

# Strengthening nursing in primary care in Poland



WHO European Framework  
for Action on Integrated  
Health Services Delivery



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WHO European Centre for Primary Health Care  
Health Services Delivery Programme  
Division of Health Systems and Public Health



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## Abstract

This report describes the findings of an assessment that explored ways to optimize the role of nurses in the context of ongoing primary care reforms in Poland. The burden of noncommunicable diseases and the ageing population in Poland have put strains on health services delivery. Since 2016, Poland has sought to strengthen primary care to tackle these trends. Opportunities for a more prominent role of the nursing workforce in primary care and for interprofessional work, supported by enabling education, accountability arrangements and financing mechanisms, are identified as needed future policy directions.

## Keywords

NURSING  
DELIVERY OF HEALTH CARE  
HEALTH SERVICES  
PRIMARY HEALTH CARE  
QUALITY OF CARE  
POLAND

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# Contents

Abbreviations	v
List of figures and boxes	v
Acknowledgements	vi
<b>Background</b>	<b>1</b>
<b>Methods</b>	<b>2</b>
<b>Current burden of diseases</b>	<b>4</b>
<b>Services delivery performance</b>	<b>7</b>
<b>Relevant primary care policies and players</b>	<b>8</b>
<b>Human resources in primary care: challenges and opportunities</b>	<b>10</b>
System capacity	10
Clinical practice	11
Governance	12
<b>Assets for strengthening nursing in primary care</b>	<b>14</b>
<b>Policy recommendations</b>	<b>15</b>
<b>References</b>	<b>18</b>

## Abbreviations

OECD	Organisation for Economic Co-operation and Development
WHO	World Health Organization

## List of figures, tables and boxes

<b>Figures</b>		<i>Page</i>
Fig. 1	Overview of the European Framework for Action on Integrated Health Services Delivery	3
Fig. 2	Cardiovascular diseases and cancer in Poland, 2014	4
Fig. 3	Top 10 causes of years of life lost in 2017 and percentage change since 2007, for all ages in Poland	5
Fig. 4	People aged over 65 years in Poland overtime	6
Fig. 5	Avoidable hospital admissions in Poland, 2017	7
Fig. 6	Share of different categories of doctors, 2016 (or nearest year)	10
 <b>Boxes</b>		
Box 1	Ten proposed changes to primary care in Poland	9

## **Acknowledgments**

This work is the result of the shared commitment of the Ministry of Health of Poland and the World Health Organization (WHO) Regional Office for Europe, through the WHO European Centre for Primary Health Care in Almaty, Kazakhstan, in the context of the biennial collaborative agreement.

The Minister of Health of Poland, Łukasz Szumowski, the Deputy Minister Józefa Szczurek-Żelazko, and the Director of the Department of Nursing and Midwifery Beata Cholewska with her senior staff contributed, supported and provided helpful insights during the assessment. Valuable input was received from representatives of the following organizations, providers and development partners (in alphabetical order): Centre for Postgraduate Education of Nurses and Midwives; Centrum Medyczo-Diagnostyczne; Department of Nursing and Midwifery; Institute for Management in Health Care; Lazarski University; Medical University in Lodz; Health Insurance Fund; National Trade Union of Nurses and Midwives; Polish Midwives Association; Polish Nursing Association; Supreme Council of Nurses and Midwives; Urszula Jaworska Foundation; and the World Bank.

The WHO Country Office, led by Paloma Cuchi and her team, comprising Dominika Miecznikowska and Anna Ksiazek, provided valuable insight and coordinated the whole assessment.

The work has been made possible by the support of the Government of Kazakhstan through the WHO European Centre for Primary Health Care in Almaty, Kazakhstan.

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# Background

Recent health system reforms in Poland have placed a sharp focus on primary care. A series of measures introduced over the course of 2016 and a primary care law passed in 2017 proposed transformative changes to the way primary care is delivered across the country to respond to people's needs in an integrated way.

These services delivery transformations involve, for example, prioritizing health promotion, population health management, care coordination and working in interprofessional teams to implement and monitor treatment plans for people with complex conditions. These emerging tasks have been associated with the nursing profession in the context of regional and global policies (1,2). Implementation will ultimately require the development of new skills and the existing nursing skills to be applied in new ways.

An assessment took place in November 2018 to identify ways in which to optimize the role of nurses to strengthen their scope of practice in the context of the ongoing primary care reforms. The assessment was requested by the Department of Nursing and Midwifery at the Ministry of Health of Poland.

The background and methods of this report are followed by five main sections. The first section presents the burden of diseases in the country. The second section provides a brief of patient-reported health status and performance of primary care by analysing hospital admissions for ambulatory care sensitive conditions. The third section describes the policy context and actors relevant to the health workforce. The fourth section summarizes major health system challenges with a focus on challenges and opportunities for human resources and the strengthening of nursing. The fifth section describes possible policy directions.

# Methods

This assessment draws on interviews and conversations with key stakeholders during a visit in November 2018. The stakeholders were identified by the Ministry of Health. The assessment used a multi-pronged approach consisting of a desk review of key documents related to nursing and primary care developments, a workshop and targeted interviews with policy-makers and representatives of patients and other nursing-relevant stakeholders. This approach allowed the assessment team to develop key recommendations on how to optimize the engagement of nurses and midwives in primary care.

