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REFORM OF THE HEALTH REFORM IN POLAND - PRELIMINARY DIAGNOSIS[1]

CASE SEMINAR

Performance of Health Care Institutions upon Reform - Premises for Change was the title of the seminar held on 9th May 2002 by the CASE - Centre for Social and Economic Research - Foundation. The meeting was devoted to presentation of the initial results of research that has been carried since March 2001 under the project of the same title. Representatives of scientific and political environments, government and NGOs took part in the seminar. The project researchers undertook to describe the experience resulting from health care functioning in Poland since January 1999, i.e. since the moment of introduction of the common health insurance, as well as to try to indicate the possible directions of changes in this field of social care. In the situation where a vision of another reform arises, the conclusions from the research must be considered a valuable contribution to the discussion of the health care's future in Poland.

The seminar was opened by Prof. Barbara Blaszczyk, Chairman of the CASE Foundation. Prof. Stanislawa Golinowska made an introduction to the object of the research. Two theses were presented in the speech supported with quantitative data analysis. First of all it was indicated that the health care system lost the susceptibility to control. Of course, no social system is fully controllable, while effective controlling of the health care system is a very difficult task. For the system to become an efficient tool for realisation of the health care policy objectives, there must be some strategic, coordination and control measures present in

[1] The aim of the paper is to get us acquainted with the topic of the seminar. The sub-titles constitute the titles of the subsequent lectures presented during the meeting. This does not mean, however, that the contents provided here constitute a simple reconstruction of the lecturers' speeches. The following conference materials have been used in the paper: *The Diagnosis of Health Care System After Three Years' Health Reform Functioning. Improve - Where and How?*; *The Problems of Health Care System Functioning Upon Reform. Improve - Where and How?* by S. Golinowska. As far as possible, our own comments were included in the particular parts of the paper.

relation to the system. In the Polish health care system none of the functions have been fulfilled in a sufficient way. The handicaps of the strategic functions (the experts have long indicated that reformers do not have a cohesive vision of the system) undoubtedly contributed to emphasising of the coordination and control problems. However, the basic reason for the controlling problems seems to be the excessive autonomy of the system participants, plus too much confidence placed in the "internal market" mechanisms. The founders of the system seemed not to perceive the experience drawn from international comparisons (to which the experts had drawn their attention), namely the fact that the growing role of the market mechanism in health care must be accompanied by increased regulation and strengthening of the coordinative and control functions against the system.

Moreover, the introductory speech stressed the fact that the system is largely limited by the budget, which however did not deter the increased expenditures for medicines. Such change in the allocation of funds has additionally reinforced the feeling of lack/ limitation of funds. The theses became the starting point for further presentations discussed below.

Political and Institutional Conditions for Changing the Health Care System[2]

The characteristic feature of the health care reform in Poland was the lack of fulfilment of substantive and political conditions allowing for efficient execution of the undertaken tasks. However, it would be improper to suspect the politicians of the lack of rationalism in their actions. In the political considerations attention has long been drawn to the double sense of the Polish term of "polityka". The first meaning (*policy* in English) refers to structured activities related to a separated sphere of reality. The other meaning of "polityka" (*politics* in English) refers to governing and the tasks undertaken by the government. In the two aspects, the criteria for assessing the undertaken activities as to their rationality are different. While in case of policy attention is paid to defining of objectives, perception of a longer time perspective and application of planning procedures, thus in politics the particular sphere (in this case the health care system) becomes the object of the political play.

The subsequent phases of the health care reform in Poland have been introduced by one political force, one coalition or even one party. The initial Act on Common Health Insurance was passed by the SLD-PLS majority that hardly tried to attract the reform supporters among the opposition. On the other hand, the AWS-UW coalition (and strictly

[2] Presentation: Prof. Cezary Wlodarczyk, Public Health Institute CM UJ.

speaking AWS), implemented the reform not only discontinued the works of the predecessors but also accented a completely new attitude, braking off with the previous changes even where the subject-matter changes were slight. The attempts to attract supporters among the political opposition were not undertaken at all at that time. A similar situation occurred during reform preparation by the current coalition. Thus, the subsequent reformers omit the fact indicated both in literature and the current experience that limitation of political back-up results in a very unstable future of the reform. Treating the reform as the political property of a single political group has caused that the new government related to another political group to rejects the current reform and starts the process form the beginning.

