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Best Practices in the European Countries

Poland

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Public service reforms in Poland. The case of the health care system

Summary

This paper presents some aspects of the ongoing reform of Polish Health Care System. The purpose is not offer an exhaustive view of the reform but simply to underline elements of innovation that could be retraced back to the recent Public Administrative Reforms.

Beyond its internal efficiency problems, costs issues and equity, the Health Care System, like other public services, is influenced by the general reform process required above all for new European Countries.

The European Union was consistent in its demand to new accession countries to prepare adequately for the transition by "increasing capacity" in public administration and enhancing "good governance" levels.

That has required strong planning and a faster adoption of a broad list of reforms in Public Administration: organizational and structural modernization; reduction of public expenditure; gain of citizens' trust and their participation through decentralization institutional process; high quality in public services; good levels of motivation and liability in public servants.

So, in designing its reforming health program, the Polish Government followed both European strategic advisers and the need to grant efficiency to a comprehensive health care system. It has included changes in four major areas: institutional setting (decentralization); financing and provider payment (public private mix), health care delivery and consumer behaviour (health care quality).

1. Public administration reform in Poland. An overview

Preparation of regional and local administration for absorption of the EU regulation and aid funds was one of the priorities of the National Programme of Preparation for Membership (2002-2003) in the EU and of the principal measures implemented under the Action Plan to strengthen Poland's administrative and judicial capacity (2002-2003).

Public administration reform is a broad notion, involving – most generally – the need to build new foundations of public life, with a broad scope. It should take into account not only reorganization of the administrative system of the state, but also reconstruction of the value of state work in civil service, as well as simple consolidation and rationality in managing public funds.

Principal objectives, in fact, that have been encouraged the implementation of the reforms concerning:

- A clear distribution of responsibilities between local, regional and central segments of public authorities to eliminate the competence and organizational disorder in the State.
- A distinct separation between politics and administration, and both areas from the economy;
- Guaranteeing civil control in all segments of public authority (improving transparency) within the framework of decentralized functions of the State;
- Reducing corruption and nepotism in the administration and for reconstructing the ethics of the civil service, improving operating efficiency of the administration;
- Ensuring efficient performance of public tasks by the administration creating professional and politically neutral staff.

In view of their importance for the implementation and enforcement of the “*acquis communautaire*”, the government adopted several programmes for the overall state of readiness of the public administration and the judicial system: the *Anticorruption Strategy*, on September 2002; under the Phare program '99 a project for the *Strengthening of the administration and human resource to prepare for EU membership* and a project for a “*Friendly Administration information service*”; the *Civil Service Code of Ethics for civil Service* on October 2002 and within the Phare 2003 planning, in years 2004 2005 the Office of Civil Service will carry out the project *Strengthening the public administration capacity*.

Administrative decentralization. According to widely accepted definitions, administrative decentralization is the transfer of authority and power in public planning, management and decision making from higher to lower levels of government or typically from national to sub-national levels. The devolution of central government functions to local jurisdictions has been realized partly in response to political pressures for local autonomy, partly as a strategy to deliver public services more efficiently. A fundamental *regional administrative reform* in Poland was put into effect at the beginning of 1999. Essentially this reform aims at putting, virtually, all decision making and financing responsibility for regional as well as local public services and investments in the hands of regional and local authorities, to complete the decentralization reforms first initiated in 1990. The number of *voivodships* was reduced from 49 to 16, an entirely new layer of county government (*powiats*) was added, and new elected *powiat* and provincial councils were created¹. This new structure is now in place, but more work is needed to develop local revenue capacity and complete the legal and administrative changes required to make the new structure fully operational. In this perspective, an important emerging issue for Poland is the question of how to upgrade the quality, efficiency and effectiveness of state administration. Such an effort requires actions to improve salaries and working conditions (so that administration can attract, train and

¹ J. Regujsky “Local Government reform: an inside story”, 2003

keep qualified and experienced personnel), streamline ministerial functions, procedures and the decision making process, and reduce unnecessary controls and regulations, to name a few.

2. Health care system reform: objectives and strategies

In the 40 years prior to 1989, Poland was a centrally planned socialist economy. This meant that the production and delivery of goods and services were a response to the often arbitrary decisions of Communist Party leaders and government officials. Consequences of this system were chronic overstaffing, as well as low levels of motivation, morale, efficiency and pay (in real terms) throughout the economy. The health sector was not an exception.