The workshop included participants from the Supreme Council of Nurses and Midwives, the National Trade Union of Nurses and Midwives, the Centre for Postgraduate Education of Nurses and Midwives, the Polish Nursing Association, the Polish Midwives Association, the Medical University in Lodz, a national consultant in the field of nursing, the Health Insurance Fund, the Department of Nursing and Midwifery, the Urszula Jaworska Foundation, the Institute for Management in Health Care, Lazarski University, and the Centrum Medyczno-Diagnostyczne.

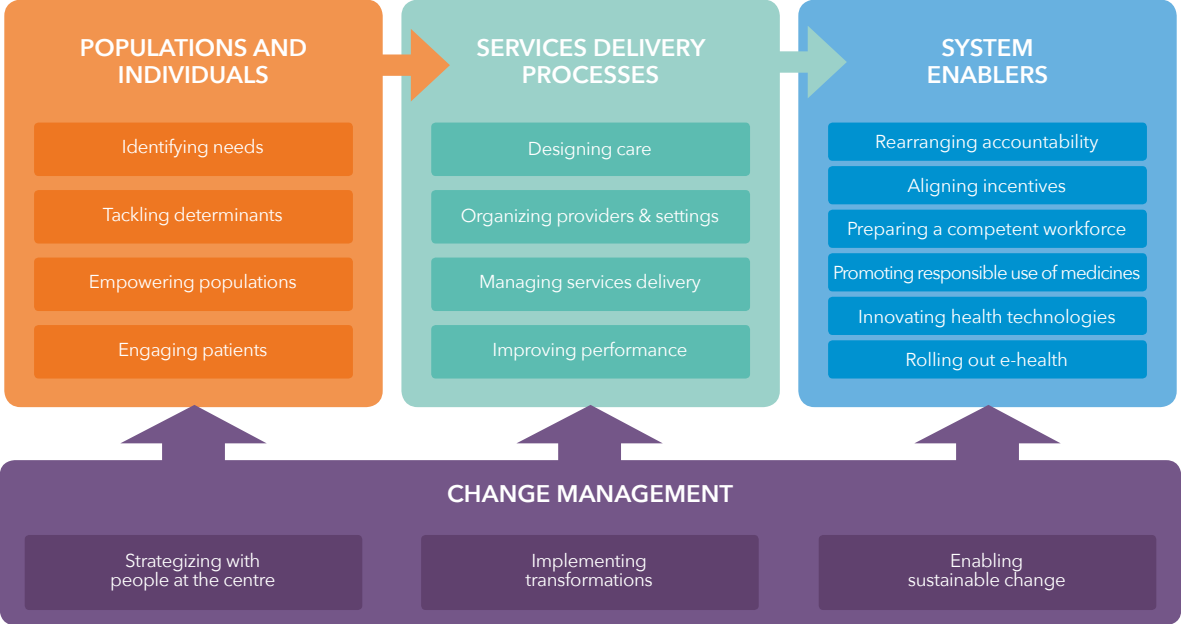
Interviews included discussions with the Ministry of Health nursing and general practice advisors, system change agents, the Supreme Council of Nurses and Midwives, the Centre for Postgraduate Education of Nurses and Midwives, the Health Insurance Fund, the Polish Nursing Association and the Department of Nursing and Midwifery at the Ministry of Health.

This report adopts a comprehensive health system approach guided by the WHO European Framework for Action on Integrated Health Services Delivery and its approach to transforming health services delivery (Fig. 1). The European Framework for Action on Integrated Health Services Delivery is a policy framework that Member States unanimously endorsed at the 66th session of the WHO Regional Committee for Europe (1). Strategically aligned with other commitments, the Framework aims to streamline and accelerate efforts to transform health services delivery to advance the Region's priority of meeting 21st century health challenges. The Framework outlines essential areas for undertaking health services delivery transformations that are results-oriented and focused on systems thinking.

Proposed transformations to services delivery present opportunities and challenges. As health services place a new emphasis on population health, quality of care and primary care, nurses, who in some parts of the Region outnumber physicians by up to four times, are assuming expanded roles. These tasks involve, for example, new roles in health promotion, population health management, care coordination, implementation and monitoring of treatment plans for people with complex conditions while working in interprofessional teams. New job titles and functions are emerging, particularly in population health management, patient coaching, informatics design and analysis, geriatric care and managing patient care transitions. Nurses are increasingly employed as "boundary spanners", connecting patients with services in health and community settings. These

emerging and expanding roles will require existing nursing skills to be applied in new ways and the development of new skills. To optimize contributions of nurses, regulation, incentives, nursing education, performance monitoring, and forecasting and planning all need to be updated.

**Fig. 1.** Overview of the European Framework for Action on Integrated Health Services Delivery



Source: (1).

