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Health Systems in Transition

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Poland

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Preface

The Health Systems in Transition profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

Health Systems in Transition profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Owing to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the WHO Regional Office for Europe health for all database, national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) health data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The Health Systems in Transition profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals. Comments and suggestions for the further development and improvement of the Health Systems in Transition series are most welcome and can be sent to info@obs.euro.who.int.

Health Systems in Transition profiles and Health Systems in Transition summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web site: www.euro.who.int/observatory/Glossary/Toppage.

This current edition of the HiT refers to the state of reforms in December 2005.

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The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The European Observatory on Health Systems

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The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos, Richard Saltman and Reinhard Busse. Technical coordination is led by Susanne Grosse-Tebbe.

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List of abbreviations

CEM	Centre for Medical Examinations
CSEE	Central and south-eastern Europe
CSO	Central Statistical Office
DRG	Diagnosis-Related Groups
DS	Dispatches Centres
EBM	Evidence-Based Medicine
EU	European Union
FSIF	Farmers' Social Insurance Fund
GCP	Good Clinical Practice
GMP	Good Manufacturing Practice
GNP	Gross National Product
HCI	Health Care Institutions
HMO	Health Maintenance Organization
MoH	Ministry of Health
NHF	National Health Fund
NMMS	Night Mobile Medical Service
PHC	Primary Health Care
PIT	Personal Income Tax
PLN	Polish currency (zloty)
SIF	Social Insurance Fund
WHO	World Health Organization
ZUS	Social Insurance Company

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Executive summary

Brief overview of the health system in Poland

The Republic of Poland is the largest country in central and eastern Europe, in terms of both population (38.2 million) and area (312 685 square kilometres). In 1989, Poland was the first country among the central and eastern European countries to re-establish democracy after 44 years of communist rule. After a severe economic downturn in the early 1990s, Poland's macroeconomic situation has stabilized, showing steady growth since the mid-1990s. In May 2004, Poland was admitted into the European Union (EU).

Poland has a mixed system for public and private health care financing. Social health insurance contributions represent the major public source of health care financing. Health insurance contributions are mandatory at a rate, in 2005, of 8.5% of its base, which corresponds for most people to taxable income. The National Health Fund (NHF) with its regional branches administers the social health insurance scheme, following the demise in 2003 of a decentralized system of 17 sickness funds, after just four years of existence. The NHF has the responsibility for planning and purchasing public financed health services. Health insurance contributions for certain groups of individuals not covered by the standard scheme and specific public health activities (such as the national health programmes which mainly focus on health prevention and promotion objectives) are funded directly by the state through general taxation. Complementary sources of financing include both formal and informal out-of-pocket payments, and to a lesser extent pre-payment schemes. Private health expenditure accounted for 27.5% of total health care expenditure in 2002. Around 60% of all out-of-pocket spending was on drugs and medical devices.

Primary health care and family medicine have been strengthened since 1991 with an increased focus on training health professionals in family medicine. There is a strict separation between outpatient specialized care and inpatient care. Outpatient specialized care is mostly based on private medical practices in large cities and independent health care institutions in the other areas. In 2003 there were 732 public hospitals and 72 non-governmental and private hospitals. Trends in the delivery of care include a decrease in the number of hospital beds from 6.6 per 1000 population in 1990 to 4.7 per 1000 population in 2002, and a decrease in the average number of hospital stays; this was accompanied by a significant increase in the number of hospitalizations from 120 per 1000 population in 1990 to 164 per 1000 population in 2001. The number of outpatient contacts in 2001 was 5.5 per person per year, which is relatively low compared to the EU average of 6.6. There is scarce state provision of long-term community care services in Poland, and the sector as a whole remains underdeveloped.

Poland's population is currently experiencing greater longevity, with life expectancy reaching 78.9 years for women and 70.5 years for men in 2003. A decrease in infant mortality and a greater focus on health prevention and promotion are also noticeable. Unfavourable trends and challenges include: unemployment, unfavourable demographic trends, lack of political stability, limited access to care, underfunding of the public health care system and rising dissatisfaction with low salaries among health professionals; this dissatisfaction has given rise to the "brain-drain" of doctors and nurses to western European countries and the widespread presence of informal payments, which are all reflected in the lack of a positive attitude towards the health system and health reforms in the general population.

Current health policy reforms are primarily aimed at: tackling the demographic challenges of population ageing; reducing hospital debts; restructuring the health sector; introducing alternative sources of revenue for health care financing; and improving the control of rising health expenditures. A comprehensive health information technology programme on a national scale is planned to better inform health policies with routine health services statistics.