A standing mistake of the reformers has been the lack of precise diagnosis of the initial status based on reliable data. At the present moment we still lack the fair diagnosis (as the "SWOT" analysis of the health care system published in February this year on the Health Care Ministry's web site cannot be perceived as such). Due to the fact that in the process of searching for reform tools, the diagnosis has been replaced with a critics of the of the previous governing team, there exists quite a substantial hazard that false conclusions will be drawn and improper solutions implemented. Of course, several problems related to carrying out of a thorough analysis of the system may be listed, inclusive of the reporting and information systems errors, however, the basic limiting factor seems to be the lack of will of the reformers to see the need for such an analysis.

During the seminar, problems related to the use of expert knowledge in our country were reflected. The leaders of the reform - the medical staff assembled around the Health Care Minister - rarely see the fact that experts specialising in the health care system issues exist outside of medical academies or government departmental institutions. In consequence, the opinions of representatives of other environments in the subsequent reforming activities matter very little. Besides, attention has been drawn to the consequently applied practice that expert status is received from the current political authorities and the opinions of scientific environments are not taken into account in this matter.

While referring directly to the recent plans of the Health Care Minister, the threat of changing the political system under the motto of health care reform has been mentioned. The threat shall be perceived bigger as the direction of the changes has nothing to do with the declared intentions in reference to the health care sector, nor the structural changes of institutional reforms in Poland.

Function and Behaviour of the Payer[3]

In the currently functioning health care system the function of the main payer has been entrusted with health care units [*kasa chorych*] established on 1st January 1999 pursuant to the Act of 6th February 1997 on Common Health Insurance (Journal of Laws No. 28, item 153, as amended). The core of the project entailed institutional separation of the payer (health care units) as an entity responsible for purchasing of services from the service providers that would satisfy the reported health care demand. The purchase of services is, however, one of the final stages of realisation of the functions entrusted with the payer. The health care units - in order to make a decision as to allocation of funds coming from the insurance contributions - must/ should, somehow along the way, fulfil the tasks related to the identification of health care demand of the persons insured with the particular unit. They should plan the ways of securing the demand, contract the services allowing for realisation of the identified demand, finance the service providers and control the execution of the concluded contracts. While executing their tasks, the managing bodies of the health care units get the answers to the questions what services, how much of them, with which service providers and for what price they should purchase. Monitoring of contracts realisation may, on the other hand, provide information that will constitute basis for at least partial assessment of the accuracy of the decisions made, and for sure - allows for supervision over the provided services quality.

During the seminar it has been stressed that the starting point for all health care units as to the tasks entrusted with them and the functions to be fulfilled was identical. Despite of that, in the course of the tasks realisation in the particular fields of their functioning, a clear differentiation occurred, reflected e.g. in the way of introducing the medical proceedings standards or differences in defining of the scope of services constituting part of the basic health care. Moreover the payers have applied different procedures as to contracting the services, with the drive to extend the duration of contracts (or automatic extension of contracts) by some of them, as well as non-uniform mechanisms for financing of the medical services providers.

It seems that this differentiation of health care units results from the drive to rationalism in the conditions of limited financial resources possessed by the payers. Any of the units, assuming that it possesses relevant knowledge is subjectively rational in its activities aimed at attaining of the planned goal. Yet, the knowledge of the managing bodies

[3] Presentation: Zofia Czepulis-Rutkowska, Ph.D., The Institute of Labour and Social Affairs.

in the particular health care units may vary. Moreover, the objectives put forward for the particular unit do not necessarily have to be cohesive with the objectives planned by the persons responsible for the execution of the imposed tasks. Shall we additionally impose the objective premisses of differentiation, say at least the differences in the demographic structure of the populations insured with the particular units, the differences as to the health status, the differences in the amounts of money to be spent by the units, as well as the differentiated technical facilities of the service providers with whom the services are contracted, and take into account the substantial autonomy of the health care units in the way of fulfilling their tasks, we arrive at the image of seventeen *"independent health care policies"* and the differences in the access to the services by the insured resulting from that.

