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Dietitians – new professionals in Poland's SME Sector

Abstract. *This paper aims to describe the profession of a dietitian as an element of the Polish healthcare system and to explore the prospects of adjusting the position of dietitians in the SME market. The authors' interest in this research problem has been driven by the perceived deficiencies of the legal and organizational framework for the profession of dietitians, which is dysfunctional vis-à-vis regulations adopted in other countries and has become a substantial constraint on the growth of the profession itself and the medical services market at large. Furthermore, these deficiencies are seen as having a number of negative effects on public health, society, and the economy. The paper discusses the roles of individual entities in the market for dietitian services, highlighting the key issues in public health and current trends in health policy. In conclusion, the authors put forth a proposal for a functional and organizational restructuring of the healthcare system, involving a more complete incorporation of dietitians. The reform proposal is aligned with the widely recommended model of comprehensive healthcare that postulates expanding the range of publicly funded services, reorganizing and rationalizing the use of human resources available to the sector, improving the system's overall performance, and increasing satisfaction levels among both healthcare customers and providers. If implemented, the proposed changes could also contribute to boosting the growth of the SME market in Poland.*

Keywords: *dietitian, public health, diet-related diseases, health policy, SME*

Introduction

The paper deals with the factors affecting the practice of dietitian profession in Poland and in some other countries. Its primary objective is to explore and assess

the role of dietitians while at the same time identifying the barriers to the development of a market for dietitian services. The authors' interest in this research topic has been driven, on the one hand, by the global and national obesity epidemic and the growing percentage of the population suffering from diet-related diseases, and on the other, by the perceived downsides of Poland's existing regulatory framework for the practice of the dietitian profession vis-à-vis solutions found in other countries. An analysis of the position of dietitian in the healthcare services market may help refine the overarching strategy to overcome overweight and obesity in Poland, as most efforts have hitherto been far from successful.

The shortage of permanent employment opportunities with public health institutions has forced many dietitians to work freelance or start their own businesses, thus becoming part of the SME sector. Once the barriers to the growth of small and medium-sized providers of dietitian services are identified, it might be possible to introduce solutions to mitigate their impact on dietitian businesses and, at the same time, better satisfy the society's health needs. Adjusting the position of dietitians in the medical services market is just one element of the proposed functional and organizational restructuring of healthcare in Poland. The change process should fully embrace the role of healthy diet in the overall healthcare system and involve the inclusion of dietitian services in the catalog of publicly financed medical services. Understandably, this will entail the need to e.g. reorganize and rationalize the use of human resources available to the healthcare system, which is likely to result, over long-term, in improved service quality standards and enhanced performance of the healthcare system. Hence, it will also help achieve higher satisfaction levels both on the part of service customers and service providers.

The research hypothesis put forth in this paper is that the Polish legal framework for the practice of the dietitian profession, as well as other systemic and country-specific factors, call for major reforms or adjustments toward smoother functioning of the medical services market. The predominant method used to validate the hypothesis was literature analysis, involving domestic as well as international sources, notably subject literature and reports by international organizations. At the same time, a variety of legal acts and internal regulations of professional dietitian associations, alongside relevant decisions by Polish courts and tax authorities, were sourced for input data. Numerical data illustrating the argument mostly come from official statistics. The choice of methodology was informed by the objective of identifying the factors that are critical to the functioning of the dietitian services market and that might help determine the direction of desirable changes. The use of functional analysis and systems analysis has allowed a dynamic and all-round approach to the research problem. Essentially, this article has been designed as a kind of "green paper" and concentrates primarily on issues relating to the practice of the dietitian profession in Poland while mak-

ing references to solutions applied in some other countries. The analysis targets specific actors in the dietitian services market and focuses on central problems of public health and current trends in health policy. The paper thus represents an attempt to provide an independent outlook on potential strategic intervention into the prevalence of overweight and obesity. Arguably, the intervention should involve dietetics professionals not just by galvanizing them into action, but by integrating them more closely with the system. So far, there have not been any significant research endeavors in Poland to investigate this issue in more depth.

1. The global obesity epidemic and diet-related diseases

According to a 2014 report by the London-based McKinsey Global Institute "Overcoming Obesity: An Initial Economic Analysis," if the prevalence of obesity continues on its current trajectory, nearly half of the world's adult population will be overweight or obese by 2030. The report underscores the fact that overweight and obesity are economic and social burdens as much as personal health problems. It is a truly global issue associated with unhealthy lifestyles and, in most countries, it needs to be addressed by developing and deploying a comprehensive strategy, through close collaboration between the private and the public sector, and through regulatory actions.[1] According to the World Health Organization (WHO), in 2008 more than 35% of the world's adult population was overweight, and 11% were obese. WHO predicts that in 2015 there will be 2.3 billion overweight and 700 million obese people worldwide.[2]

Obesity, manifesting in body weight increase due to excessive growth of adipose tissue, by 25% in men and by 30% in women, is among those non-communicable diseases whose treatment presents the greatest difficulty.[3] WHO ranks obesity among the principal problems of public health and, acknowledging its rapid spread rate, designates it as a global epidemic. Between 1980 and 2008, the number of obese persons nearly doubled worldwide, and even tripled in some European countries.[4] National estimates show that in 2008 in the European Region of WHO more than 50% of men and women were overweight and some 23% were obese. The most recent statistics for the European Union member states reveal that, depending on the country, 30-70% of adult population are diagnosed with overweight, and 10-30% – with obesity. What is even more worrying, the propor-

[1] www.mckinsey.com/insights/economic_studies/how_the_world_could_better_fight_obesity [12.12.2014].

[2] www.who.int/mediacentre/factsheets/fs311/en/ [15.10.2014].

[3] M. Wąsowski, M. Walicka, E. Marcinowska-Suchowierska, *Otyłość – definicja, epidemiologia, patogeneza*, "Postępy Nauk Medycznych" 2013, No. 4, pp. 301-306.

[4] www.who.int/mediacentre/factsheets/fs311/en/ [20.05.2014].

tion of overweight and obese infants and children is, too, on the rise. Child obesity is, alike adult obesity, strongly correlated with risk factors for cardiovascular disease, type 2 diabetes, orthopedic problems, and mental disorders. Further, it can be also linked to difficulties at school and low self-esteem.[5] Furthermore, childhood obesity has been found to increase the risk of obesity in adults, considerably worsen the quality of life, and raise the risk of metabolic disorders.[6] It is reported that, at the moment, there are more than 30 million overweight children in developing countries, and about 10 million in developed countries.[7] Paradoxically, in many developing countries obesity coincides with undernourishment.[8]

For a number of years, the prevalence of obesity has been brought to public attention, alongside compelling arguments for policy initiatives to counteract its health, social and economic impacts, in reports published by the Organization for Economic Cooperation and Development (OECD). The most recent OECD report indicates that obesity rates in some countries are stabilizing. More importantly, however, over the last five years the obesity epidemic has continued to spread, becoming a critical public health burden.[9] Obesity rates for selected OECD countries are given in Figure 1.

