

## THE POLISH HEALTH CARE SYSTEM'S ENDLESS JOURNEY TO PERFECTION – A NEVER ENDING STORY

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### Abstract

**Purpose:** The main aim of this paper is to show the Polish health care system's transformation process in recent years and to answer the question whether there is a simple path from centralization to decentralization or another form of centralization. The transformation process has changed the health care system's financing from budget planning to compulsory health insurance deducted from workers' and employers' premiums. In addition, the transformation has strengthened the autonomy of the health care at a local level and made it less dependent from the public sector. Different health care systems correspond to each period respectively. It is believed that the main change in Polish health care took place in 1999 when the function of the payer which formerly belonged to the government administration was overtaken by an independent institution (Health Care Fund).

The article not only describes and explains functioning of each health care model existing in Poland in the past but also puts them in the international context. In addition, the article shows difficulties each model had to face and cope with and indicates the underlying reasons for changes in the Polish health care and their consequences.

**Design/methodology/approach:** A range of recently published (1990-2012) works, which aim to provide both theoretical and practical view on the health care system in Poland, has been analyzed.

**Findings:** The final thesis stated in this article presents a way of interpretation changes that the Polish health care system has been undergoing in recent years. This paper challenges a thesis according to which the Polish health care system is decentralized.

**Research limitations/implications:** The scope of this article is limited and does not allow to perform further research. Additionally, the research was based on the very scarce literature on the issue of health care system in transition.

**Practical implications:** This paper reveals several practical applications worthy of future study in health care system changes (mainly decentralization). First, it would be valuable not only to further investigate and determine a range of financial and legal instruments which are used by local governments to affect the health care system, but also to evaluate these instruments in terms of their suitability for performing statutory duties imposed on the local governments in this respect.

**Originality/Value:** This paper is part of a growing body of research on local government's role in the health care system. It will contribute to future research on similar topics.

**Keywords:** health care, health care system, Semashko model, health care decentralization

**Research type:** general review

## Introduction

For many years the Polish health care system has been subjected to numerous analyses and researches conducted by representatives of different fields of science – not only law, but also economics, sociology and psychology. As a complex issue the Polish health care system has undergone large – scale and highly dynamic changes in the recent years. Those changes have been strongly connected with social and economic processes resulting from political transformation, changes in financing of medical services from public sources, new tendencies in illness` epidemiology, and appearance of new medical technologies together with general technological progress in science which could be applied to medicine (Szelemej, 2009).

The process of transformation of the communist countries which took place in Central and Eastern Europe affected the whole structures of those states, including health care systems. Before the collapse of communism, the health care systems in those countries were highly centralized and based on Soviet – designed Semashko model. It is said that health care in communist countries was ineffective and chronically underfunded. (Marree and Groenwegen, 1997).

It is worth emphasizing that while many system components were common, the health care reform experiences in Central and Eastern Europe differs considerably from that of the successor states since the dissolution of the USSR. This is probably due to being relatively more prosperous and having had experience with private practice and social health insurance before the Second World War (like it was in Poland in 20`s XX c.) (<http://www.euro.who.int/en/what-we-do/health-topics/Health-systems/primary-health-care/facts-and-figures>).

An analysis of the subject literature shows that whereas before the Second World War the East European Countries had a Bismarck health care system after the Second World War a Semashko system was introduced. Later, after the breakdown of the communist regime those countries have reintroduced a Bismarckian social insurance system (Marree and Groenwegen, 1997).

## Historical Background

### a) Before the Second World War

In order to understand changes of the Polish health care system and its present shape it is crucial to present the historical background . The current Polish health care system has been a result of the transformations in the last 100 years. At the beginning of XX c. authorities has accepted the role of the state in providing health care services to

citizens. Later, because of wars and other conflicts the state became very poor and could not follow its mission regarding medical services.