At the moment of introducing the health care units as institutions, it has been assumed that their functioning will be based on the internal market mechanism, while starting from the beginning the actual competition on the part of service payers was made impossible. The planning of sixteen territorial units and one sector-related unit resulted in fact in the model of a monopsonistic market organisation that is characterised with a great number of suppliers and a small number of recipients.

At the initial stage of the common health insurance functioning, the hope for a change in the situation was aroused by Article 4a of the said Act, that provided in the initial wording, that starting from 1 January 2002 persons subjected to the common health insurance will be able to fulfil their duty not only with the public health care units but also other institutions for health insurance that will operate based on separate regulations as to insurance activities. However, due to the Act's update of November 2000, the hope has perished or at least has been deferred far in the future that - taking into account the proposals of the residing Health Care Minister - does not look good for the health care units. The updated Article 4a was re-worded to reads that "the realisation of the common health insurance by insurance institutions other than health care units shall be regulated by a separate act of law".[4]

During the discussion it has been revealed that the units competed for the insured. This referred mostly to the competition between the regional health care unit operating in the particular area and the sector-related unit. Moreover, the competition is very strong in the boundary areas where the neighbouring regional units compete for the insured. Interesting was the comment of the health care units representative who indicated some activities aimed

[4] Art.1 item 2 of the Act of 30th November 2000 on Amending of the Act on Common Health Insurance (Journal of Laws No. 122, item 1311).

at attracting of less well-to-do insured who pay lower contributions but simultaneously use the services less frequently and therefore are more profitable to the health care units. Facing such phenomena, it is worth to draw attention to the fact that the "cream skimming" popular in literature and usually related to the payers drive to insure young people, educated and well paid, may take quite a different face in reality.

One may list the examples of health care units misfunctioning, yet, honesty requires us to remember also about the positive changes that were brought into health care with their creation. Most of all the presence of the health care units as the administrator of funds forces the service providers to undertake activities aimed at cost calculation. The persons implementing the units stressed that "for the first time in the history of post-war Poland the health care units forced the service providers to count costs". In this aspect the actions of some health care units must be assessed critically - namely the ones that were reducing the debts of health care centres thus squandering the chances for a more effective cost policy.

In the context of the currently discussed change proposals as to health care that are related to winding up of the health care units and establishment of the National Health Fund with sixteen provincial branches, the conclusion drawn from the research carried within the project should be considered crucial. The research indicated that the problem of the not quite effective operation of the units does not depend on the form of organisation of the payer but the lack of clearly defined and uniform instruments that remain at the payer's disposal while executing the imposed tasks. This means that the simple liquidation of the health care units and replacing them with a more centralised system shall not change the situation of the Polish health care. It will, moreover, expose the system to additional costs/ losses related to the expenditures already made and the ones that have not yet been made but are necessary for the purpose of reorganisation.

Local Government's Functions in the Health Care System. Problems with Realisation[5]

The carried diagnosis indicated that local governments are among the weakest links in the functioning the health care system. Among the major reasons the limited financial independence of the local government, as well as lack of precisely specified tasks for the particular levels of the local governments have been listed.

[5] Presentation: Michal Sitek, CEU.