Statistical evidence shows that in recent years overweight and obesity rates have remained steady in England, Italy, Korea and the USA but have risen in Australia, Canada, France, Mexico, Spain, and Switzerland. A positive trend that can be observed is that over the five past years the rate has been growing less rapidly compared to the previous five-year period.[10] The risk of obesity chiefly concerns less-educated individuals of inferior social status. Understanding the detrimental effects of obesity and other diet-related diseases, WHO and the Council of Europe have been encouraging and implementing programs to combat unhealthy diets and physical inactivity, which are the major causes of overweight and obesity.[11]

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[5] www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/data-and-statistics [17.06.2014].

[6] P.T. Katzmarzyk et al., *An evolving scientific basis for the prevention and treatment of pediatric obesity*, "International Journal of Obesity" 2014, No. 38, pp. 887-905.

[7] www.who.int/mediacentre/factsheets/fs311/en/ [15.08.2014].

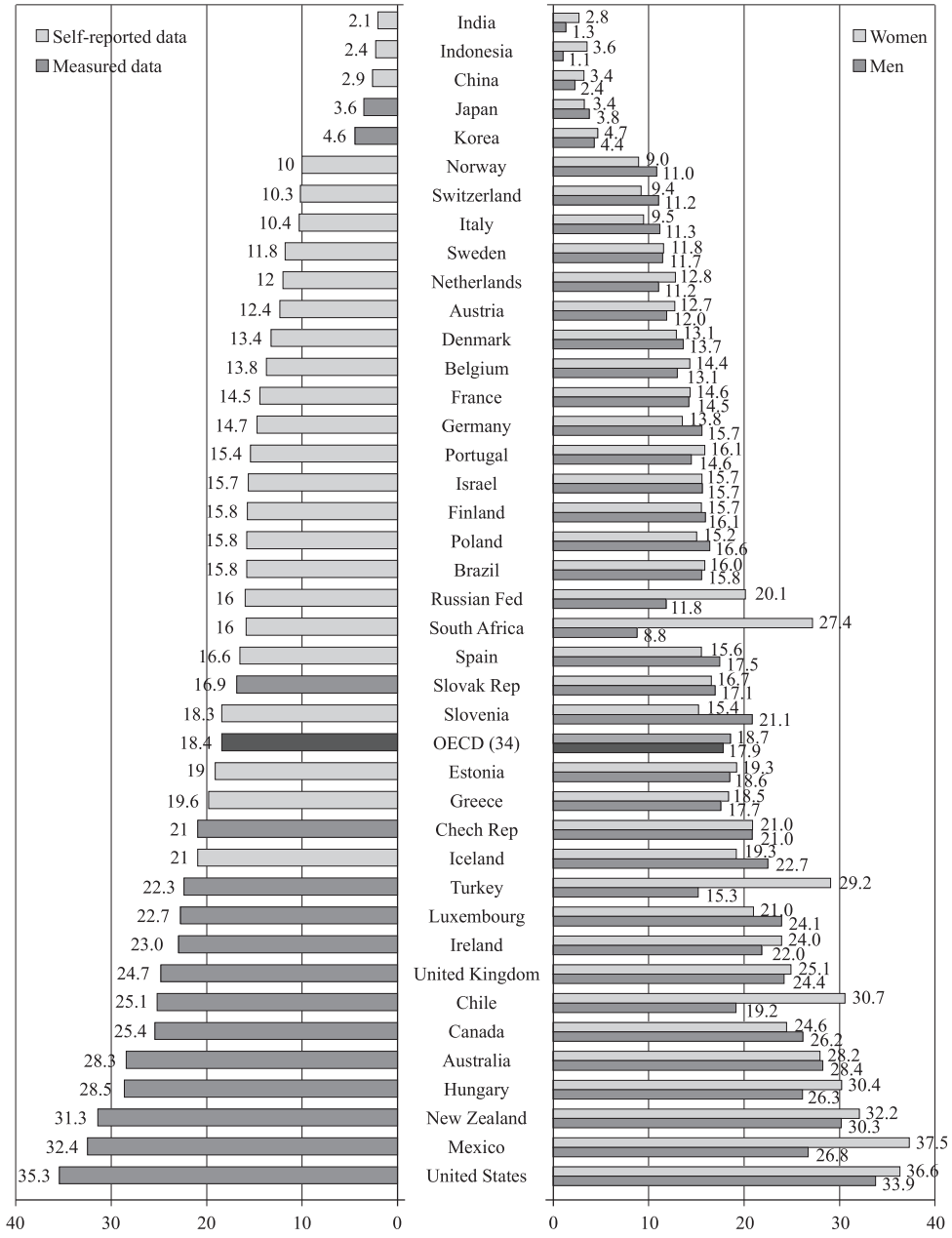
[8] www.who.int/dietphysicalactivity/end-childhood-obesity/en// [15.08.2014].

[9] www.oecd.org/health/obesity-update.htm [18.12.2014].

[10] www.oecd.org/els/health-systems/Obesity-Update-2014.pdf [18.08.2014].

[11] The major global and European intervention initiatives concerning overweight and obesity include: "The World Health Organization Global Strategy on Diet, Physical Activity and Health" (2004), "European Charter on Counteracting Obesity" (2006), "White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity Related Health Issues" (2007), and "WHO European Action Plan for Food and Nutrition Policy 2007-2012". In Poland, the key measures are as follows: "The National Program for Combating Overweight, Obesity and Non-Communicable Diseases through Healthy Diets and Physical Activity. Stage One: 2007-2011 (POL-HEALTH)" developed in collaboration with WHO and the European Commission, "The Charter on Diet and Physical Activity of Children and Adolescents in Schools" (2007), "My Playing Field Football Pitch – Orlik 2012."

Figure 1. Obesity among adults in 2012 or nearest year



Source: www.oecd.org/els/health-systems/Obesity-Update-2014.pdf [18.08.2014].