Although Poland is viewed an economic leader among former communist countries, the development of health care reform has lagged behind. Poland introduced its national health insurance system only in 1999, ten years after the fall of communism. This reform marked an important shift from a centrally controlled, budget-based system to a decentralised insurance-based system, operating through multiple regional funds and a special fund with nation-wide coverage. It also intended to encourage the development of primary care services promoting the role of family doctors to rise delivery health care efficiency.

The health care system that Poland inherited in 1990 from the communist era offered universal coverage with a comprehensive programme of health care benefits distributed through facilities owned and run by the state. Although the system provided universal health care coverage, it was over centralised, over-specialised and did nothing to nurture cost awareness. Regional inequalities, rationing and misallocation of resources emerged, with growing unofficial payments to public health care providers.

Increasingly, patients perceived the quality of health care offered by the system to be poor and general public dissatisfaction began to grow. So in recent years, health care reform has figured on the government's list of priorities and some changes were introduced in the early 1990s:

- legislation and other initial steps to create and run hospitals and ZOZs (publicly owned integrated health care provision organizations) as independent units;
- *decentralization* of ownership, as well as financial and management authority to the gmina level (for primary care) and to the voivodship for many other services;
- extensive, but as yet poorly regulated, *private* ambulatory medical practices for general and specialist services;
- implementation of a "family doctor scheme": a new model for the general practitioner role for delivery of primary *costs reduction* care;
- management and public health care *innovation*

2.1 Decentralization of the health care system

Decentralization has become a popular management strategy in many European health care systems. It is deeply ingrained in some parts of Europe (Nordic countries) and types of health systems (social health insurance) where recent extensions of decentralization draw on more of organizational and managerial experience. Elsewhere it is a recent development, seeking to remedy the inadequacies of centralized national models of health system decision-making (Mediterranean countries; countries of central and eastern Europe).

Also in Poland, recent reforms in health care system have marked a radical change from a highly centralized system to a decentralized insurance-based system. The role of the *voivodships* in the administration of health care was increased, and these in turn passed management responsibility to the ZOZ, which amounts to de-concentration within a devolved framework.

During the 1990s, health care was substantially decentralized. *Gminas* became increasingly responsible for primary health care, and some large city *gminas* now also manage secondary health care services previously administered by the ZOZ.

The recently re-established and elected district level *powiats* may also come to play an increasing role in funding the capital costs of health care services, such as renovating hospital premises.

Health care institutions are becoming autonomous registered organizations or 'independent units' that will be responsible for their own budgets and service decisions. They will be subject to civil law and be able to contract for services. These self-managing institutions will obtain income from various sources: health insurance funds, Ministry of Health and Social Welfare, their government sponsor (if relevant), and private organizations and private persons.

The implementation from 1999 of the 1997 General Health Insurance Act will transfer recurrent health sector financing and administration to the regional funds. It may also facilitate an expansion of non-government health services.

The role of the Ministry of Health and Social Welfare is evolving from health care funder and provider to policy-maker and regulator. This Ministry is responsible, in general, for national health policy, for major capital investments and for specialist health services. It has administrative responsibility only for those health care institutions that it directly finances.

The organisational structure consists of 16 regional health funds (covering at least one million insured each) corresponding to the new administrative division into 16 voivodships plus an additional branch fund which operates nation-wide². These funds will be autonomous. The intention is that government funding will be scaled back as insurance cover expands, and government administration will be phased out as service providers contract directly with the insurance funds. Some specialized services (such as organ transplants) and also public health programmes (such as the National Health Programme, National Heart Protection Programme and the Cancer Control Programme) will remain financed from the state budget.

Health services owners now have more autonomy in planning, regulating and managing health services in their areas. These owners include the voivodships, the *gminas*, other ministries, and also the *powiats*.

Voivodships. Under the previous regime, these regional units were the administrative arms of central government. Since 1992, their health budgets have come directly from the Ministry of Finance. The voivodships plan health services, organize the structure of health institutions and allocate funds. They run the regional (provincial) hospitals that offer secondary care and also run some specialized tertiary care hospitals. Each voivodship also administers a number of ZOZs. The policy and fiscal autonomy of the voivodships potentially allowed considerable diversity in health and social services across the country.