# Current burden of diseases

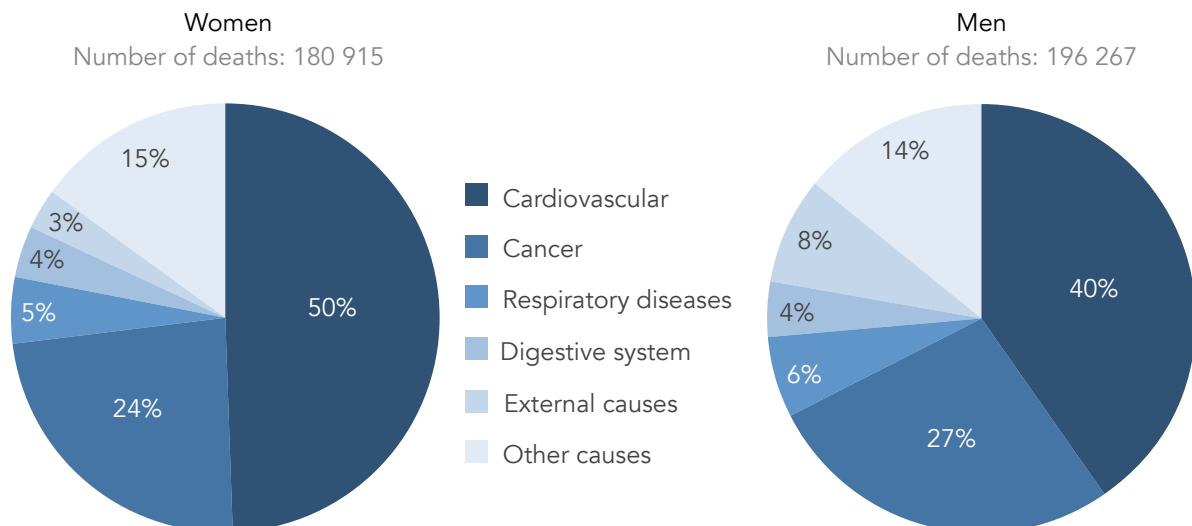
In Poland, life expectancy has been increasing since 1991 (3). Between 1990 and 2011, average life expectancy increased by 6.2 years for males and 5.7 years for females (3). By 2015, the average life expectancy reached 73.6 years for males and 81.3 years for females (4). Despite these positive changes, average life expectancy remains below most other European countries (3).

Cardiovascular diseases are the leading cause of death causing around 50% of all female deaths and 40% of all male deaths in 2014 (Fig. 2). In Poland, people are about 60% more likely to die from circulatory diseases than the average European Union resident. While cardiovascular mortality has declined (6), progress has been slower than in most other European Union countries (6).

## Cardiovascular diseases and cancer are the largest contributors to mortality

More specifically, heart diseases and stroke remain the most common causes of death, followed by lung cancer and pneumonia. In addition to cardiovascular diseases and cancer, mental health problems including major depressive disorders and self-harm are leading causes of disease (Fig. 3).

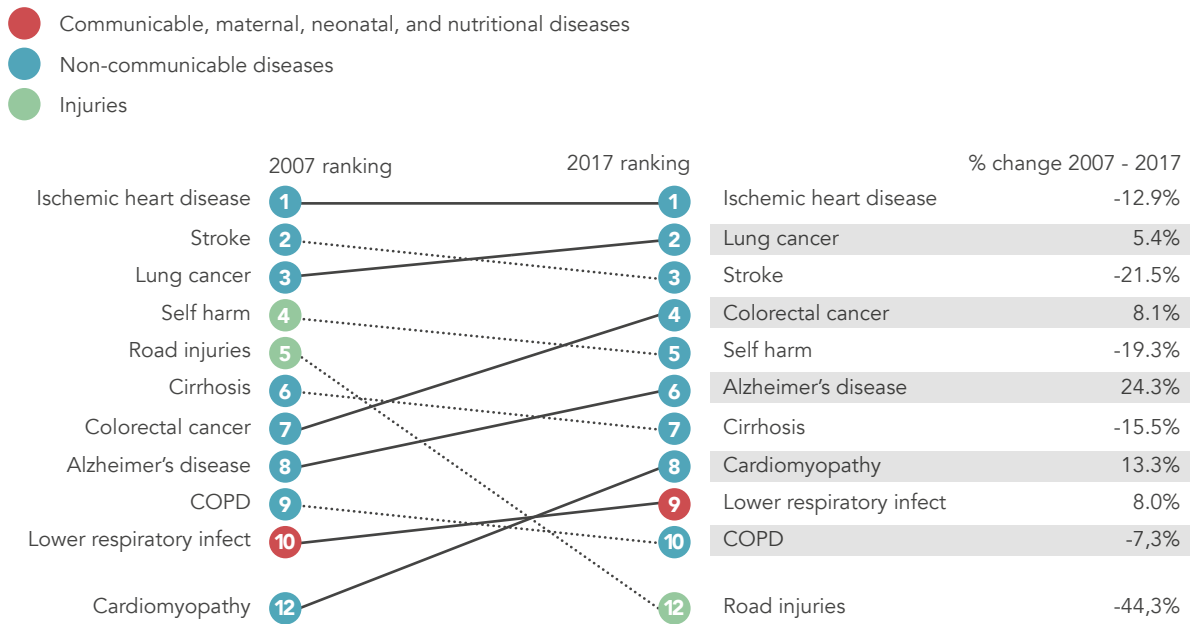
**Fig. 2.** Cardiovascular diseases and cancer in Poland, 2014



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: (6).

**Fig. 3.** Top 10 causes of years of life lost in 2017 and percentage change since 2007, for all ages in Poland



Note: COPD=chronic obstructive pulmonary disease.  
Source: (5).