Post 1st January 1999 local governments were expected mainly to fulfil the owner's functions in relation to health care centres and to create the health policy at the local or regional level. The situation of local government in relation of the owner's duties fulfilment is highly differentiated. This is a consequence of unequal spatial structure of hospitals on the one hand and the diversified economic and institutional potential of districts on the other hand. Generally what is visible it is not only the lack of infrastructure but also of skills or even the will to properly execute the ownership supervision functions. The situation looks worst at the district level, where various health care related tasks are arranged by only one person. The influence of local government at the district level on major decisions related to health care centres is, admittedly, partially limited by the existing legal conditions, however, the level of awareness as to the relation between the quality of management and the financial situation of the particular centre is still low. The district authorities begin to be interested in the problems of the centres subjected to them only when the indebtedness constitutes a hazard of the centre's closure. The practice shows that the wealthier districts may order the elaboration of remedy programs with consulting companies - nevertheless the quality of such programs is either very doubtful or the districts cannot afford to implement the developed concepts. The basic issue is to prevent indebtedness before it is too late. The existing situation may only be changed while we change the attitude to health care management within a district. If the district is not willing to cope with the problems of repaying the debts of its centres, its bets interest is to provide comprehensive legal and economic service, as the owner of the centres. It was stressed during the conference that a slightly better situation in that scope can be observed at the provincial level. The health care departments that possess larger human and infrastructural potential are able to provide the subjected centres with a more professional support, which is translated into the situation of the hospitals subjected to that level of authority.

The lack of funds for investment and restructuring tasks is a common problem of the local governments - this is of course a wider problem that surpasses the issues related to health care system functioning. A low level of financial independence (measured by the share of own revenues in the total revenue of the local government) substantially prevents the local governments to realise their own investment policy. The key decisions, e.g. about the value of funds granted for restructuring programs are made at the central level. This is only one piece of evidence that the subsidiarity policy promoted by the politicians is only a declaration in Poland.

In the provided diagnosis it has been revealed that there are no precise principles of cooperation and coordination of the local governments' regional health care policy with the policy implemented by the health care units. Taking into account the information, headcount and financial advantages of the units it is hardly surprising that they "dictate" the conditions of operation to the local government. Yet, the problem here is not the strength of the units (the more efficient and professional is the payer - the better for the patients) but the weakness of the local governments. In such a situation, not only the deficiency of money but also lack of competence division between the local governments and health care units make it difficult to realise the regional health care strategies. Of course, one may notice some examples of a fruitful cooperation between the units and the local governments, however, it is interesting that often the promoter of such initiative is the health care unit and not the self-government. Sill the issue of health care promotion remains open. The existing health care strategies of the provinces stress the importance of such undertakings, while this is not reflected in the expenditures of the local governments - the seminar stresses that many districts do not spend any money on such activities.

Basic Health Care Functioning - Research Results[6]

Currently the most important and most efficient tool for improving the processes of satisfying the health-related needs is the development of the basic health care (POZ). International comparisons show the major importance of the family doctor function in shaping the costs of the system. In Poland the growing importance of POZ and introduction of the family doctor's institution were common features of all of the health care reform projects. Nevertheless, regardless of the posed postulates, the decisions related to education of family doctors were made too late and to an inadequate extent. Additionally the interest in this speciality appeared to be low - the lack of recognition for a family doctor specialisation in our medical environment contributed to such situation. In effect we were not bale to provide enough human potential that would condition the fulfilment of expectations by POZ.

It has been underlined in the seminar that family doctors were supposed to fulfil the gate keeper's function - yet only positively, i.e. by keeping the patients with them due to the undertaken treatment, and not by the simple limitation of entering a further path in the public sector. It has been accented that undertaking treatment requires not only higher qualifications

[6] Presentation: Prof. Cezary Wlodarczyk, Public Health Institute CM UJ.

but also the awareness of the role in the system, responsibility and courage. The diagnosis made revealed that often family doctors are the fast-educated doctors of the previous health care centres that often send away the more difficult cases, usually for hospital treatment. This situation results from improperly constructed motivating instruments.

As refers to POZ, important is the perception of a family doctor's institution by the society - for sure the precondition for the success of the planned changes is the increase of social trust to such an institution. One may expect that this is going to be a long lasting process where the key role is to be played by the family doctors themselves. In the discussion it has been indicated that some upstream initiatives appeared directed to raising of qualifications of this speciality doctors. It has also been stressed that taking into account the income of family doctors they may be considered the "winners" of the reform. This may positively affect the development of such speciality.