Overview and structure of the Polish HiT profile

The HiT profile on Poland reflects upon the health system in the country by examining various external and internal influences, which are reviewed in 7 different chapters: 1. Introduction; 2. The organizational structure of the health system; 3. Health care financing and expenditure; 4. The health delivery system; 5. Financial resource allocation; 6. Health care reforms; 7. Conclusion.

Chapter 1 lays the foundations for the external influences on the health system by discussing Poland in terms of: geographical positioning, historical background, economic, political and demographic conditions, health status of the population, as well as the historical background of the health care system itself.

Chapter 2 describes the organizational structure of the health care system. The functions of the health care system in terms of stewardship, management and financing are discussed in terms of the organizations responsible for them; these include: the Ministry of Health, medical academies, university hospitals, research institutes, the National Health Fund, territorial self-governments, health care institutions, the private sector, voluntary organizations and local centres of public health. The role of various bodies in terms of planning, regulation and management, and the decentralization of the health care system are also examined. The role of the NHF in management, planning and contracting is discussed in detail as well as the interplay between the NHF, the Ministry of Health and the Government in the formation of national health policies. Improving the health status of the population and related quality of life indicators is analysed in terms of the functioning of the National Health Programme. Legislation towards decentralizing the health care system is also discussed in this chapter.

Chapter 3 describes and analyses the system of health care financing and health expenditure in comparison to other EU countries. Poland has a mixed system for public and private financing. Public financing comes from social health insurance contributions, budgetary expenditures from the state budget and budgets of voivodship, county and commune authorities and private financing, which includes both formal and informal sources of payments, as well as some pre-paid plans. In this chapter the basis for calculating insurance contributions is discussed, as well as the role of the state budget and the NHF with regards to financing the health system. The health care benefit package, as well as complementary sources of financing for services that may or may not be included in the benefit package, is examined along with the structure and rising costs of health expenditures.

Chapter 4 discusses the health delivery system in terms of primary, secondary and tertiary care, social care, human resources and training, pharmaceuticals and health technology assessment. The rise and value of primary health care is examined, as well as the health services infrastructure for primary, secondary and tertiary care. Trends in utilization such as outpatient contacts, the number of hospital beds and the average length of stay, and the resulting rise in the number of hospitalizations are analysed from a comparative perspective.

This chapter also reviews the numbers of health care professionals and training requirements. The number of physicians, nurses and other health care staff per capita in Poland is lower than in most western European countries and the EU average. Despite the recent emphasis on family medicine, the number of specialists still exceeds family medicine practitioners. Pay levels, working conditions, low staff morale and ensuing migration to western European countries remain problematic. The training, registration and licensing requirements for physicians, nurses and other health care personnel and the organizations and/or chambers responsible for carrying out each of these functions are also outlined.

Chapter 4 also examines the pharmaceutical sector and the role of health technology assessment in Poland. The make-up of the Polish pharmaceutical industry in terms of key players, revenue and infrastructure are outlined. A key issue here is the rapid rise of pharmaceutical expenditure which, with 2.4% of GNP in 2002, is among the highest in Europe. This development is to the detriment of the other sectors, which have seen their funding decrease over the same period of time. Furthermore, the increase in pharmaceutical expenditure seems inefficient: prescribing behaviour is often irrational leading to the second highest per capita consumption of drugs in Europe, with 29 packets of pharmaceuticals per inhabitant consumed per year. The recent rise of consumption of expensive imported drugs is another reason. The high out-of-pocket spending for pharmaceuticals due to very limited reimbursement by the NHF is a particular concern. The chapter describes the laws governing the pharmaceutical sector in Poland in detail, such as the Pharmaceutical Law, the Law on Medicinal Products, Medical Devices and Biocides, the Law on Medical Devices and the Law on Prices. The process of gaining medical authorization is discussed, as well as the system of reimbursement, pricing and pharmaceutical consumption.

Chapter 5 examines financial resource allocation in the health system. The NHF is the main payer for health services in Poland, and providers need to have the status of independent institutions in order to enter into a contract with the Fund and get reimbursed for publicly financed services. This chapter examines the different methods used by the NHF to reimburse hospitals and physicians, as well as key issues that have arisen as a result of the reimbursement models pursued (such as increasing hospital debts for hospitals totalling PLN 5.5 billion (€1.5 billion) in 2004, and the geographic variation of capitation rates in the payment of physicians which led to inequalities in health care delivery).