In February 1917, as a part of a program of reconstructing Polish government institutions, the Temporary Council of State established a sanitary unit in the Ministry of Home Affairs. When First World War came to an end the necessity of rapid changes in the Polish health care system was accentuated. Poor health conditions, extremely high death rate and ruined medical infrastructure were signs that health care reform are highly demanded. Just a while before Poland regained its independence, In May 1917, a draft public Health Law had been presented – the main idea concerning multisectoral health care system with the public sector dominating over the private sector (Godycki – Ćwirko, Oleszczyk and Windak, 2010). It should be emphasized that the role of public sector was significant and medical services were provided by county physicians (state health service), hospitals (local government health service) and health centers and self governed Sick Funds for employees. A system of treatment service for working group of people was established by “Mandatory Insurance in Case of Illness Law” on 19<sup>th</sup> May 1920. There was introduced an insurance obligation which meant that insurance was compulsory and universal. Medical services were provided by licensed physicians contracted by The Sick Funds. The Ministry of Public Health was liquidated in January 1924, and its responsibilities were taken over by the General Directorate for Health Service in the Ministry of Home Affairs, transformed in 1928 into the Department of Health of the Ministry of Social Welfare (Godycki – Ćwirko, Oleszczyk and Windak, 2010).

There were also many small sick funds which, due to high unemployment, united less and less workers. The economic crisis from the 20’s hastened the reform – in 1933 Sejm adopted the new Social Insurance Law (called “consolidating law”) and established The Social Insurance Enterprise – a new institution that took over the responsibilities of Sick Funds. It is worth noticing that in 1937 only 1,5 million people from 36 million of Poland population used medical services provided by local government health centers, and only 2 million people made use of outpatients clinic managed by the Social Insurance. In addition, in 1938 only 14,7 % of the Polish population was covered by sickness insurance; this is because insurance did not covered rural population which constituted 70 % of the nation. Nevertheless, in comparison to the rest of Eastern European countries such as: this system was considered as modern and innovative.

## **b) After the Second World War**

The new communist government founded a National Health Service based on the Shemashko model (called also a “soviet model”) of the Soviet Union and in 1952 constitution (article 3), proclaimed the principle of great importance: health care freely accessible and delivered free-at-the-point-of-need to the whole population (although, many authors point out that country at that time was devastated and lacked the capacity to guarantee free health care). But a catchy slogan “free health care for all” remained as an essential element of the Shemashko model and returned in the early 90’s when Poles still

demanded free medical services. (Marree and Groenwegen, 1997). In 1991 over 70 % Poles declared, that the health care system should be financed only from the state budget (Krynicka, 1992).

In Semashko model health care is considered to be an integral part of planned economy which runs similarly to other sectors. In other words, there is no difference between health care and, for instance, industry. All sectors are centrally planned. The Ministry of Health is the key policy maker and regulator of the health system. All institutions responsible for health care are state-owned. This means that all decisions regarding investment projects are made by the central administration. The quality/condition of the health care system is a result of the politics/political game. The political party decides which sector of economy should be provided with money. Therefore, the armaments industry, considered as the most important, has been always well funded whereas health care was usually financially neglected. As well as in other sectors of the economy, health care chronically experiences shortages. Due to the fact that all citizens have the right to use free health care services, their quality and availability is rather poor. A deep conviction of equal access to medical treatment and feeling of security are discredited by symptoms of corruption (Kornnai and Eggleston, 2002).

Above factors caused that at the turn of the 80's and 90's the system was extremely inefficient.

### **Transformation**

In 1989, after over sixty years of being dominant system in Polish economy, communist regime has ended. Since its fall in 1989 Poland has been reforming the public sector, particularly public finances. We should remember, that the transformation of the health care system in all countries of Central and Eastern Europe started under very difficult conditions (Marree and Groenwegen, 1997). Health care, which was inherited from the communist system, was pathological in many aspects.

There was gross negligence regarding management, employment policy and the system's financing. First of all, the health care system was over employed – it is estimated that in the 80's only 52% of medical staff were professional medical staff (doctors and nurses). The rest of the people employed in this sector were working in administration. Due to constant price rises, staff demanded higher salaries. Personnel costs constituted the biggest part of every entity's budget. It was typical to Semashko model which focused on increasing number of medical personnel and hospital beds in order to compensate the scarcity of supplies and the poor quality of facilities (Marree and Groenwegen, 1997). The key factor was that medical staff constantly made demands for increases in remuneration. In addition, significant impact on the bad condition of the health care system was done by poor management i.e. during over 50 years medical establishments were managed without any reference to economic accounts. The relation between medical services and their costs was not noted.