Health Care Centres Behaviour - Research Results[7]

The analysis of the situation of hospitals upon the reform does not result in a clear picture. On the one hand, negative processes are visible: further indebtedness of the hospitals and major decaptialisation of the possessed equipment, on the other hand undertaking of rationalising activities has been observed - as the reform forces professional management and cost calculation. The hospitals react to the financial mechanisms activated by the reform, yet visible is the non-adjustment of the mechanisms to the desirable direction of hospital resources restructuring. While presenting the research results the lecturer stressed that low-rate payment for hospitalisation is a basic financial parameter and leads to maintenance and development of internal medicine departments, that provokes the detainment of "cheaper" patients. There are no incentives for development of the required specialised resources.

Very controversial are the differences in the rates applied by the particular health care units. The analysis made reflected that application of various rates, depending e.g. on the reference level, cannot be always justified in a convincing way. Yet, it seems that regardless of who is going to be the payer, the situation in this scope will not improve much without specifying of uniform medical standards. Activities in that area seem to be the more necessary as the diagnosis of the condition of hospitals reflected the lack of quality improvement mechanisms. It has been stated that the quality improvement mechanisms introduced, e.g. by

[7] Presentation: Christoph Sowada, Ph.D., Public Health Institute CM UJ.

way of hospitals accreditation, are not working properly. According to the diagnosis of the authors, the most common problem is not the type of the applied mechanism, but its insufficient implementation, omission or lack of respect for the applied criteria.

Patient's Empowerment[8]

Health care functioning would not be so important, shall it not be for the fact that the consequences of efficiency and quality of such functioning are born by the patient - the medical services customer. The persons carrying out the project devoted one of the modules of the executed research to the patient, and strictly speaking the rights of the patient. In the patient - doctor relation, the patient is perceived to be the weaker party, especially due to the asymmetry of information resulting from lack of specialised knowledge necessary in the treatment process. Thus the patient fully relies on the knowledge and professionalism of the service provider, while the doctor becomes the a person of the highest confidence, somehow the "obmudsman" of the patient's interests[9], yet with the standing advantage of the doctor in this relation. Therefore, the patient - doctor tie is not a relation of two equal partners, it rather reflects the subordinate - superior relation.

The permanent advantage of a doctor over the patient that - as it seems - is at least partially objective, should not be identified with the incapacitation of the patient and lack of mechanisms guaranteeing the actual liability of the service providers for the actions made (or not made). In this situation it becomes crucial for the patient to be guaranteed the right of choosing a doctor, the right of being served properly, the right to the information on the course of treatment, or the right to compensation of damage incurred due to medical mistakes. Beside of the rights guaranteed by the "Patient's Rights Charter"[10] important is the possibility of the actual enforcement of the rights. While even the most extensive guarantees are incapable when reality makes them only paper-based declarations. Paraphrasing the statement

[8] Presentation: Agnieszka Sowa, CASE Foundation.

[9] Nevertheless, we must remember that beside of undertaking actions for the purpose of realising the "service orderer's" goals - i.e. bringing the latter back to health - the doctor as the ombudsman (agent) of the patient also realises his/her individual goals, such as for example maximising of income, or gaining prestige and recognition in their environment.

[10] The Announcement of the Minister of Health Care and Social Support of 11th December 1998 on Public Announcement of the Patient's Rights Charter; www.mzios.gov.pl

we may say that “people not only need the rights but also the possibility to implement them”. In the context of this discussion disturbing may be the conclusion of the research showing that the changes implemented in the Polish health care system “did not create conditions for enlarging the possibilities of the actual enforcement of the rights given to the patients”.

Everyday life is not beneficial to patients. In the conference difficulties in the access to both basic and specialised health care services has been indicated, as well as lack of uniformity in the institutions representing patients, lack of mechanisms for the service orderers’ influence on the medical services market, and problems in claiming the rights in case of a medical mistake.

In the current legal situation, the institutions to which the patient convinced of his rights being broken may apply are the Citizen’s Rights Ombudsman and the Patient’s Rights Ombudsman, the latter operating with the regional health care units. Yet, due to pragmatic and formal reasons the possibility of their intervention are limited. There are no legislative tools that would regulate the procedures for filing claims as to presumable infringement of the patient’s rights, as well as the procedures for intervening with the service providers by the entities with which the claim has been filed. Nowadays, as the lecturers underlined, the aforementioned institutions rather play the role of a “post office box”, while the effects of the undertaken actions cannot be foreseen.