### More than one third of the overall burden of diseases can be attributed to behavioural risk factors

It is estimated that more than one third (36%) of the overall burden of disease in 2015, measured in disability-adjusted life years, can be attributed to behavioural risk factors such as smoking, excessive alcohol consumption, poor diet and low physical activity (6). This is higher than the 29% European Union average. The proportion of daily adult smokers fell from 28% in 2001 to 23% in 2014 but remains higher than in most European Union countries. Lung cancer mortality is among the highest in the European Union (4). The smoking rate among 15-year-old adolescents also dropped, from 21% in 2001–02 to 15% in 2013–14 but is still higher than in most other European Union countries.

Alcohol consumption among adults has increased substantially since 2000, rising from 8.4 litres per adult in 2000 to 10.5 litres in 2015, which is above the European Union average. More than one in six adults (17%) reported regular heavy alcohol consumption (so-called binge drinking) in 2014, although this is lower than the European Union average (20%) (6).

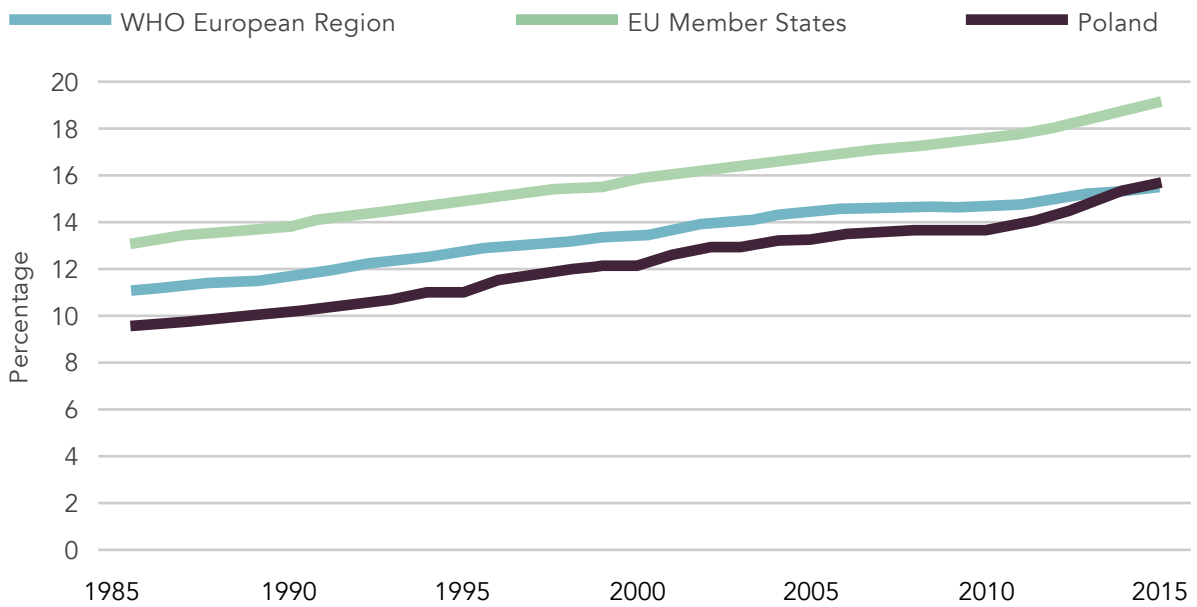
### High preventable mortality

Key indicators of preventable mortality, notably deaths related to traffic injuries, smoking and harmful alcohol consumption, place Poland above the European Union average. Although the traffic accident mortality rate has halved since 2000 (7), it remains among the highest in the European Union, over 10.3 per 100 000 population in 2014 compared to the European Union average of 5.8.

### Rapid population ageing

As with other countries of Europe, the population in Poland is ageing rapidly. Since its accession to the European Union in 2004, Poland has seen significant emigration among the working-age population. Low birth rates are also contributing to an

**Fig. 4.** People aged over 65 years in Poland overtime



Source: (4).

overall population decrease, with fertility rates declining from 3.7 children per woman in the 1950's to an estimated 1.32 in 2014 (8). The median age has increased from 28.8 years in 1950 to 40.7 in 2018 (9; 10). The proportion of people aged over 65 years is expected to double by 2035 (7). In 2017, the population over 65 years represented 16.86% of the total population, up from 13.5% in 2010 (9). By 2030, 27% of the population is projected to be 65 or older (10). Fig. 4 shows the current steep rate of ageing in Poland.

# Services delivery performance

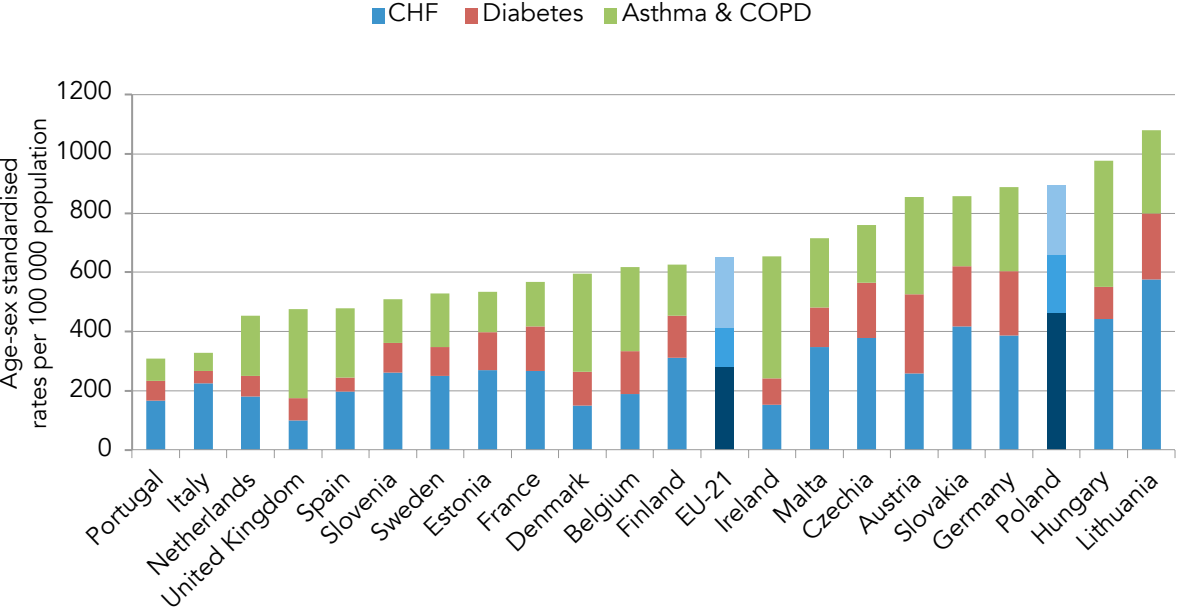
## Low self-assessment of health conditions