Relevant research and statistics show that in Poland overweight and obesity have also become an important and growing health burden. "The population's health in 2009," a report by the Central Statistical Office of Poland [Główny Urząd Statystyczny – GUS], ascertains that one in two Poles is overweight and that excessive body weight is more often found in men than in women. Between 1996 and 2009, the number of overweight and obese adult men grew by 32%. In 2009, more than 61% of men weighed too much, of which around 45% were overweight and 17% were obese. Over that same period, the number of overweight and obese adult women increased by 19%. Nearly 45% of women weighed too much, of which 30% were overweight and 15% were obese.[12] Another GUS report, "Health and Healthcare in 2011," illustrates that 54% of all adult Poles were either overweight or obese, and that 64% of those were men while only 36% were women. Although overweight and obesity visibly become more common with age, the proportion of children with excessive body weight is growing, too, which is most alarming. Overweight or obesity is diagnosed in some 29% of boys and 15% of girls.[13] The findings of a nationwide research program conducted in Polish hospitals and coordinated by the National Food and Nutrition Institute indicate that diseases relating to overweight and obesity are the likely causes of 25% of hospitalizations. Obesity is also reported to raise the rates of work disability and sickness absenteeism, impinging on productivity and business profits while at the same time entitling employees to sickness benefits.[14] Obesity and overweight are difficult to overcome without the assistance of a qualified dietitian. Moreover, there are not any safe pharmaceuticals known to effectively support the body weight loss process. Therefore, professional nutritional advice is these days considered key to successful treatment of most diseases of affluence. A major role should be played by preventive healthcare measures, including pre-therapeutic health education provided to healthy rather than to ill patients.

Encouraged by similar international initiatives, more and more countries adopt their national obesity control programs. Obvious as it seems that dietitians should be actively engaged in such initiatives, issues relevant to dietitians and to the practice of their profession were not at all addressed by the Polish "National Program for Combating Overweight, Obesity and Non-Communicable Diseases through Healthy Diets and Physical Activity for 2007-2011."[15] At the moment,

[12] www.stat.gov.pl/cps/rde/xbcr/gus/ZO_stan_zdrowia_2009.pdf [22.12.2014].

[13] www.stat.gov.pl/cps/rde/xbcr/gus/zo_zdrowie_i_ochrona_zdrowia_w_2011.pdf [22.12.2014].

[14] M. Jarosz, E. Rychlik, *Otyłość wyzwaniem zdrowotnym i cywilizacyjnym*, "Postępy Nauk Medycznych" 2011, No. 9, pp. 712-717.

[15] www.mz.gov.pl/zdrowie-i-profilaktyka/promocja-zdrowia/dzialania-w-ramach-programow-zdrowotnych/narodowy-program-przeciwdzialania-chorobom-cywilizacyjnym/modul-i-program-zapobiegania-nadwadze-i-otylosci-oraz-przewleklym-chorobom-niezakaznym-poprzez-poprawe-zywienia-i-aktywnosci-fizycznej-pol-health [18.08.2014].

the program is not running any longer. For a policy to be effective, one would think, it should be comprehensive, coherent, and pursued with persistence. To be able to prevent obesity and overweight, we need to change attitudes in the society toward healthy eating habits, which is a lengthy process involving systemic measures applied at many levels. The effects of unhealthy diets can only be prevented by changing people's eating habits and increasing their physical activity, which most overweight and obese people do not succeed in doing unless supported by professional dietitians. For example, in 2013 the government of Mexico initiated one of the most comprehensive strategies for easing the social burden of obesity. Mexico's "National Strategy for the Prevention and Control of Overweight, Obesity and Diabetes" is founded on three complementary components: public health improvement and supervision, better medical care for persons with chronic diseases, and new legislation in e.g. fiscal policy.[16] Some other countries have developed and launched similar programs based on an approach that successfully accommodates the interests of most stakeholders. Initial evaluations of their effects have already been published, even if, since 2008, the credibility of these accounts has been compromised by the aftermath of one of the most severe economic crises in history.

A review of subject literature demonstrates that international and national obesity control policies have improved much – but still not enough. It is clearly necessary to further pursue and adjust strategies to changing conditions. However, the limited effects that such strategies have had so far imply that there may be no single systemic and strategic response to the global obesity epidemic. Healthcare experts, economists, sociologists and politicians should therefore work together on coherent action plans to develop viable models tailored to the needs and the potential of each country. Arguably, dietitians merit a central place in this model.

2. Health and the dietitian profession

Health is commonly represented in literature as every individual's basic and essential asset and a fundamental part of human rights, as well as a precondition of the society's prosperity and continued development.[17] The holistic WHO definition, commonly adopted in medical sciences, represents that health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[18] Major international organizations tend to define health

[16] www.promocion.salud.gob.mx/dgps/interior1/estrategia.html [13.06.2014]; www.who.int/dietphysicalactivity/meetingmexicofebruary2014/en/ [13.06.2014].

[17] M. Miller, J. Opolski, *Zdrowie publiczne w Polsce a polityka zdrowotna w świetle dokumentów Światowej Organizacji Zdrowia*, "Postępy Nauk Medycznych" 2009, No. 4, pp. 282-289.

[18] www.who.int/about/definition/en/print.html [16.12.2014].

either as a certain condition and a collection of properties (structure and function) or as a process that leads to the attainment of such a condition (delivery of healthcare). Public health policy, on the other hand, establishes health goals at the international, national or local level, and specifies the decisions, plans and actions to be undertaken to achieve these goals.[19] The National Health Plan for 2007-2015 adopted by the government of Poland assumes that human health depends on a number of interrelated factors, of which the major ones are: lifestyle (contributing about 50% of the total), an individual's physical and social environment – family, work, school, etc. (about 20%), genetic factors (about 20%), and healthcare (some 10%).[20] While envisaging the main priorities of health policy, the document points out the growing incidence of chronic non-communicable diseases, presenting it as a challenge for public health that calls for the involvement of various actors in promoting healthy diets and physical activity. Unfortunately, the functions and responsibilities of dietitians, or the role of diet therapy within health policy, have not been addressed in the document.[21]

Healthcare is today a question of policy making and of how policy choices are transformed into legislation. Relevant laws determine e.g. the availability of medical services as well as the terms on which medical services are provided and medical professions, including that of dietitian, practiced. Other countries' experience shows that dietitian services can become a central element of modern healthcare systems and, consequently, a key determinant of economic growth and competitive position in the global market. Unless the role of dietitians is better aligned with the healthcare system and unless legislation is in place that establishes an appropriate regulatory framework for the practice of the profession, the health sector cannot be truly optimized, since dietetics very closely corresponds to health in its broadest sense, i.e. public health, as well as in its narrow, personal dimension. In the broad sense, public health is about efforts to solve health problems and social problems. What dietitians can offer in this context is both general and specific dietary recommendations for both the ill and the healthy, and professional assistance in designing public health policies. As their services are known to contribute to the maintenance, recovery and improvement of the society's health status, and to be able to effectively support medical interventions undertaken within a treatment process, whether for medical reasons or in performance of pertinent regulations, they can be definitely termed as medical services.[22] Medical services should be

[19] www.euro.who.int/en/health-topics/health-policy/health-policy [14.12.2014].