With reference to lack of mechanisms for the patient’s influence on the quality of provided medical services the contributions to conference discussion are worth noting. It is true that the patients’ influence on the activities of the service providers is limited. Surely, the patients have the right to choose a doctor, and in consequence even to change the doctor in the course of treatment, yet patients choose the latter option in extremity. The patients would expect the health care unit to affect the doctor whose services are not satisfactory, rather than using the indicated right - despite of the fact that this is a very good instrument for verification and assessment of the service providers’ activities.

As to extension of instruments the patients’ influence on the quality of the services provided, the persons carrying the research postulate the systematic implementation of patient made assessments and further use of the assessment in the managing of the service provision process. However, it seems that such systematic solution requires clear definition of the area of research. This means we must answer the question who should be subjected to the research - the persons that actually use the services or perhaps also the patient’s family, what to research - the quality of service perceived by the satisfaction of the patient, not necessarily connected with the consequences of the service, or the actual effects of the medical service,

when to carry the research - during the treatment, shortly after the treatment, or after a longer period of time, how to research - the aspect is related to the technical side of the research, i.e. whether the patient should fill in a questionnaire in a hospital, or perhaps it would be better that the interview be carried by independent entities which are not related to health care. In practice it may be much easier to dwell with the current assessment solutions, namely research carried by public opinion research centres and by the service providers themselves - the latter form is a reflection of the market focused attitude and interest in the opinion of the consumer, assuming that there is a will to change the areas from which the patients are not satisfied. Moreover, the service providers' voluntary subjection to the accreditation processes is also an instrument of assessment. Also valuable are the upstream initiatives, just to mention the "Give Birth in Decent Conditions" campaign carried by Gazeta Wyborcza and the "Give Birth in Decent Conditions" Foundation.

Raising the problem of asserting the patient's rights in the situation of a medical mistake, the lecturers indicated a "strong dependence of the court adjudications for damages payment on the decision of the occupational self-governments as to the doctor's default". It has been said in the discussion that this situation is changing gradually, and year by year the number of civil law cases against the medical profession representatives responsible for occupational mistakes is increasing, with simultaneous increase of court cases ending with a compensation imposing decisions. The causes of such status would be worth considering. First of all the growing number of suits against service providers may result from the growing number of medical mistakes or the growing awareness of the patients as to the possibility to claim compensation for the incurred damage or harm. Secondly, it would be worth researching whether the increased number of adjudicated compensations is connected with the fact that the entities responsible for medical mistakes are insured against civil liability (obligatorily[11] or voluntarily) against the damage inflicted by way of the carried activities. While in such a situation the court that has adjudicated the compensation is aware that the amount will not be paid out of the doctor's or the health care centre's pocket but it will be covered by a sort of a "third party payer".

[11] The Ordinance of the Minister of Finance of 17th November 1998 on General Conditions of Obligatory Civil Liability Insurance of an Entity that Accepts the Provision of Medical Service as Refers to the Damage Inflicted While Providing the Services (Journal of Laws No. 143, item 921).

Final remarks

In the context of the above discussion, interesting may be the question about the future of the Polish health care system. Whether it would be good - in the situation of limited possibilities to finance health care from public funds - to consider the formal possibility of diversification of the sources of finance? Yet, it this case it would be necessary to clearly specify the relations between financing of health services from the public funds and the financing from private sources. Right now we observe a coexistence of public and private finance, with a growing share of the latter one, that is however often accepted as informal payment. One of the solutions could be a "systematic introduction" of private health insurance. Then we would have to answer the question whether common and private insurance would be exchangeable, or they should function parallelly (double insurance). This relation will be a consequence of one of the most difficult political decisions, namely "specification of the limits of public service entitlement".

The conference may be summed up with a conclusion that establishment of a mixed public-private health care system is inevitable. A sample concept of such a system was presented in the last speech given by the guest team of researches from the Main School of Commerce that deal with the problems of health care system financing while applying private health insurance as a surplus-type one.