Chapter 6 discusses recent and forthcoming health reforms in Poland. Among the reforms discussed is the Law on Financing Health Services from Public Resources passed by the parliament in August 2004, which has ramifications on the way the NHF contracts health services. Other policies discussed are

looking at the ways to control pharmaceutical expenditures and to address the demographical challenges faced by the country. Examples of these reforms are the Insurance Law that mandates an increase in the health insurance contribution rate from 8.5% in 2005 to 9% in 2007, and changes to hospital restructuring, which will be looking at further developing rehabilitative care and strengthening the national networks of hospitals. New legislation aimed at tackling the challenges of increasing hospital debts is also examined, such as the Law on Public Help and Reorganization of Public Health Care Institutions and how it may impact on the current amount of debt accrued by hospitals.

Chapter 7 gives an overall summary and assessment of the health system. The chapter starts by discussing recent reforms, and the successes and challenges Poland faces as it develops its health sector in the future. Topics examined in this section include: the funding of the health care system, measures to raise alternative sources of revenues, the improvement of the health information system, and opportunities and challenges.

1 Introduction and historical background

Introductory overview

Political and economic background

The Republic of Poland is the largest country in central and eastern Europe in both population (38.2 million) and area (312 685 km^2). It is also the largest country among the ten countries admitted to the European Union (EU) in May 2004. Poland has a common frontier with Lithuania, Belarus and Ukraine to the east, the Czech Republic and Slovakia to the south, and Germany to the west. The north of Poland adjoins the Baltic Sea except for the Russian enclave, Kalingrad, towards the north-east (Fig. 1.1).

The area of Poland was settled by Slavic groups in the sixth and seventh centuries, with the Polish state being founded in 966. Poland has had a turbulent history of repeated invasions. Between the 14th and 17th centuries, it was a strong and prosperous country with a flourishing culture, but by the end of this period, it had ceased to be a great power. In the 18th century Poland was further weakened by the Polish Succession War and was finally annihilated when Austria, Russia and Prussia agreed to partition Poland, leading to its occupation, which lasted 123 years. Between the first and second World Wars, Poland was again an independent country, but in September 1939 it was invaded by Nazi Germany and later by the Soviet Union, and from 1945 it came under the Soviet sphere of influence.

In 1944, when Warsaw was still occupied by Nazi Germany and Russian troops were at the opposite bank of the Vistula River, which divides the city, an uprising began as a result of a very complex political situation. The Warsaw uprising did not yield the expected political effects, but led to the complete

Fig. 1.1 Map of Poland

Source: UN Cartographic Section.

destruction of Poland's capital. The country was devastated during the war, with one fifth of the population killed, including virtually all its Jewish population.

The German army was expelled in 1945 and the state of Poland was re-established, but communists strongly supported by the Soviet Union dominated the Polish Government, and took it over completely in 1947, establishing a people's republic. In 1989, Poland was the first country among the central and south-eastern European countries (CSEE) to re-establish democracy after 44 years of communist rule.

Economy

The Polish economy was traditionally based on industry and agriculture. However, the services sector is rapidly growing and accounted for 66.4% of the country's gross domestic product (GDP) in 2002, compared to 30.5% for industry and 3.2% for agriculture (World Bank 2004). After a severe downturn in the late 1980s and early 1990s, the economy showed signs of recovery, and

on most measures has grown steadily since the mid-1990s (Table 1.1). The Polish stabilization programme, implemented in 1990, entailed far-reaching consequences for the country's economy and heavy social costs including rising poverty levels. At the outset of the transformation from a centrally planned to a market economy, inflation increased to 70% per year. However, its gradual but constant decline over a ten-year period led to a level of inflation of 1.9% in 2002, comparable to that noted in western European countries. After a sharp decline in the country's GDP during the early 1990s, GDP growth attained 7% in the mid-1990s. With the downturn in the global economy since 2001, GDP growth has come to a halt, as in most European countries. In 2002, the value of debt totalled US$ 66.6 billion (World Bank 2004).

By 2003, the real GDP per capita had more than doubled compared to 1990 and accounted for US$ 11 350 (adjusted for purchasing power parity (PPP)). However, other CSEE countries have achieved substantially higher GDPs per capita, such as the Czech Republic (US$ 15 850), Hungary (US$ 15 150) and Slovakia (US$ 12 850), which are also among the new entrants to the EU (WHO Regional Office for Europe Health for All database June 2005).

Unemployment has been a serious problem since the economic transformation, manifested by a threefold increase in the annual registered unemployment rate (an underestimate of real unemployment) since the early 1990s, reaching 18% in 2002 (Table 1.1). Despite these difficulties, Poland further improved its ranking on the human development index in 2001, and is now third among CSEE countries after Slovenia and the Czech Republic, and ahead of Hungary, Slovakia and the Baltic states (UNDP 2003).