Self-assessment of health conditions in Poland is the lowest among Organisation for Economic Co-operation and Development (OECD) countries (11). Comparative analyses based on the European Project SHARE (12) showed that people older than 50 years in Poland had the lowest level of subjective well-being among surveyed Europeans and the highest level of affective disorders such as depression and negative affect (13; 14). Results showed that life satisfaction declines with age for men and women (13) and that people are more likely to leave the workplace as soon as they reach the required age for their pension; reasons include leaving to look after grandchildren, but more often due to poor working conditions and inadequate salaries (14). Only 10% of those aged 65 years and over reported themselves to be in good health, compared to the OECD of 45%.

## Avoidable hospital admissions are among the highest in the European Union

Poland has comparatively high hospitalisation rates for chronic conditions such as asthma, chronic obstructive pulmonary disease, diabetes and congestive heart failure. As these conditions are generally considered manageable within primary care, hospitalisations therefore suggest a lack of effectiveness and coordination in primary care and non-acute sectors (Fig. 5).

Fig. 5. Avoidable hospital admissions in Poland, 2017



Note: CHF=congestive heart failure; COPD=chronic obstructive pulmonary disease.  
Source: (5).

# Relevant primary care policies and players

The health system in Poland protects patient rights, involves patient organizations in decision-making processes and patients have access to medical records (7).

In response to demographic changes, the Ministry of Labour and Social Policy established funds to support programmes for promoting active ageing in 2012. The Programme for Senior Citizens Social Activity 2014–2020 was established with the goal of promoting well-being and extending the working life of older adults through engagement in social activities such as volunteering and learning opportunities. The main objectives of the programme are: (i) education of older adults; (ii) intergenerational social activities such as recreation activities for grandparents and grandchildren; (iii) participation of older adults in social activities such as gardening, inter-action through learning and physical group exercises; and (iv) recruiting older adults as volunteers to assist with tasks such as grocery shopping or cooking (8). Several research grants have also been established in the field of gerontology (8). Research on ageing is also funded by local and city governments, within the framework of programmes to promote human resources, health and social welfare.

To tackle rising obesity rates, a mass media campaign promotes healthy eating and increase fruit and vegetable consumption (6). Promotion and advertising of certain foods sold at primary and secondary schools is also regulated by law. Economic levers such as taxes and broader regulation of sales, similar to the strategies for limiting alcohol consumption, have not been adopted (15).

A two-year pilot project Comprehensive Care for People with Heart Failure [Kompleksowa Opieka Nad Osobami z Niewydolnością Serca (KONS)] started in November 2018. The pilot project will be implemented by six coordinating centres and cover over 5 000 patients. The approach comprises ambulatory, hospital and home care coordinated by a team consisting of a family doctor, nurse, cardiologist and other specialists. Telemedicine will be used to improve coordination between the general practitioners and cardiologists. Patients with advanced heart failure will be referred to education and advisory centres where they and their families will receive dietary advice and psychosocial support (7).

## **The National Health Programme 2016–2020**

The National Health Programme 2016–2020 [Narodowy Program Zdrowia] marked a significant step in strengthening public health. The Programme set out seven strategic goals covering nutrition and physical activity, addiction prevention, mental health and well-being, environmental risks including work, habitation and education, healthy ageing, and reproductive health.

Citizens entitled to primary care currently include almost 98% of the population of Poland (6). The Ministry of Health aims to strengthen the role of primary care as pivotal in health system. In 2016, a series of reforms to primary care aimed at improving its effectiveness. The National Health Programme proposed 10 major changes (Box 1). A primary care law has been in place since the beginning of 2018 (16).



## The Primary Health Care Plus Pilot Project

Since 2016, the *Primary Health Care Plus Pilot Project* focuses on reforming the organization of services towards integrated primary care. Forty-two primary care practices across the country seek to integrate general practice and ambulatory specialist services for chronic patients. The primary component includes a general practitioner, two nurses and a midwife. The pilot project has identified two new roles for nurses: coordinator and patient educator. The Ministry of Health envisages to roll-out this model based on the aftermaths of the current experience. The project is implemented by the Health Insurance Fund with the support of the World Bank.