The Ministry of Health and Social Welfare was responsible for the major part of health care – it also financed most of the health care expenditures at the national level,

including drugs, regional hospitals, rescue and ambulance services, prevention programs... . Poland was divided into 49 small regions which received their budgets for health care directly from the Ministry of Finance. A special feature of the Polish health care sector was formed by almost 400 integrated health services (health care institutions - ZOZs). The ZOZs were established by the Instruction of Ministry of Health in 1973. They were funded by voivodships and their budgets were global “and ZOZs were therefore largely free to set their own priorities” (Marree and Groenwegen, 1997).

The term transformation refers not only to system changes but also economic mechanism. In the public eye transformation is mainly considered as economic and political changes. Reform of the health care system has been rather ignored in both political and social discourse. By many authors it has been emphasized that during the time of transformation the system faced overlapping crises – the financial crisis was accompanied by systemic and political crises. Galloping inflation (in January 1991 amounted 75 %) caused rapid growth in prices which made medical services financing in view longer than 1 month almost impossible (Kulak, 1999). The repeated growth in prices of importing medical devices and drugs caused the situation in which hospitals were no longer able to buy ordered products. Planning the health care system expenses was no longer possible.

Consequently, the problem of growing debt of the health care centers occurred. In 1991 the debt rate amounted 250 million PLN, in 1998 – the rate achieved 750 billion PLN. As many authors underline, this situation was caused by defective exercised ownership and mistakes in investor’s supervision over the operations and finance.

It should be emphasized that Poland was the first socialist country in Eastern Europe to have free elections – new government announced to continue publicly financed health care and to decentralize the health care organization It has determined the direction of reforms (Marree and Groenwegen, 1997).

### **Apparent Decentralization**

Simultaneously to the reform of the health care system the administrative reform was carried out. Since 1999 there have been three levels of territorial administration and self-government in Poland. The principal unit of administrative division with territorial self-government status, established in 1990, is the *gmina* (often translated as commune or municipality). It is followed by the *powiat* (often translated as a county or a district) and the *województwo* (a voivodeship, or an area governed by a voivode; also translated as a region), which form the second and third level of administration and territorial self-government, respectively (*Poland. Health system review*, 2011).

The law on territorial self-government compelled districts and provinces to assume the responsibility over health promotion and health care made districts and provinces take responsibility for this tasks. Nowadays, the local self – governments are able to operate their own health care units. However, they do not have direct control over the resources required to finance the units. The money mainly comes from health insurances in a form of payment for services. What is more, the responsibility of the government

administration in health care is significantly curtailed and the scope of the regulatory role of the Health Minister is unclear. The duties of local government are not clearly defined either.

Apart from legal and organizational changes, the reform of the health care system brought a significant change in financing the system. Before the beginning of gradual public sector devolution in 1989, the Polish health system was strongly hierarchical and predominantly funded from the central budget. In the course of the political and economic reorganization that followed the collapse of communism, the strongly centralized system based on the Soviet model of health care was replaced with a decentralized system of mandatory health insurance, complemented with financing from central and local budgets. During the 1990s, the administration of most health care services and the ownership of most public health care facilities were transferred from the Ministry of Health initially to the voivodeships and *gminas* and later also to *powiats*, which were re-established as an intermediate level of public administration in 1999.

The transformation of the system has brought, among others, the change in the method of financing from budget planning to compulsory health insurance deducted from workers' and employers' premiums. Before the reform in 1998, the system was strongly hierarchical and predominantly funded from the central budget (the function of the payer in the health system belonged to the government administration), Since 1 January 1999, by virtue of The Act of 6 February 1997 on public health insurance this function was overtaken by the Health Care Fund and since 1 April 2003 also by the National Health Fund (NFZ). Therefore, the management of funds allocated for this purpose has been excluded from the structure of public administration and the funds allocated for this purpose which came from the tax revenues were excluded from the state and local government budget (in the wake of the administrative reform, 17 sickness funds were created within the system of mandatory universal statutory health insurance (SHI). The SHI contributions subsequently became the major public source of the health care funding, relegating the state and territorial budgets to a complementary role. After only four years of activity, sickness funds were replaced by a single institution – the NFZ – in 2003).