[20] www.mz.gov.pl/zdrowie-i-profilaktyka/narodowy-program-zdrowia [12.08.2014].

[21] Ibidem.

[22] J. Gładys-Jakubik, *Kulturowe aspekty zmiany organizacyjnej*, in: *Zarządzanie systemem ochrony zdrowia. Aspekty ekonomiczno-społeczne*, eds. K. Walshe, J. Smith, Wyd. SGH, Warszawa 2011, p. 280.

provided solely by members of medical professions with relevant education and practical experience. Hence the dietitian profession, once properly regulated and aligned with the system, can be instrumental to achieving an overall improvement of public health as well as of the health status of each individual.

Polish law does not unequivocally define each citizen's right to healthcare. The rules for practicing some medical professions, including that of dietitian, are not delineated precisely, either. Most jurisprudence and commentaries agree that the right to healthcare should be construed as one of the so called individual public rights that are articulated in the constitutional provisions on the powers and responsibilities of public authorities, primarily of central and local government bodies, and that may be further detailed in relevant parliamentary laws.[23] The right to healthcare consists in an individual's entitlement to using access to the services provided by a system designed to overcome and prevent diseases, injuries and disabilities.[24] The Constitution of the Republic of Poland does not explicitly prescribe how the system should be designed. On the other hand, it may not be shaped by the legislature at its sole discretion, as some constraints can be inferred from the principles and values upheld by the Constitution. For example, if the right to healthcare is to be taken seriously, the obligation imposed on public bodies to ensure that citizens can exercise this right implies that the healthcare system as a whole must be efficient.[25] Having analyzed the Polish legal framework for the profession of dietitian, particularly in the context of popular access to dietitian services and in the context of its financing mechanism, one may be in doubt as to whether the system performs efficiently enough.

From a legal perspective, there are three central principles governing healthcare: public health, health insurance, and health services delivery. The principle

[23] M. Serwach, *Prawa pacjenta do świadczeń zdrowotnych i ich kontekst*, "Polityka Społeczna" 2011, No. 1.

[24] The Constitution of the Republic of Poland of April 2, 1997, Journal of Laws No. 78, item 483, as amended.

[25] Access to healthcare services should not be conditional on an individual's contribution toward the public funding of these services. The Constitution of the Republic of Poland does not guarantee the availability of all known and existing healthcare services offered elsewhere. Since the range of, and the terms of access to, publicly funded healthcare services is to be laid down through an act of parliament, the lawmaking body may decree a healthcare system that is partly financed from private sector funds, whether individual or institutional. At the same time, statutory law should clearly state the range of medical services to which beneficiaries of the public healthcare system are entitled, alongside the mechanism for its funding. Although pertinent constitutional provisions and Constitutional Court judgments demand that public authorities provide equitable access to healthcare services to all citizens, it is not to be understood that all of these services must be provided free of charge. Cf. D.E. Lach, *Zasada równego dostępu do świadczeń opieki zdrowotnej*, Wolters Kluwer Polska, Warszawa 2011, pp. 283-355; Constitutional Tribunal Judgment of January 7, 2004, case file K 14/03.

of public health entails a society's organized effort, in most cases mediated by public institutions, toward the improvement, promotion, protection and recovery of the population's health.[26] Under the WHO definition, the notion of public health encompasses any organized measures, whether public or private, to prevent illness, promote health, and prolong life among the population as a whole. Hence, activities performed in the public health domain should aim to create conditions in which people can be healthy and should focus on entire populations rather than on individual patients or specific diseases.[27] Dietitians seem to be a professional group that can do particularly much toward the promotion of public health. It should be noted that the idea of public health can be embodied through different healthcare models – health insurance or health services delivery, or a mixed one combining both the methods. From 1999 on, Poland gradually transited from a government funded model to an insurance model, with an increasing proportion of commercialized and market-based components. The future of the universal health insurance model in its current form – i.e. lacking financial viability and consistency in applying the principles on which it is founded – is unclear, given the privatization and commercialization projects that are underway.[28] The functioning of healthcare is heavily criticized, and one of its oft-quoted flaws is the ambiguous positioning of many medical professions, including dietitians, within the system.

The findings of an analysis of relevant Polish legislation points to an urgent need to enact a public health law that would address all public health issues in a single act, replacing and repealing regulations contained in many other legal acts.[29] This new single law could be a starting point for a system overhaul involving e.g. a redefinition of the dietitian profession and its proper alignment with the healthcare system. The solutions prescribed by the current legislation are found to encumber the functioning of the medical services market and the effective performance of public authorities' constitutionally established responsibilities in the area of healthcare. As long as these solutions remain in force, they will also constitute an important barrier to the growth of the SME sector. Dietitians and patients who seek their help – not only obese and overweight persons, but also patients suffering from diet-related diseases – are clearly disfavored, with a very likely negative impact on economic, demographic and social development.

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[26] J. Jończyk, *Zasady i modele ochrony zdrowia*, "Państwo i Prawo" 2010, No. 8.

[27] www.who.int/trade/glossary/story076/en/ [13.06.2014].

[28] J. Jończyk, op. cit.

[29] A. Kaczmarek, *W oczekiwaniu na zdrowotną konstytucję*, "Rynek Zdrowia" 25.08.2014, www.rynekzdrowia.pl/Polityka-zdrowotna/W-oczekiwaniu-na-zdrowotna-konstytucje,144027,14.html [6.09.2014].