### Box 1

Ten proposed changes to primary care in Poland

- Primary care for everyone, including those without public insurance
- Primary care based on family medicine
- Teamwork of physicians and nurses with one shared patient list
- Improved funding
- Strengthened preventive care
- Intra-sectoral and cross-sectoral integration
- Informatisation of primary care
- Reduction of bureaucracy
- Quality improvement
- Research support

## The Primary Care Advisory Board

In 2016, the Ministry of Health established a Primary Care Advisory Board. The Board includes representatives of the Ministry of Health, the World Bank and a series of doctors and general practitioners. Informants from different interviews suggested that doctors of the Board are not representative of general practitioners willing to see transformations in primary care and an increased role for nurses.

## The Health Insurance Fund

Health services delivery is extensively regulated. Standard setting and implementation regulations mainly concern the conditions in which health services are delivered, operation of service providers, financing, availability of health services and medicines including the level of cost-sharing and patient rights (7).

The Health Insurance Fund is responsible for quality of care, e.g. internal and external quality assessment and accreditation. This plays out in the competitive contracting process in place. Contracts between the Health Insurance Fund and health facilities contain provisions on the principles of quality control, adequacy and accessibility of services. The Health Insurance Fund, in its capacity of monitoring accessibility and quality of care but also as implementor of the Primary Health Care Plus Pilot Project, will only increase its position in the strategic planning of services.

# Human resources in primary care: challenges and opportunities

The demand for human resources is determined by the Health Insurance Fund's Plans for Purchase of Benefits which determine staffing needs as well as requirements for facilities and medical equipment (7). Informants reported that this is not cross-checked with available data, for example for nursing, held by the Chamber of Nurses.

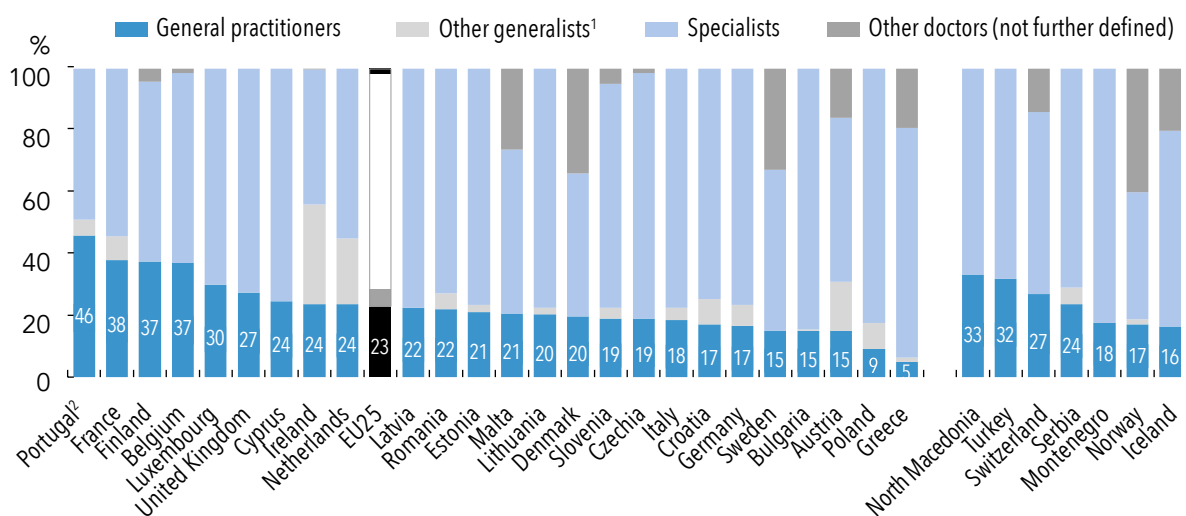
There is, therefore, a gap between demand and supply of human resources, particularly acute in primary care. The main challenges of this mismatch, for the potential role of nurses, are described below.

## System capacity

### Depleting supply of general practitioners

The supply of general practitioners has not kept pace with the increased demand for primary care services (6). Geographic distribution of general practitioners is uneven. It tends to be concentrated in urban areas reflecting the distribution of health facilities (7).

**Fig. 6.** Share of different categories of doctors, 2016 (or nearest year)



1. Other generalists include non-specialist doctors working in hospital and recent medical graduates who have not started yet their post-graduate specialty training.

2. In Portugal, only about 30% of doctors employed by the public sector (NHS) are working as GPs in primary care, with the other 70% working in hospital.

Source: (20).

Most general practitioners are employed in public facilities or medical practices publicly funded. In 2016, there were 0.22 general practitioners per 1 000 inhabitants, compared with the OECD average of 0.80 (6). In 2016, across European Union countries, general practitioners made up less than 25% of all physicians with Poland sharing the lowest share, Fig. 6 (20).

Although the number of people per general practitioner has nearly halved since the end of the 1990s, in 2016, there were still close to 6 000 patients per general practitioners — nearly six times higher than the European Union-15 average.

General practitioners represent 9.6% of the total number of physicians. However, it may be that some of those general practitioners do not work in primary care. This makes projecting and planning the workforce for primary care challenging.

### Shortage of nursing workforce

Poland also faces a chronic nursing shortage compounded by a rapidly ageing nursing workforce. In 2018, there were 5.2 nurses per 1 000 inhabitants compared to the WHO European Region average of 9.1. This is also lower than the European Union-12 average of 6.0, in 2016. There is no information on the proportion of nurses working in primary care.

