at a workplace are also classified in the group of primary centers.

The concept of recognizing an individual physician with adequate qualifications as an element of the organizational structure of the system is something of novelty in the Polish tradition of health care organization.

All primary health care centers despite their varied organization are equipped with a uniform range of responsibilities and rights. They are subjected to registration, professional and specialist surveillance typical of the Polish health care system. In this field the Occupational Health Services Act was exceptional with respect to all previous legal regulations, which up till now applied only to health care institutions.

Contrary to the pluralism at the primary level, the uniform OHS organizational structure at the regional level is obligatory. This is a public health care institution established by a regional self-government, and thus is an instrument for the state intervention in the free-market health care system for the working population.

Regional centers of occupational health services are responsible for:

- inspecting and monitoring primary centers;

- providing primary centers with expert advice and supporting them in their activities; and
- providing post-graduate education.

**Finance for occupational health services.** The Act specified the sources of finance for individual OHS tasks with a clear indication which of these tasks result from the responsibilities of a service purchaser, for example from the responsibility of the employer with respect to the employee, already specified in the Labor Code, and which of them can be paid by a client. The latter indicates that the occupational health care of the self-employed is provided on the purchase basis. Services can be purchased in any OHS centre by clients with their own financial means.

**The role of occupational health services in the system of health care of the working population.** Pursuant to the provisions of the Act, OHS centers are not only an integral part of the health care system (health services) but also an element of the workers' health care system, respecting at the same time the inter-sectoral structures, the links between them, differentiated activities and their individual responsibilities. Bearing this in mind, the areas of co-operation, and what is even more important, the range of mutual responsibilities and forms of co-operation between OHS centers and individual partners are laid down in the Act. In particular, these applies to:

- employers and employees (and organizations representing these groups);
- inspectors active in the occupational settings (the State Labour Inspectorate, the Sanitary Inspectorate, and sectoral inspectorates);
- other institutions and organizations involved in protecting and promoting workers' health.

The recommended fields of the co-operation between the OHS personnel, general practitioners and other primary health care centers, operating in the patient's residential area deserve special mention.

The whole set of legal regulations concerning occupational health care is considered as one of the most important phase of the structural reform. The implementation of these regulations allows for the development of the designed infrastructure of the system and its effective

operation, especially at the primary care level. That is quite obvious that this is only a beginning, and a number of problems still remain to be solved. The present state of health of the working population indicates that further profound changes are required, particularly in regard to the establishment of interaction mechanisms, but this applies not only to Poland. The difficulty lies in the fact that no system of occupational health care that could be directly transferred to Polish conditions does really exist in the world, and each country tries to find the best possible solution. Of course, the possibility of adapting foreign systems differs, depending on a particular problem. Nevertheless, all these observations highlight an urgent need for the international exchange of information and experiences.

The identified problems which require urgent changes may be characterized as follows:

■ Thus far the occupational health care system has been targeted at workers employed on the basis of a labor contract. The present model of economic development in the developed countries relies to a great extent on owners and co-owners of units engaged in economic activities, including helping members of their families (so called "the self-employed"), in which the traditional employer-employee relationship does no longer exist. This kind of business is already on the increase in Poland. At present there are about 3 million farmers and 2.5 million owners of small and medium-sized enterprises (who take the position of employers, and thus are deprived of occupational health care provided for in the Labor Code). There is no doubt that the work performed by these groups brings about health hazards, while the preventive procedures applicable to workers employed on the basis of a labor contract cannot be used.

■ The distinction between an "organized" employment and that outside a conventional workplace gradually disappears. A truck driver, a salesman or another person using a computer, providing services or engaged in the production, often in the place of residence, may serve here as examples. The fact that accidents at home, according to the statistical data, outnumber now the road accidents and accidents at work provides evidence that the



problem is becoming more and more serious and should be tackled in a quite innovative way.

■ It has to be remembered that new technologies and developments in many branches of the national economy induce new work-related health hazards. This applies in particular to the excessive mental load and stress, as well as to the application of the ergonomic principles at workplaces. It is essential to develop methods for identifying and diagnosing these new hazards and ensure adequate preventive measures.

■ The above-mentioned disappearance of the distinction between an “organized” employment and work performed on one’s own account, gradual replacement of conventional workplaces by those “self-organized”, and new health hazards encountered in the occupational settings have changed the pattern of occupational pathologies. The distinction between diseases identified as those induced by the occupational exposure (now known as “occupational diseases”) and diseases usually occurring in the general population has become less and less visible. The problem of diseases defined now as “paraoccupational diseases” or “work-related diseases” is still growing, and it is most likely that in the near future it will become even more serious. The lack of adequately sensitive methods for identifying these pathologies and defining the relationship between their occurrence and the kind of job and the way it is performed is an essential drawback.

It is now quite clear to all of us that the detrimental health effects of work (obviously, in the context of the cause-effect relationship) must not only be dealt with by the occupational health care system but also be reflected in the health policies adopted by individual countries. This is a difficult issue, as detrimental health effects should also be related to unemployment, not only in terms of better recognized effects of this phenomena, but also in terms of excessive stress induced by fear of losing the job. The problem of the occupational health care and its significance is closely related to the social and economic aims of every country, and it is of particular importance in the countries characterized by long life expectancy and consequent aging of the population. This results in the proportional, or in some countries, absolute decrease in the

number of employees who produce the gross national product distributed finally among the whole society, including children not yet employed, and the aged or disabled who already stopped working. Poland has recently been challenged to this problem. Just in reducing the number of disable pensioners (people who untimely lost their ability to work) lies the economic rationale for developing an efficient occupational health care system.

It is our feeling that the following objectives will serve this purpose:

■ The organization of modern program of specialized education in the field of occupational medicine.

In 2000, a fundamental reform of medical specialization took place. A two-grade specialization was replaced by only one-grade specialization, possible to obtain after completing an organized process of education provided by accredited educational institutions and passing the final state examination.

Occupational medicine has remained a basic specialization, which creates special requirements as to the proper content of a five-year program of specialization studies. However, in our opinion, this process will not be complete if it is not preceded by introducing basic knowledge of occupational medicine to the curriculum of undergraduate medical studies.

■ The establishment of an effective system for monitoring the quality of occupational health services.

At the present, relatively early stage of establishing the system of quality assessment within the Polish health care system, a significant disproportion between the advancement of activities concerning the in-patient (hospitals) and out-patient medical care, to an advantage of the former, can be observed. The essence of the problem is in the methodology, as it is easier to formulate different approaches to group structures than to individual initiatives [6].

The current advancement in developing the occupational health care system expressed by the explicit definition of qualifications required of occupational medicine physicians and nurses, the introduction of new medical documentation, and first of all by the implementation of prophylactic standard procedures, adjusted to identified kinds and levels of occupational exposure, provide an

excellent ground for further developments in which we anticipate the accreditation of occupational health care service providers.

■ The development of more effective measures to support health care at large, including health care of those self-employed. We intend to look for solutions in the modification of social insurance regulations, taking advantage of the opportunity created by the separation of contributions to accident and illness insurance (do not confuse with health insurance) of workers. The proposed changes should provide the self-employed with the opportunity for individual insurance against detrimental health effects potentially related to their working conditions, introducing at the same time certain incentives (reductions in contributions) to encourage them to improve their own working conditions.

This is our program, its implementation is facilitated by the changes already introduced to the legal and formal regulations concerning health care of the working population in Poland.

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