3. Dietitians in Poland – classification, education and training, job market

The practice of medical professions is subject to many regulations and influenced by a variety of social, economic, political and ethical considerations. Dietitians and nutritionists have been present in the International Standard Classification of Occupations 2008 (ISCO-08) since 1967. The International Labour Organization describes dietitians as professionals engaged in such areas as: planning, supervising and administering diets as part of hospital treatment or institutional food services; preventing and treating diet-related diseases; or assessment of nutritional status, eating habits, and intake requirements for specific nutrients. In addition, dietitians and nutritionists should be committed to nutrition education, i.e. disseminating knowledge on healthy diet throughout the society. Examples of professions found in the ISCO include: clinical dietician, food service dietician, nutritionist, public health nutritionist, and sports nutritionist.[30] Pursuant to a 2009 European Commission Recommendation on the use of the International Standard Classification of Occupations 2008, dietitians and nutritionists were classified under number 2265, in group 22 – "Health professionals", subgroup 226 – "Other health professionals."[31] The Regulation of the Minister of Labor and Social Policy of August 7, 2014 on the classification of occupations and specializations for labor market needs and on its application puts dietitians among healthcare professionals, in group 229 – "Other healthcare professionals", subgroup 2293 – "Dietitians and nutrition professionals", under the name of "Dietetics professional" and number 229301.[32] Under the Regulation of the Council of Ministers of Poland of December 24, 2007 on the Polish Classification of Economic Activities [PKD Classification], dietitian services are classified in section Q – "Human health and social work activities", part 86 – "Healthcare", subclass 86.90.E – "Other health-related activities, not classified elsewhere."[33]

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[30] *International Standard Classification of Occupations 2008 (ISCO-08): Structure, group definitions*, www.ilo.org/public/english/bureau/stat/isco/isco08/ [14.08.2014]; L. Pachocka, *Rola dietetyka w ochronie zdrowia publicznego*, "Żywienie Człowieka i Metabolizm" 2010, Vol. XXXVII, No. 3; Commission Recommendation of 29 September 2009 on the use of the International Standard Classification of Occupations (ISCO-08), 2009/824/EC, Official Journal of the European Union L 2009.292.31. In Poland, as a matter of fact, no further distinction into specializations is made either during education and training or in respect of the practice of the profession.

[31] Official Journal of the European Union L 2009.292.31.

[32] Regulation of the Minister of Labor and Social Policy of August 7, 2014 on the classification of occupations and specializations for labor market needs, Journal of Laws 2014, item 1145.

[33] Regulation of the Council of Ministers of Poland of December 24, 2007 on the Polish Classification of Economic Activities, Journal of Laws 2007, No. 251, item 1885, as amended.

Not only does Polish legislation lack a legal definition of the dietitian profession, but also there is no single act laying down a legal framework for the practice of this profession. Instead, there are a number of specific provisions in different laws establishing the rules on the acquisition and recognition of professional qualifications and determining the forms in which a specific profession can be lawfully practiced. In the absence of a normative definition, it is difficult to interpret laws with respect to dietitians, as is the case with e.g. tax law – critically relevant to those running businesses. The drafting of a single act addressing the regulatory needs of specific medical professions took off several years ago, but the law has not yet taken shape. The act is supposed to introduce mechanisms to restrict access to the dietitian profession by enumerating the prerequisites and the eligibility criteria for its lawful practice. In the meantime, however, Poland remains one of the few European Union member states where the profession of dietitian has not been aligned with the healthcare system and is not protected by national laws. Albeit not directly overlapping with the area regulated by Community law, the projected law is essential to securing a fundamental freedom advocated by the EU – that of the free flow of persons. As long as qualification requirements for medical practitioners are not determined, patients are at risk of experiencing substandard medical services that could be hazardous to their health or life. Despite deregulatory changes being made to a number of professions, the draft bill does not intend to open up access to the dietitian profession.

Education and training for the dietitian profession is provided at university level via nutrition and dietetics programs. First-cycle higher education programs in dietetics lead to the award of the Bachelor's degree and take at least 3 years (6 semesters) to complete. Second-cycle (Master's) programs take 2 years (4 semesters) to complete at a minimum. Both first- and second-cycle programs comprise a compulsory work placement. Regulations adopted in 2011 withdrew dietitian training at post-secondary level.[34] The professional title of dietitian cannot be earned through post-graduate training courses, which offer a qualification upgrade but not the award of the title itself. Individuals graduating from higher education programs in dietetics are prepared for work as dietitians at public and non-public health institutions, food service facilities, research centers and institutes, nutrition counseling and education centers, in the media, and – upon completion of a teaching major – as instructors in schools. In addition, they can run their own nutrition clinics and consultancies.[35] The number of dietetics program graduates is greater each year. Even if it is a medical profession, dietitian training is offered by many non-medical colleges and can be obtained from both state and non-state institu-

[34] Regulation of the Minister of National Education of December 23, 2011 on the classification of qualifications in vocational education, Journal of Laws 2012, item 7.

[35] *Kształcenie w zawodzie dietetyka*, Polskie Towarzystwo Dietetyki, 2012, www.ptd.org.pl/index.php/kwalifikacje-dietetyka/ksztalcenie-w-zawodzie-dietetyka [10.07.2014].

tions of higher learning. Programs are delivered either on a full-time or a part-time basis, and their curricula are not standardized nationally. They continue to be advertised as providing attractive qualifications, whereas public healthcare institutions employ fewer and fewer dietitians each year. Table 1 shows the number of dietitians and, for comparison, of other mid-level medical personnel in employment with public sector institutions over recent years.

Table 1. Mid-level medical personnel employed in public healthcare units, classified by primary place of employment (as on December 31)

Specification	2005	2010	2012	2013
Dietitians	1665	1372	1192	1168
Masseurs	1410	1777	1658	1659
Occupational therapists	1384	1524	1396	1378
School nurses	1121	920	749	695
Dental nurses	1304	1582	1743	1920
Childcare workers	1418	2111	270	268

Source: own based on Biuletyn Statystyczny Ministerstwa Zdrowia 2014, www.csioz.gov.pl/publikacja.php?id=6 [16.08.2014].

In the last several years, dietetics programs have been fashionable. Their immense popularity with students seems to stem from a "dieting fashion" rather than from a job market analysis.[36] The total number of dietitians licensed to practice the profession in Poland and actually practicing it is difficult to estimate, since no relevant statistics are available. There are no widely accessible data on the total number of persons graduating from dietetics programs every year, either. It can be thus said that the Polish dietitian services market is still to be researched. It is very likely, however, that the market is fully or nearly saturated, getting rapidly filled with privately-held nutrition centers and clinics, especially in large cities. Dietetics program graduates who contemplate starting commercial clinics must therefore realize that they would be entering an increasingly competitive market. Estimates published by dietetycy.org.pl demonstrate that the largest dietitian markets exist in Warszawa, Poznań and Wrocław. In small towns, qualified dietitians are scarce, hence access to their services is rather poor.[37] As interdisciplinary medical professionals, dietitians are becoming more and more popular with patients, and their perception is quickly improving, too. However, unlike in most economically developed countries of Europe, North America and Australia, they are not entrenched in the healthcare system. Most dietitian services are provided

[36] K. Rożko, *Na uczelniach to modny i oblegany kierunek, ale szpitale zwalniają dietetyków*, "Rynek Zdrowia" 22.06.2011, www.rynekzdrowia.pl/Nauka/Na-uczelniach-to-modny-i-oblegany-kierunek-ale-szpitale-zwalniaja-dietetykow,110111,9.html [22.12.2014].