Political system

Economic problems through the 1980s led to the rise of a strong independent trade union, *Solidarnosc*, which forced elections in 1989. After the re-establishment of democratic rule in 1989, Lech Walesa was elected President in 1990 and the first full parliamentary election was held in October 1991. Parliamentary elections in 1993 saw a swing back to the left, with the post-communist Democratic Left Alliance (SLD) receiving the majority of votes.

The parliament has a lower house (*Sejm)* and an upper house *(Senat*). The President of the Republic of Poland is elected in a general election for a 5-year term. This can be extended for another 5 years. The President appoints the Prime Minister with consent of the Sejm. The cabinet consists of the Council of Ministers, who are proposed by the Prime Minister, appointed by the President, and approved by the Sejm. The President has a veto over any legislative proposal or action which can be re-passed by a three-fifths majority vote in the presence of at least half of the statutory number of members of parliament. Since the

parliamentary elections in 2001, the SLD and the Union of Labour (UP), who ran together on electoral lists but constitute separate political "clubs" in the Sejm, held 75 out of 100 seats in the Senat, and 216 out of 406 seats in the Sejm. To achieve a three-fifths majority in the Sejm, SLD-UP formed a coalition with the Polish Peasants' Party (PSL), which held 42 seats in the Sejm. This coalition dissolved in March 2003. Since then the SLD-UP have formed a minority government, initially headed by Prime Minister Leszek Miller (SLD). In March 2004, a divide formed within the SLD, forcing the resignation of Leszek Miller in May 2004, and his successor, Marek Belka (SLD) was voted into office. In the most recent presidential and parliamentary elections in October and September 2005, respectively, Lech Kaczynski from the nationalist-conservative Law and Justice Party (PiS) was elected president, succeeding Alexander Kwasniewski (SLD), who was president from 1995 to 2005. The PiS party also came out winner of the parliamentary elections, gaining 155 seats in the Sejm. Initially a coalition was planned with the liberal-conservative Civic Platform Party (PO), who gained 133 seats in the Sejm, but negotiations broke down and the new PiS Prime Minister Kazimierz Marcinkiewicz now leads a minority government, in which the independent Zbigniew Religa has been nominated as the new Minister of Health.

Table 1.1 Macro-economic indicators

Indicators	1991	1992	1995	1996	1998	1999	2000	2001	2002	2003
GDP growth rate (% change)	–7.0	2.6	7.0	6.0	4.8	4.1	4	2	1.3	–
Annual inflation rate	70.3	43.0	27.8	19.9	11.8	7.3	10.1	5.5	1.7	–
Real GDP per capita PPP US$	4 500	4 994	7 003	7 383	8 472	8 989	9 529	9 450	10 800	11 350
Annual index of real wages (1989 base =100)	75.4	73.3	73.7	77.9	85.2	109.3	110.8	114.3	–	–
Registered unemployment	11.8	13.6	15.2	13.2	10.4	13.0	15.1	17.4	18.1	–

Source: UNICEF TransMONEE database; WHO Regional Office for Europe Health for All database, June 2005.

Until 1999, the country was divided into 49 provincial administrative units called *voivodships*, which were then replaced by 16 new voivodships. The administrator of each voivodship, the *voivod,* is appointed by central government.

At a third level of public administration, the local government councils were set up as independent legal entities in 1990. A *gmina* (commune) is an elected council representing the district population. There are now 2489 gminas which cover, on average, a population of 2400, but their size varies considerably. For

example, the central Warsaw gmina has a population of 700 000. An intermediate fourth level, the *powiat* (county), was added in the elections in October 1998. This marked a return to the traditional county system of government that had been abolished in 1975 (at that time the voivodships were increased from 17 to 49). Each of the 308 powiats covers several gminas.

The territorial self-government administration is exercised by gmina offices, urban, rural and urban-rural, and self-government regional councils elected every four years. The activities of territorial self-governments are financed partly from local budgets and partly from the central budget.

Poland is a member of the United Nations, the Council of Europe, the Organisation for Economic Co-operation and Development, the Central European Free Trade Association and the Central European Initiative.

In March 1999, Poland became a full member of the North Atlantic Treaty Organisation (NATO). On 16 April 2003, Poland signed the Accession Treaty in Athens, which forms the legal basis for Poland's European Union membership. Since 1 May 2004, Poland has been a full member of the EU.