Powiats. This traditional district form of government, abolished in 1975 and established again in mid 1998 are an intermediate level between the large voivodships and the small *gminas*. *Powiats* will become the owners of some health care organizations within their territory. These include the district hospitals (with the specialties of internal medicine, paediatrics, surgery, obstetrics & gynaecology, anaesthesiology unit and an intensive care unit).

Gminias Some *gminas* now manage primary health care and some secondary health care services with grants directly allocated by the Ministry of Finance or by the voivodships. Since the 1995 enabling legislation, nearly fifty *gminas*, mostly in the cities, have taken over health care services previously run by voivodships. Also, some have been commissioned by their voivodships to take over some health care services previously run by a ZOZ.

ZOZ is an acronym for integrated health and social services unit. ZOZ have been much criticized and the system is in the midst of change. Recent legislation, although so far not used, allows for a

² Ref: "Health care system in transition, 1999"

ZOZ to be dissolved, since some saw these as a symbol of centralized power. Each of the over 500 ZOZ provided primary and secondary care. These included at least one hospital, community-based facilities such as polyclinics staffed by generalist and some specialist health professionals, small outpatient centres staffed by primary care physicians and nurses, specialized services such as school and enterprise-based health facilities, and social services to a more limited extent.

Proceeding to dismantle much of legacy of “bureaucratic socialism” in the new political system, no central health sector body has full power for planning, regulation and management of health care programmes. The Voivodships, gminas, other ministries, and also the powiats have more control in managing their own budgets and making staff and services decisions. Considerable power over financing and services will shift to the regional health insurance organizations.

Professional associations, statutory bodies and professional colleges or academies are developing within this system, and they increasingly influence planning and regulation.

Institutional setting of the Polish health care system

The Polish health care system provides services through three tiers of a highly structured network. The three tiers comprise the central level, the regional level (voivodship), and the communal level (gminas) with autonomous health care administration units (ZOZ). Parallel health services organised on corporatist lines operated independently.

At the central level, the Ministry of Health (MH) is directly responsible for national health services and programmes, including hospitals associated with medical academies, medical research institutes, and education and postgraduate training of medical staff. Recent devolution of power to regions and communes, and increasing privatisation within the health care sector have reduced the role of the MH in the provision of health services. Moreover, with the introduction of health insurance, the financing role of the central government has been reduced.

At the regional level, hospitals provide acute care and hospitalisation and usually have an emergency unit. Outpatient health centres provide specialist and primary care. The autonomy of regions and their independence from the MH has been strengthened since 1992 with funding coming directly from the Ministry of Finance.

At the local level, autonomous health administration units (ZOZ) were established in the mid-1970s to provide basic health care. A single ZOZ serves a population of 30 000-150 000 people. Primary and secondary cares are vertically connected through ZOZs. Each ZOZ was expected to have at least one hospital and several ambulatory care facilities; however, in practice there are several facilities which only provide outpatient services. Long-term care is provided in both general hospitals and sanatoria. Local hospitals provide extensive outpatient care through specialist outpatient clinics, diagnostic and physiotherapy departments, and emergency services.

Certain government ministries (Defence, Interior, Justice, and Transport) operated parallel health care services for some of their employees and their dependants. These systems provide both ambulatory and hospital care.

2.2 Reform effects on public-private mix in health sector

The privatization of health care units has been planned in accordance with the privatization guidelines of the Polish Government, and with reference to European Union law.

In its report on monitoring progress toward accession, the EU commission affirms that “.... Poland has completed transition reforms in terms of trade and price liberalisation, is well advanced in privatisation and has made considerable advances in second generation reforms. This is particularly the case of the

major systemic reforms in pensions health care, education and the territorial organisation of the country that will serve to place welfare regimes on a more sustainable financial footing in the medium term and improve efficiency provision of services in the long term.

Financial aspects. Polish health care in the 1990s has been largely financed by government sources through budget allocations made by the Ministry of Finance with the funds then spent by the major health care providers: the central ministries, the voivodships and to a lesser extent the gminas³.

With the restructuring of health care finances and the introduction of the new insurance scheme (General Health Insurance Act, 1997), it became easier to tap new sources of revenue, formalize health sector financing, further decentralize the administration of health care services and introduce market practices in order to increase efficiency.