[37] www.dietetycy.org.pl/rynek-dietetyczny-w-polsce-2013/ [16.07.2014].

Table 2. The job market for dietitians and dietetics professionals

Profession / Year	New persons in unemployment records in respective year	New job openings in respective year	incl. subsidized jobs	New persons in unemployment records vs. new job openings	Percentage of subsidized jobs in total job openings (%)	Deficit/Surplus ratio – W*	Registered unemployment in persons as at year end incl. previously employed persons currently out of work for more than 12 months since registration		
	in absolute numbers						in absolute numbers		% of total registered unemployment
2013									
Dietitian (s)**	1 091	183	74	908	40.4	0.1677	914	305	33.4
Dietetics professional	185	10	5	175	50	0.0541	90	7	7.8
2012									
Dietitian (s)	1 032	144	–	888	–	–	910	304	33.4
Dietetics professional	121	7	–	114	–	0.0579	69	8	11.6
2011									
Dietitian (s)	1 074	114	–	960	–	0.1061	939	257	27.4
Dietetics professional	58	5	–	53	–	0.0862	38	4	10.5
2010									
Dietitian (s)	578	97	–	481	–	0.1678	808	188	23.3
Dietetics professional	23	3	–	20	–	0.1304	20	1	5
2009									
Dietitian (s)	1 299	190	–	1 109	–	0.1463	869	196	22.6
Dietetics professional	35	6	–	29	–	0.1714	13	0	0
2008									
Dietitian (s)	1 312	186	–	1 126	–	0.1	848	175	22.6
Dietetics professional	21	5	–	16	–	0.2	7	1	14.3

(s) – relevant vocational education available from public schools; "–" – data unavailable; * W – the deficit/surplus ratio ($W < 0.9$ – surplus, $0.9 \leq W \leq 1.1$ – equilibrium, $W > 1.1$ – deficit).

Source: own based on Ministry of Labor and Social Policy reports *Zawody deficytowe i nadwyżkowe for 2008-2013*, www.mpips.gov.pl/analizy-i-raporty/raporty-sprawozdania/rynek-pracy/zawody-deficytowe-i-nadwyzkowe/ [11.11.2014].

commercially via privately-run clinics and, as a rule, cannot be obtained free of charge from public healthcare facilities. Being aware of the limited number of jobs available at healthcare units, many dietitians choose to retrain or seek employment outside the health sector. The question arises whether it makes sense to train more and more dietitians in costly higher education programs, particularly in publicly funded medical programs.

Under the act on the promotion of employment and labor market institutions, voivodeship-[38] and poviat[39]-level governments are required to continuously analyze and monitor the job market for surplus or deficit of workforce in particular professions.[40] Job market statistics for dietitians are given in Table 2.

The surplus or deficit of workforce in a particular profession is captured on a countrywide basis by comparing the number of officially reported job openings against the number of persons in unemployment registers. According to a report by the Department of Labor of the Ministry of Labor and Social Policy, an oversupply of dietitians and nutritionists in the job market has been observed since 2008.

4. Taxation of dietitians

Dietitians choosing self-employment need to consider the ways to optimize their tax burden. In the Polish tax system, the responsibility for computing and remitting tax, as well as for recording business transactions relevant to the amount of tax payable, is generally placed on the taxpayer. Without requisite knowledge and experience, interpretation of tax law is a difficult and tedious task; to make things worse, too many official interpretations – some of them, regretfully, discrepant – are issued by tax authorities. Hence many dietitian businesses find it convenient to hire a professional accountancy to keep their accounts. Helpful tips can be also derived from administrative court rulings and decisions. There are cases, however, some involving the taxation of dietitians, that cannot be resolved until they are referred to the Supreme Administrative Court or the Constitutional Tribunal.

The key two types of tax concerning self-employed dietitians are income tax and value added tax. Other taxes that may apply include stamp tax and property tax. The Polish tax system allows individuals to choose among the following personal income tax schemes:

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[38] Voivodeship – the highest level of local government and administrative division in Poland, corresponding to region or province.

[39] Poviat – an equivalent of district or county, the middle level of local government and administration in Poland.

[40] Act of April 20, 2014 on the Promotion of Employment and Labor Market Institutions, Journal of Laws 2013, item 674, as amended.

a) the general scheme – with options to pay under a progressive schedule or at a flat rate of 19%,

b) the simplified scheme – including the fixed rate tax schedule based on recorded income, and the fixed amount method.

Freelance dietitians, however, can only use the general schedule. Regulations of the Act on Fixed Rate Taxation of Some Incomes Received by Individuals do not hold dietitians eligible to use either the fixed rate or the fixed amount method.[41]

VAT is a universal tax, which means that essentially each instance of sale of goods or services is taxable.[42] Exceptions have only been made for several services specified in relevant laws. Under the Act of March 11, 2014 on the Goods and Services Tax,[43] taxpayers can be exempt from VAT if their sales are under the VAT threshold (this was termed as "small business exemption" until the end of 2013), or if they deal in VAT-exempt goods or services.[44]

Newly founded dietitian businesses are exempt by law as not registrable for VAT. As a result, small businesses that are entitled to the exemption do not need to submit any statements to notify a tax authority of their decision to not register for VAT. They are, nevertheless, required to record their sales of goods and services. Records must be completed daily prior to the commencement of sales on the following day. If a dietitian business using the "small business exemption" (i.e. not registered for VAT due to being below the VAT threshold,) fails to keep fair sales records, it will be denied the VAT exemption with immediate effect and liable for a penalty under penal tax law. If a VAT-exempt entrepreneur goes above the VAT threshold, the exemption becomes void upon recording the transaction that exceeds the threshold. There are also VAT payers in Poland that are not required to pay VAT on their transactions regardless of turnover, if the goods and services involved in these transactions are listed in relevant regulations as VAT-free. It is a common business practice among small and medium-sized enterprises to perform operations involving VAT-exempt goods or services solely. This could

[41] Act of November 20, 1998 on Fixed Rate Taxation of Some Incomes Received by Individuals, Journal of Laws No. 144, item 930, as amended; Act of July 26, 1991 on Personal Income Tax, Journal of Laws 2012, item 361, as amended.