In 2007, a new nursing profession of medical caregiver [opiekun medyczny] was introduced to offset the low number of nurses. In 2009, there were approximately 1600 medical caregivers. Medical caregivers cannot establish individual practices or be directly contracted by the Health Insurance Fund. This impedes to know the number of medical caregivers employed within the public health system.

## Clinical practice

### Nursing education and practice not aligned

Barriers to preparing the primary care nursing workforce include an outdated approach to primary care modules, a shortage of faculty and mentors familiar with the roles demanded of nurses in new models of care, a lack of community-based practices in which to place nursing students and insufficient protected time for staff to supervise students during clinical placements.

Most nurses still receive most of their clinical education in inpatient settings. The current approach of introducing nurses to primary care through placements to study healthy populations is misleading to the complexities primary care must address. For nurses to be effective in care management and coordination roles, students need exposure to how the community affects each patient and how broader community interventions can improve individual outcomes. This perspective demands greater knowledge on epidemiology, sociology and the

**“It is simply not feasible to leave general practitioners to manage the complexity of primary care alone”**

Informant

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**“There is a need to better understand through evaluation and monitoring the role of nurses and their possible care models. To date, no one has made plans to do this.”**

social determinants of health. A focus on how to navigate the social, political and economic factors that influence individual and population health is thus critical for ensuring equitable access to primary care. The risk is that newly trained nurses will be placed in new positions only to be overwhelmed by challenges for which they were not prepared.

A scarcity of nurses available to support learners during placements in primary care is another barrier to learning. New training approaches are needed to protect time for primary care nurses to teach nursing students.

Interprofessional learning at initial training levels is absent. Informants reported that two medical universities have attempted to develop such programmes. Interprofessional training teaches the benefits and principles of interprofessional competencies (24) and fosters familiarity with each other's contributions.

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## Informant

### **Continuing professional development not prioritized**

Currently, there are no plans of regulating or making continuing professional development mandatory. As priorities develop, given the shortage of nurses and the fact that nurses prefer to retire due to unfavourable working environments (14) this will need to be reconsidered. Continuing professional development opportunities need to be conveniently located and time protected, so that nurses do not have to take time out of their personal lives to gain new skills and competencies. Efforts to define a set of primary care competencies for nurses (23) or a set of integrated care competencies may also be useful (24).

### **Governance**

#### **Lack of monitoring and evaluation of the reforms on nursing**

Several reforms over the past 13 years have favoured the development of nursing. These reforms have included raising the level of basic training of nurses up to graduate and postgraduate levels, introducing nurse prescribing, establishing specialties on family medicine and palliative care (21) and creating nurse-led practices. These initiatives move in the direction of strengthening nursing in primary care. However, improvements cannot be quantified due to the lack of a monitoring and evaluation framework. This and the possible incentives are deemed important to build the case for further investing in the nursing workforce.

### **Payment models hinder performance**

Despite being included as a priority for changing primary care (Box 1), it has not been possible to introduce new payment models to incentivize performance improvements and coordination. Nurses and general practitioners continue to receive salaries based on contracts with the government (22). In 2016, the Ministry of Health announced funding increase for primary care and proposed the introduction of incentives. However, some general practitioners, members of the Polish Association of Health Providers, rejected the conditions. As contracts were not signed between these general practitioners and the Health Insurance Fund, people experienced difficulties accessing primary care services. In 2016, this resulted into 10 300 visits to hospital emergency departments or long-term care facilities (7).

### **Insufficient role of patient organizations**

Patient organizations, together with the Chamber of Nurses and the Polish Nursing Association, have evaluated patients' trust in health professionals and the perceived challenges experienced when communicating with them. There is a high degree of public trust in the nursing profession, ranking it second to firefighting (26). Patient organizations are also engaged in teaching initiatives at Warsaw and Krakow medical universities.

Patient organizations can have a role in understanding patient needs and how these translate into demand for primary care services. They could also have a more pro-active role in health literacy.

### **Suboptimal use of digital records and telehealth**

Health records have been digitized but they are not shared to facilitate population stratification, progress monitoring, communication among professionals or services and information exchanges across regional and national levels. Telehealth is scarcely available.

# Assets for strengthening nursing in primary care

The burden of noncommunicable diseases and the ageing population will require primary care services to take a greater role in patient education, disease prevention and management of chronicity and polypharmacy. At present, a growing share of long-term care is being provided in home- and community-based settings through home health, adult day care, and other support services. However, there is a need to scale up targeted care of older people in primary care to prevent and manage multi-morbidity and disability (9).

## Expanded scope of practice of nurses

In practice, given the rising numbers of patients under their care, general practitioners are increasingly turning to nurses and other allied health professionals to manage patients. Indeed, nurses are well-placed to tackling noncommunicable diseases, comorbidities in ageing populations and the needs of children and adolescents (2). Interviewed nurses reported providing preventive, diagnostic, treatment, rehabilitation and medical emergency services, despite not being mandatory. Some informants described models in which general practitioners and nurses are jointly accountable for a group of individuals. In this type of models, nurses take on many tasks formerly done by general practitioners as long as they have the knowledge, skill and judgment to assess when the task is for them or the general practitioner to perform. In Poland, nurses participate in collecting and entering information into electronic health records, reviewing medical history, discussing medication lists, assessing social factors and providing preventive services (18).