Since the beginning of the 90's both public and private health care centers have been established. Therefore the Act on Health Care Institutions constituted a theoretical possibility of differentiating ownership relations by establishing and overtaking health care centers by a wide range of entities, particularly by communes. In a current state of the law, regulated by the Act of Medical Activities a medical entity can be established and maintained in a form of a limited liability company or budget unit by the Treasury (represented by the minister, central government authority or governor), or by the local government units. These entities may join a limited liability company performing medical activities (Article 6. section 8), and they may also run the Independent Public Health Care Institution (IPHICIs).

Because of the reactivation of the local government, its role in the health care system has significantly increased. The local government has been obliged to take over the responsibilities for the health care. Initially, this liability applied only to communes. In

1995, on the basis of the pilot program and Article 3 - so-called the City Act of 1995, municipal communes were given the responsibilities and powers under the Act on Health Care Institutions. Previously, health care institutions were run by the government administration. Since then, however, running health care institutions has become the responsibility of municipal communes. Financing these tasks was defined in the Article 11 of the aforesaid Act, which stated that the income of municipal communes, which overtake responsibilities and powers, increases by an amount equal to the product of the share ratio of personal income tax and the total amount of country's income from the personal income tax planned in the budget act. In addition, it has been predicted that the amount would increase by additional 2% in order to finance capital expenditures. Therefore, health care entities, previously supervised by governors, now, on the basis of governors' decision have become communal organizational units and the powers of the founding body have been passed from governors to local government units. District and provincial governments have become responsible for exercising founding and supervisory functions over the health care institutions.

Despite the fact, that the payer in this system is the National Health Fund, the local government, as an establishing entity, still bears financial responsibility for protecting citizens' health. In accordance with the regulations of the Act on Medical Activity, significant financial consequences result from ownership entitlements of local government units in relation to medical entities According to Article 59 Section 2 of the aforesaid Act, a local government unit, as an entity that establishes the IPHCI can (within 3 months following the deadline of approval of the IPHCI's financial statements) cover the net loss of this institution for the financial year , on if after adding depreciation the result is negative - up to the amount of this value (Article 59 Section. 2). In case of dismissing this option, the establishing entity, shall either issue a regulation or disposition, or pass a resolution on changing the form of business (i.e. transforming it into a limited liability company or a budget entity) or liquidating the IPHCI (Article 59 Section 4) within 12 months of expiring date specified above.

This legal status constitutes a serious threat to the financial stability of the local government (Babczuk, 2010). It is widely known that many health care institutions report that the level of their debt exceeds the budgets of the establishing entities. It is said that liabilities of medical entities in 2012, compared to the previous year, increased twice. The doctrine emphasizes that responsibilities concerning state health policy, which are generally the domain of the government, are being transferred onto the local government without providing it with adequate financial resources. It is the establishing entity that has to cover the expenses of maintaining IPHCIs because they are not financially supported by the National Health Fund and the Ministry of Health. This solution is inconsistent with general principles regarding methods and forms of financing health care services by public entities, which assume that the latter (local government units in particular) can finance the IPHCIs only within the scope needed to meet the general guidelines indicated in Article 48 of the Act on Health Care Services Financed from Public Funds. The basic right of local government is the possibility of transferring funds to the IPHCIs. The right was included in the Act on Health Care Institutions (Article 55), as well

as in the Act on Medical Activity that would replace the former one. However, in practice, there are serious limitations, i.e. it does not take into consideration the possibility of advancing funds by the local government in order to cover liabilities arising from the National Insurance Contributions, the Health Insurance Contributions and the Labour Fund (liabilities to the Social Insurance Institution).

According to Gorzelak, the urgent need for the decentralization of the state administration in Poland was frequently expressed in various reports. It was emphasized that centralized management of hospitals, secondary schools, state industries – those which belonged to the state rather than to local government – was becoming more and more difficult. Local government would be much better allocated to manage these facilities than the central administration could ever hope to be. Furthermore, the budgetary independence of the new administration units would have allowed for the scope of the central budget to be significantly limited (Gorzelak and Jałowiecki, 2000). Decentralization envisages that not only functions, powers, duties should be redistributed from the state to the local authorities, but also, or probably above all, funds and resources. Nevertheless, many authors pointed out that still an unresolved matter remained - a lack of the budgetary decentralization in provincial government and the funds which they have at their disposal fall far short of their needs (Gorzelak and Jałowiecki, 2000). In brief, the fundamental aim of the reform – the decentralization of the state – has only been partially achieved. Although new local government units have been introduced, these governments have not been given adequate legislative powers or independent budgetary means.