[42] Act of March 11, 2014 on Goods and Services Tax, Journal of Laws 2011, No. 177, item 1054, as amended.

[43] Journal of Laws 2011, No. 177, item 1054, as amended.

[44] The first type of exemption can be used by small businesses whose sales were below, or equal to, 150 000 PLN in each of the last two consecutive years. To use the exemption, the taxpayer must simultaneously meet two requirements: first, taxable sales in the previous year may not have exceeded the threshold of 150 000 PLN, and secondly, taxable sales in the current year may not exceed the threshold of 150 000 PLN. Cf, Journal of Laws 2011, No. 177, item 1054, as amended. The Act on the Goods and Services Tax stipulates some exceptions where the exemption does not apply, e.g. imports of good and services, intra-EU purchase of goods, and delivery of goods where the tax is paid by the buyer.

be e.g. the case with dietitians. The catalog of VAT-exempt goods or services is included in the Act on the Goods and Services Tax. Both types of VAT exemption, i.e. the one based on a sales threshold and that involving the exclusive sales of VAT-exempt goods and services, are optional. If a dietitian business provides VAT-free services only, then, under Art. 109 § 3 of the Act on the Goods and Services Tax and in connection with Art. 43 § 1 (19) thereof, it is not required to keep any VAT records. As a rule, if a business chooses to use either of the VAT exemptions, it may no longer deduct input tax (incurred in purchases of taxable goods) from output tax (included in the price of goods sold). In real business settings, a dietitian may engage in transactions involving VAT-exempt as well as VAT taxable goods and services. Therefore, a dietitian business may have:

a) the VAT-registered status – computing, remitting and recovering VAT except for transactions in VAT-free goods and services on which VAT is not payable,

b) the VAT-exempt status based on its sales volume – not remitting and not recovering VAT because its income is below the VAT threshold of 150 000 PLN,

c) the VAT non-registered status – performing solely transactions in goods and services that are VAT-free regardless of the VAT status of the business itself; these transactions will be VAT-exempt in either case.

Only businesses with the VAT-registered status are registered with an appropriate tax authority.

In line with the amendments made to the Act on the Goods and Services Tax in January 2011,[45] exemption based on the income threshold applies, under Art. 103, to businesses providing dietetics services whose total taxable sales did not exceed 150 000 PLN in the previous tax year. It should be added that the taxable income computed for VAT purposes does not include the amount of tax. Further, a business can opt for the VAT-exempt status (i.e. not to register for VAT) even if it does not commence dealings in taxable goods and services from the beginning of the tax year. The applicable VAT exemption threshold is then computed in proportion to the part of the tax year elapsed before and remaining after the first taxable transaction occurred.[46] To be able to engage in transactions in VAT-exempt goods and services, a business with the VAT non-registered status has to meet certain criteria specified in the Act on the Goods and Services Tax and unrelated to the volume of sales. Compliance with these criteria is commonly examined by tax inspectors. Pursuant to Art. 43 § 1 (18) of the Act on the Goods and Services Tax, VAT exemption applies to medical care services relating to health prevention, maintenance, recovery and improvement as well as to supplies of goods and services that are closely linked to these services and are performed by healthcare entities as part of

[45] Consolidated text: Journal of Laws 2011, No. 177, item 1054, as amended.

[46] Art. 113 § 9 of the Act on the Goods and Services Tax, Journal of Laws 2011, No. 177, item 1054, as amended.

their medical activities. Art. 43 § 1 (18) (a) extends VAT exemption to similar services provided to healthcare units on the premises where their medical activities are performed. Further, under Art. 43 § 1 (19), VAT exemption may be applied to healthcare services provided as part of the practice of such professions as physician, dentist, nurse, midwife, other medical professions referred to in Art. 2 § 1 (2) of the Act of April 15, 2011 on Medical Activities[47], and psychologist.

To find out whether specific services provided in the home country by a dietitian business will be exempt from VAT, it is necessary to:

– verify that the services fall within the area of healthcare activities delimited in relevant legislation; if they do, then exemption applies;

– ascertain that the activities serve one of the following purposes: health prevention, maintenance, recovery and improvement, or the supply of goods and services in direct connection with these activities; these and only these activities, when conducted for the purposes stated above, will be VAT-exempt;

– consider whether a particular service provider is eligible for VAT exemption (physician, nurse, midwife, another medical profession, psychologist); dietitians belong in "other medical professions" and are therefore eligible.[48]

As a matter of fact, such an exemption is of hybrid nature: VAT exemption is limited by law to eligible service providers and, at the same time, applies to certain goods and services only. A close scrutiny of the relevant regulations reveals that dietitian services can be exempted from VAT if both of the following two conditions are fulfilled:

A condition pertaining to the type of services being provided – this condition is met if the services can be categorized as healthcare activities, i.e. they relate to health prevention, maintenance, recovery and improvement, or to supply of goods and services in direct connection with these activities.

A condition pertaining to the service provider – this condition is met if the provider is an individual practicing the profession of physician, dentist, nurse, midwife, psychologist, or another medical profession within the meaning of Art. 2 § 1 (2) of the Act on Medical Services.[49]

In its ruling of January 18, 2012, the Voivodeship [Provincial] Administrative Court in Poznań states that there is not grounds to not treat dietitian services as

[47] Act of April 15, 2011 on Medical Activities, Journal of Laws 2013, item 217, as amended.

[48] A. Bartosiewicz, *VAT. Komentarz*, Wolters Kluwer Polska, Warszawa 2013; Individual Interpretation of February 15, 2013, case IBPP3/443-47/13/LŻ, by the Director of the Tax Chamber in Katowice; Individual Interpretation of March 1, 2013, case ITPP1/443-1482/12/MS, by the Director of the Tax Chamber in Bydgoszcz; Individual Interpretation of June 6, 2013, case IPTPP1/443-201/13-4/MW, by the Director of the Tax Chamber in Łódź, biblioteka3.inforlex.pl/ [3.01.2015].

[49] Individual Interpretation of February 19, 2013, case IPPP2/443-1177/12-5/KG, by the Director of the Tax Chamber in Warszawa, www.mofnet.gov.pl [15.07.2013]; www.administracja3.inforlex.pl/ [4.01.2015].