Examples across the country show nurses play a central role in meeting the needs of older people. For example, with the support of general practitioners, the nurses working at the Centrum Mdyczno-Diagnostyczne assess the long-term needs of individuals with physical or cognitive impairments, develop customized care plans, coordinate care across providers and settings and oversee the adequacy of services. These initiatives leverage nurses to improve care transitions which prevent physical and cognitive decline and facilitate that older people live longer in their communities (19). For these initiatives to be rolled out it is important to introduce regulations that allow this kind of “top of the licence practice” to take place. In absence of suitable regulation, nurses dependent on a general practitioner to oversee their work.

## Committed nursing leadership

There is devoted leadership at the Department for Nursing and Midwifery and several nurses in high ranking ministerial roles. This offers opportunities to give nurses a voice in decisions related to services delivery design and reorganization. These officials have easy access to the media and steer messaging about the important role of nurses. This has allowed government to promote reforms to nursing training and care (17) and may come in use should the government want to promote increased roles for nurses in primary care.

# Policy recommendations

Investing in nursing and midwifery and enabling nurses and midwives to work to the full extent of their potential is essential in pursuing universal health coverage. Several global initiatives have called for a greater role of nurses in primary care. The Declaration of Astana on primary health care (25), the Sustainable Development Goals agenda and the Nursing Now campaign each call for the prioritization of the role of nurses in delivering primary care. Nursing stakeholders are aware of this and keen to demonstrate the importance of nursing.

In order to strengthening nursing in primary care in Poland, the following policy directions are proposed.

## **Linking strategic planning on nurses in primary care to population health needs**

The development of nursing should align to population trends, the evolving health needs and the changes in the model of care. This implies organizing providers in innovative ways. Once primary care models are defined, the nursing workforce for primary care should be planned based on the quantity and distribution of nurses currently qualified to meet population needs. Data is available, for example at the Nursing Association. Analysing data also helps to understand the motivations of the health workforce.

The WHO Labour Market Framework (27) provides a good approach to organize this analysis and to identify moments for targeted interventions e.g. education, recruitment, performance management, retirement. It is important to engage nursing stakeholders at all times in planning processes.

## **Rolling-out the expanded scope of practice of nurses in primary care**

A range of good practices already exist for developing and expanding the scope of practice of nurses in primary care. The ongoing Primary Health Care Plus Pilot experience will be particularly useful in understanding the role of nurses in models of care that revolve around managing patients with chronic conditions, caring for ageing populations and supporting preliminary diagnosis. Other good practices include prescribing nurses and practices led by nurses. Nursing-led practices allow general practitioners and specialists to focus on acute or complex patients.

These examples also provide crucial insights for planning the future nursing workforce and possible financial arrangements that incentivize innovative practices.

## **Increasing investment on competencies**

Nursing schools need to better match education programmes with the complexities of caring for older adults such as managing cognitive impairment or multiple chronic conditions, advancing faculty expertise in geriatric care, building on the research initiatives taken place across the country and integrating competencies of those working in long-term care.

There is need to adjust the entry requirements to nursing programmes and the clinical experience of pre-licensure students to increase focus on primary care. This will likely require a qualification system for mentorship in primary care. Non-nurses may mentor some specific curricular components such as population health management or informatics.

The development of nursing training in primary care could be further enhanced by establishing partnerships between academic and in-service sectors, advancing online education and developing simulation and reflective learning exercises.

Continuing education programmes should provide in-service nurses opportunities to develop competencies in caring for older patients. Better assurance is needed that nurses are meeting continuing professional development requirements in primary care.

Preparing the primary care nursing workforce requires protected time for primary care nurses to teach nursing students.

## **Ensuring enabling accountability and incentives arrangements**

Policy and regulation changes are needed to support nurses practicing in new roles to the full extent of their education. Regulatory barriers that prevent nurses and other health professionals from applying their competencies for the benefit of patients should be removed. This means reviewing accountability arrangements to align them with the expanded role of nurses in primary care.

Practitioners need to increasingly improve coordination, strengthen engagement of patients, increase disease prevention services and manage chronicity. These new roles and responsibilities should be fostered by aligned payment and incentive arrangements that redirect focus on quality and health outcomes, moving away from models that pay for services provided.

There is also need to identify and advocate educational and regulatory changes that support nurse educators to build the competencies of the future nursing workforce to match shifts in employment settings and new roles (28).

## **Strengthening interprofessional platforms for primary care**

The primary care advisory board has the potential to increase its capacity by engaging nurses and other professionals of primary care such as social workers or physiotherapists. This would also help to foster an interprofessional approach to primary care transformation. A more representative membership in the advisory board could be particularly useful for defining evaluation criteria for revised nursing roles and design incentives for nurses to perform preventive care and patient management.

It would be valuable to establish a primary care association that brings together the expertise of various health and social care professionals engaged in primary care. The association could, for example, strengthen the knowledge base for



primary care and provide inputs on implementation and further scale up of pilot projects. There are examples in other European countries where this mechanism has shown to build the prestige and identity of primary care.

A task force could also be established for guiding initiatives such as developing a set of primary care nursing competencies and assessing progress of pilot projects. The task force could also provide inputs for exploring financing mechanisms that promote interprofessional collaboration and overall performance improvements. The task force should involve, for example, the nursing leadership and include nursing stakeholders such as patient groups, academic institutions and other professionals working in and with primary care.

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