Centralized system has many weaknesses – in Poland there is a model based on administration of existing resources and structures; there is a little analytical work in departments of the Health Ministry, which “could serve as a basis for new policies and programs”. Unfortunately, the problem concerns not only the lack of many fundamental analytic tools but also the information system which is very much inadequate when it comes to “the proper monitoring and more insightful analysis of the state of health of the population”. As a result, there is a lack of knowledge on local government potential relating to the formulation of health policies (Wojtyński and Goryński, 2008).

Sadly to say, there is no need-based allocation formula to support national, regional or local decision-making process with regard to distribution of funds among regions and different types of health institutions. The state and the territorial self-governments directly finance health services, but their shares are not as sizeable. Since 2007, the largest item in the state budget related to the financing of health care services has been emergency services, for which PLN 1.2 billion was allocated in 2007, PLN 1.6 billion in 2008, and slightly over PLN 1.9 billion in 2009. Financing from the state budget also covers certain highly specialized services (e.g. organ transplants, certain cardiological expensive and radiological interventions). Limited financing seems to be the greatest barrier in achieving accessibility and good quality of health care services and in improving patients` satisfaction.

## Conclusion

The Polish health care system has undergone several huge changes during the previous years. The direction of changes was influenced by many factors – economic position of the Polish state, its financial situation, and, mainly, the political system. In a historical perspective, the long- time process when changes occurred, can be divided into 3 periods: before The Second World War, after The Second World War, and after the systemic Transformation. Contemporary Polish society’s problems are forcing the health care system to undergo permanent changes. Population ageing, technological development and illnesses caused by modern civilization start to challenge the Polish health care. The system must adjust to new problems which the future brings. Unfortunately, old management structures are poorly prepared to meet the challenges, and the system seems to struggle to survive. Governments must be facing difficult task to establish an affordable health care system. Nowadays, when the system constantly struggles with a crisis, the government assigns the responsibility for health care to local government (named it “decentralization”).

“In recent years a major experiment took place in the health care system in Poland, consisting of a smooth transition from a centrally controlled, public, fossilized system of budgetary units (hospitals) to the phase of self – managing pseudo-companies, still operating in a single payer system, but often subjected to the influence of aggressive elements of the market”. Author points out that Polish legal system when it comes to creating new subjects on the market of medical services and applying for public (budgetary) resources is the most liberal in the world (Szelemej, 2009).

The actions and measures which were taken and adopted in recent years targeted at improving the competition in the health care sector. According to reformers, money wasting should be limited by introducing a competition policy. On the other hand, the authors emphasize that free market in health care system in a myth – health can’t be compared to profit, and health care units can’t focus only on overall yield. The fundamental aim in health care should focus on prevention measures and action protecting life and health. These values, health and profit, can’t be contrasted.

The privatization of health care has many supporters (Goodman, Musgrave and Herrick, 2008). However, the “free market” introduced by new legal solution seems to be free only in theory. In other words, the Polish market of medical services is fully controlled by National Health Fund, and works like a regulated market, which means that the health care system in Poland doesn’t belong to the free market. (Zalicki, *Konkurencja ograniczy...*, 2012).

Privatization of the public hospitals as a result of inefficient management and accumulated debt has been strongly politicized. At the same time, however, privatization of health care institutions by self- governments, encouraged by the 2011 Law on Therapeutic Activity has been taking place. Time will show how commercialization of hospitals impacts on the accessibility, affordability and quality of medical care in Poland.

To briefly summarize: The Polish health care system has undergone deep changes during the last century. Whereas before the Second World War the system was

decentralized with clearly outlined role of the state, after the Second World War it was strongly centralized and financed from budgetary funds. After transformation in 1989 the direction of reforms was not explicitly stated. Poland has not yet declared clearly whether it would adopt government financed or market based method regarding financing health care. Hence, the current system is called “mixed”.

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