The fundamental idea of the 1999 national health insurance reform is to separate the payment for health services from the delivery of those services. The expenditure on health care depends at present on citizens paying insurance premiums. Financial resources for health care are distributed to 17 sickness funds⁴.

These funding bodies agree contracts with individual health care units for the delivery of particular health care services. Their remuneration is based on the number of patients treated, the number of services performed, or some combination of the two.

It is expected that the combination of competition for patients⁵ and competition for sickness fund contracts will lead to an efficient and satisfying health care through natural market forces.

Currently funds would then come from two main sources. First, the insurance funds will finance the direct costs of health services to patients through contracts with service providers. Second, government budgets (state, voivodships or gminas) will continue to finance public health services, the capital costs of all health services, and specialist tertiary care services (such as organ transplants) and very expensive drugs (such as immunosuppressive drugs).

National government budget has historically been the principal source of health care financing but private firms also contribute with alternative and complementary financial sources.

There are no voluntary health insurance funds in Poland and sometimes private patients use out-of-pocket payments for several good and services. Generally the mechanism of co-payment is adopted to limit inappropriate over-utilization of expensive resources but in Poland it has had an alternative illicit use. It is confirmed by some surveys that patients pay substantial "informal" gratuities to physicians and other health care professionals. Such payments, although illegal, were said to be widespread by the end of the 1980s.

Also, Charitable associations such as the Catholic Church 'Caritas' funds and the Red Cross make some donations or pay for medical equipment.

Health care institutions are not at present permitted to market their services to earn additional revenue. In theory, autonomous hospitals could borrow money from banks that are a potential new source of funds such as offering credit lines and new legislation provides for the possibility of private health insurance schemes from 2002.

Delivery aspects. In the past, **private owned health care institutions** and public institutions were linked by various forms of cooperation, which established a kind of order on the health system. The public sector was ineffective, but did not collapse, and maintained strong links with the private sector. Formal and informal regulations, among which market forces were of minor importance, controlled the behaviour of various actors. Households had to spend an increasing proportion of their income on health care, while public health care institutions became debt-ridden. Public dissatisfaction with the health care system grew.

³ Gminas contributes with a small percentage from their own budget.

⁴ Ref: "Health care System in Poland, 2003"

⁵ This reform also ensures a free choice of physician for patients

Since 1997 the national health insurance system has adopted several regulations which slightly increased the financial responsibility of various actors for their decisions giving private health service providers the opportunity to obtain public money.

Also, local government's difficulties in applying soft budget cuts and the necessity of finding capital in order to offer competitive quality of service will cause some public health care institutions to go private.

In the next few years, privatization of the health care system will still probably consist mostly in the establishment of new firms. It is planned, however, that liquidation of public health care institutions and the capital privatization of others will increase in importance. A number of hospitals, in fact, have been restored to their original owners, either private organizations or the church, although there is no deliberate programme of hospital privatization.

Private medical practice, which existed legally under communism, increased sharply in 1988 with the enactment of the Law on Economic Activity and a number of private companies, mostly located in big cities, have opened facilities for ambulatory and hospital care.

In 1990 private medical practices were legalized, beginning to operate as small businesses on a "fee-for-service" basis. As such, they must register with the local authorities, provide financial statements, and, of course, pay tax on their income.

Since the second half of the '90s privatization has been proceeding with pharmacies, dental practices and private medical practices. These professionals may work only as private practitioners or in addition to their public sector employment.

In the mid-1990s there were several thousand private clinics and some private hospitals. Hospitals have mostly remained in the public sector and there are only a few non-public hospitals mainly run by voluntary organizations (Ref. "Public service reforms and health care")

Personnel in private institutions are more motivated to work than their public-salaried counterparts. The number of services supplied by private physicians, dentists and paramedical staff working on contract is significantly higher than salaried staff. For example, the number of consultations and visits provided by dentists on a fee-for-service contract was more than double that provided by salaried dentists.

2.3 Measures for an higher health care quality

2.3a Good human resources management to improve efficiency

Reforming the public health service will necessitate professional skills and investment in training. A decentralized approach, in fact, requires the development of new functions and ability to manage financial and administrative autonomy as well as to improve delivery system efficiency (both in terms of services and expenditure)

In Poland, health care units are generally run by physicians without any **training in management** or finance. Currently, there is a trend towards the competitive employment of professionals with the relevant qualifications. It is still unusual, though, to have a hospital director who is not a physician. Since January 1999, all health care providers in Poland are part of a typical internal market; that could serve, amongst other things, to make managers more responsible for their decisions.