VAT-exempt, since dietitians are, beyond any doubt, professionals providing services that benefit their patients' health. On the other hand, it argues that dietitian services provided online via the Internet cannot be deemed medical care services because, in such settings, the patients are not directly examined and observed. Consequently, not all dietitian services are VAT-exempt. It should be observed that the Court's refusal to recognize such services as VAT-exempt is not based on the fact alone that the services are provided over the Internet or that computer software supporting diet composition is used on many occasions. In the judges' opinion, the problem is not that medical services relating to health prevention, maintenance, recovery and improvement are provided via the Internet, for it cannot be generally assumed that they may not be. Art. 43 § 1 (19) of the Act on the Goods and Services Tax does not explicitly deny VAT exemption in case services are provided online via the Internet.[50]

A tax law expert from Ernst & Young comments that the ruling leaves room for arguments in favor of VAT-exemption for specialized healthcare services such as medical examinations involved in prescribing and administering further treatment. Therefore, the expert recommends that the ruling become food for thought for all businesses providing dietetics services.[51]

Conclusions

Dietetic treatment leads to health benefits as well as to a number of economic and social benefits. Besides betterment in health, patients and their families experience improvement in the quality of life and in work performance, while the society profits from savings on the cost of healthcare. Nutritional advice also plays a vital role in preventing many diet-related diseases, in that way reducing the mortality rate among persons seeking the support of professional dietitians. An efficient, well-organized system of bringing nutritional advice to the patient helps lower expenditure on healthcare, primarily by economizing on the cost of hospitalizations. There is strong evidence based on research suggesting that dietetic treatment is very economical. Dietetics will not be able make a difference, however, unless the dietitian profession has an adequate systemic status and unless favorable conditions are created for dietitian businesses to emerge as new players in Poland's SME market.

The research findings presented in the paper allow the following conclusions:

In Poland, the legal and organizational framework for the profession of dietitian is rather inadequate and compares unfavorably with regulations found in

[50] Ruling of January 18, 2012 by the Voivodeship Administrative Court in Poznań, I SA/Po 767/11, www.orzeczenia.nsa.gov.pl/cbo/query [14.12.2014].

[51] www.podatki.gazetaprawna.pl/artykuly/617953,e_dietetyk_nie_skorzysta_ze_zwolnienia_vat.html [15.12.2014].

many developed economies. This puts patients at risk of using medical services provided by individuals lacking relevant education and clinical experience. Other concerns are associated with the confusion around procedures for recognition of medical qualifications and the frustration over interpretation of tax law. It appears necessary to take immediate legislative action and adopt a single act laying down a coherent legal framework for the practice of "other medical professions" as well as standards for professional liability.

As very few dietitians are employed in public health service facilities, many of them choose to set up small and medium-sized businesses and offer their services commercially. The number of such businesses is not known because no relevant data are publicly available.

It is to a limited extent only that dietitians have been incorporated into the Polish healthcare system. Their complete integration with the system should not occur, however, until a functional register of persons practicing "other medical professions" is in place. As a next step, the system's multiple dysfunctions should be remedied by introducing adaptive modifications. What really matters here is that all the stakeholders perceive the need for changes, and that the changes be initiated and implemented with due diligence. The key objective of the proposed changes is to popularize the use of dietitian services and to facilitate access to these services by making them available through the public healthcare system, either free of charge or under a partial payment scheme, to both healthy and ill patients. As a result, the primary goal of medical services provided by the state – improvement in the health of each individual as well as of the population at large – will be better met. The suggested organizational and functional changes to the healthcare system involving the incorporation of dietitians are consistent with the widely recommended model of comprehensive healthcare. They are aimed not only at extending the range of available medical services and optimizing the use of the sector's human and material resources, but also at improving the system's overall performance and increasing the satisfaction of both healthcare customers and providers. In addition, the proposed reforms may have a stimulating effect on the growth of Polish SME sector.

Training for the profession of dietitian lags behind the job market requirements. The available market data indicate that the supply of workforce is higher than the demand – while the number of people seeking dietitian jobs increases from year to year, the number of openings does not. It may be also surprising that, although it is a medical profession, there are no compulsory standards for education and training in the field and no pre-defined paths for professional development or skills improvement.

The ambiguous position of the dietitian profession, notably within the public health system, results in the lack of medical basis for contracting dietitian services

by the National Health Fund and hence in measurable adverse effects on public health, the society and the economy.

Organizational changes in the healthcare system should be based on reliable statistics and calculations relating to dietitians and diet-related diseases, yet such data are hardly available in Poland. The measuring and tracking of incidence and prevalence rates is among the key problems of Poland's public health and its healthcare system. It seems that for health policy makers accurate medical information would be instrumental to making rational decisions and evaluating the effectiveness of existing policies.

Since dietetic services are VAT-exempt, dietitians have an alternative of benefiting from this exemption or exercising the status of a VAT non-registered entity based on the VAT sales threshold. In lieu of subject literature and judicial decisions, the taxation of distance sales of dietitian services (i.e. provided via the Internet) raises substantial doubts and has become an important constraint on the growth of some Polish small and medium-sized businesses, viz. nutrition centers and clinics.

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Dietetyk – nowy zawód na rynku małych i średnich przedsiębiorstw w Polsce

Streszczenie. *Celem artykułu jest prezentacja znaczenia zawodu dietetyka w polskim systemie ochrony zdrowia oraz analiza perspektyw usytuowania dietetyków na rynku małych i średnich przedsiębiorstw. Przesłanką podjęcia problematyki badawczej jest dysfunkcjonalność regulacji prawno-organizacyjnych wykonywania zawodu dietetyka w porównaniu z innymi krajami, co stanowi istotną barierę rozwoju zawodu i rynku usług medycznych. Powoduje to też wiele innych negatywnych skutków: zdrowotnych, społecznych i ekonomicznych. W artykule zaprezentowano działalność poszczególnych podmiotów kreujących rynek usług świadczonych przez dietetyków, z uwzględnieniem najważniejszych problemów zdrowia publicznego i kierunków współczesnej polityki zdrowotnej. W podsumowaniu zawarto postulat funkcjonalnej i organizacyjnej restrukturyzacji systemu opieki zdrowotnej, mającej na celu włączenie dietetyków do systemu w szerszym zakresie. Postulat wpisuje się w zalecany współcześnie model kompleksowej opieki zdrowotnej, której celem jest nie tylko rozszerzenie zakresu usług zdrowotnych, reorganizacja i racjonalizacja wykorzystania zasobów ludzkich dostępnych dla sektora, ale również poprawa jakości, skuteczności i efektywności systemu oraz wzrost satysfakcji usługobiorców i usługodawców. Realizacja postulatu pozwoliłaby także na zdynamizowanie rozwoju rynku małych i średnich przedsiębiorstw w Polsce.*

Słowa kluczowe*: dietetyk, zdrowie publiczne, choroby dietozależne, polityka zdrowotna, małe i średnie przedsiębiorstwa*