Private health care units, in competition for contracts from the sickness funds, require effective and flexible health care managers, drug management specialists, and public health specialists. Under the new system, these must not only think about health care itself, but also its economic sustainability. While negotiating with sickness funds, they must represent the interests of their populations. They also have to allocate resources, budget expenditures as well as keep up with

changes in human resource management; it means that directors of hospitals and outpatient clinics must know something of business, law, planning and human resources.

Because of the increasing importance of the managerial role in health care organizations, one of the main goals of health sector transformation is to hire managers for managerial positions in the health sector, enhancing medical qualifications. However only few public medical schools have postgraduate programmes in areas such as health care management and administration (the first school of public health was funded in 1991).

In line with their new duties, there is a new employment mechanism for them: the managerial contract. This contract links their responsibilities to suitable monetary rewards.

Education and training for health care workers has also been subject to reform. Here efforts are aimed at developing nationwide standards with corresponding independent examination boards.

While Poland needs to improve the educational standards of its health care personnel, at the same time it needs to reduce their number. The main problem is, in fact that there are too many specialists compared with primary care doctors: until recently, there was no concept of a family physician or general practitioner. Primary care has historically been undervalued. Narrow specialties have dominated the system and undergraduate medical education does not hold primary care in high regard. Primary care physicians referred patients on to specialists for conditions which in western Europe would have been treated by a general practitioner. People also bypassed the primary health care level and went straight to specialists who usually had access to better medical resources. Health sector reforms aimed at strengthening primary health care. Primary care physicians were poorly trained and their clinics lacked diagnostic equipment. As a result, the work lacked status among the medical profession and to some extent among patients. The current strategy is to improve the status and quality of primary care.

Common to all physicians are **pay level standards**. Pay levels, and so working conditions and morale, remain problematic among health care personnel in Poland. Wages for health sector workers in the former socialist states historically were lower than the workforce average and this has remained the case in Poland.

The remuneration of health workers is relatively low and provides little pecuniary incentive to work.⁶ Salaries are often supplemented by payments for private sector consultations and by unofficial out-of-pocket payments which constitute an important source of earnings for providers, increasing take home pay of all medical personnel by about 15 per cent on average (*Ref. "Health care system in transition"*).

2.3b Communication in the health care delivery system: between a traditional and an innovative approach.

Poland is arguably now among the most active Central European countries in the field of health promotion. The National Health Programme calls for more national level health education and health promotion. Previously these activities were not seen as part of a public health policy and had been left to individual health professionals and to voivodship sanitary and hygiene institutions.

Health promotion has begun to develop at the national level with the creation of a health promotion department in the National Centre for Health System Management. Recent initiatives include the healthy cities network (covering 6 million people in 29 cities), the healthy schools and healthy workplaces networks, and an interdisciplinary healthy housing project. There are now health promotion units attached to central medical research institutes such as the Institute of Cardiology, the Institute of Occupational Health, the Institute of Oncology and the Institute of

⁶ The average monthly salary in the health sector in 1996 was 84 per cent of the average salary for the public sector (*Ref. "The health care system in Poland"*)

Food and Nutrition. Parallel to more traditional measures other sophisticated and innovative communication tools are attended for the future.

The adoption of the Strategy on the Development of the Information Society in Poland for the years 2004-2006 in fact, could improve the quality of life of citizens by efficient implementation of the information technology. Some actions in the areas of common access to electronic content and services have been developing. Among these is the anticipated completion of a project in the field of health care system: *Telemedicine*⁷. It will support the use of the electronic communication to increase the effectiveness of health services by better utilisation of distributed resources and equalizing the quality of services in different areas of Poland. The objective is that by the second half of 2005, at least 5% of medical establishments offer e-health services and that patients can contact them via the Internet.

The popularity of telemedicine, or more generally of electronic communication in medicine depends on its acceptance by medical professionals. Here the state should be less concerned with "providing the required environment", and more with showing the benefits and promoting the best solutions

⁷ For further more detailed information see Ministry of Scientific Research and Information Technology of Poland