Demographic and health status development

In 2002, 62% of the total population lived in urban areas. Warsaw, the capital, has a population of 1.6 million. In recent years, the number of births has fallen below that of deaths, resulting in negative natural population growth, as in many other EU countries (Fig. 1.2). Because of the population decline, it is estimated that by 2050 there will be 31.9 million inhabitants in Poland. This figure is 6.3 million less than the population in 2003. The proportion of people over the age of 65 (12.9% of the population in 2003) is projected to increase to 37.9% of the population by 2025 (Table 1.2).

Poles make up 97.5% of the population, with Belarussian, German, Lithuanian and Ukrainian minorities accounting for the remainder. Ninety-five per cent of the population is Roman Catholic. In terms of ethnicity, language and religion, Poland is more homogeneous than most countries in the region.

After years of decline during the 1970s and 1980s, average life expectancy at birth began to increase after 1991 (Table 1.2, Fig. 1.3), reaching 78.9 years for women and 70.5 years for men in 2003, and this figure is expected to rise to 81.4 years for women and to 72.2 years for men in 2020–2025. Nevertheless, there is still a vast life-expectancy gap between Poland and western EU countries, which widened considerably between 1975 and 1991, and has only recently started to recede (Fig. 1.3). If the slow pace of progress observed at present continues, about 12 years will be needed to bridge the current gap of 4.3 years in life expectancy. However, since 1991, life expectancy at birth in

Poland has developed in parallel with the average of other new EU Member States (Fig. 1.3).

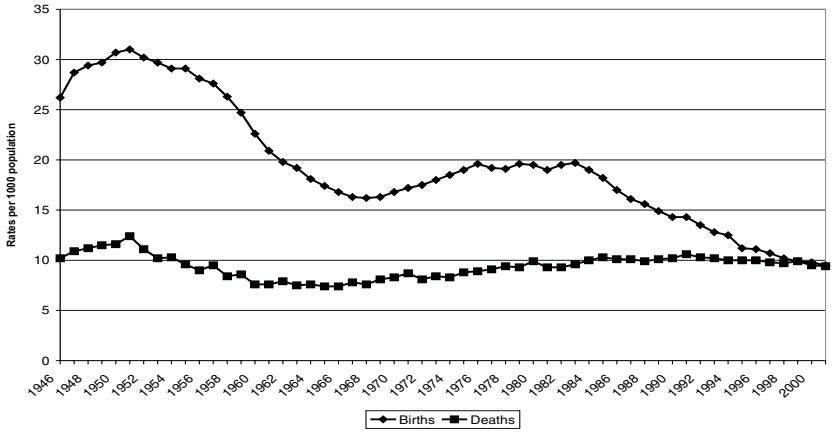
Over recent years, a substantial decrease in infant mortality has been observed. In 2003, the infant mortality rate was 7.0 per 1000 live births (Table 1.2), but it is still higher than the average rate for EU countries (4.9 per 1000 live births in 2003). Total fertility rates fell from 2.33 in 1980–1985 to 1.26 per 1000 live births. This, together with the increase in life expectancy, will lead to a significant ageing of the population in the future. This would further impact on the health care system financially as there would be a greater demand for health services. The ageing of the population together with its decreasing size would disproportionately increase the tax burden for the working population, as health care would be financed by a smaller number of people and would, therefore, be more costly. This may ultimately lead to a new spending structure.

As in other industrialized countries, cardiovascular diseases are the major cause of death in both men and women (about 50%). They are followed by neoplasms (24%) and external causes such as injuries and poisoning (about 10% for men and 4% for women).

Historical background of the health care system

During the period of Polish independence between 1918 and 1939, health services were expanded, and some extra finances were tapped through a limited Bismarckian social health insurance system which covered about 7% of the

Fig. 1.2 The pattern of natural movement in the population, 1946–2001



Source: Health Status of the Polish Population. National Institute of Hygiene, Warsaw, 2005.

Table 1.2 Demographic and health indicators, 1991–2003

Indicators	1991	1992	1995	1996	1998	1999	2000	2001	2002	2003
Population (millions)	38.2	38.4	38.6	38.6	38.7	38.7	38.7	38.6	38.2	38.2
% over 65 years	10.2	10.4	11.1	11.3	11.8	12.0	12.2	12.4	12.7	12.9
Crude birth rate (per 1000 population)	14.4	13.5	11.1	11.1	10.2	9.9	9.8	9.5	9.2	9.2
Crude death rate (per 1000 population)	10.6	10.3	10.0	10.0	9.7	9.9	9.5	9.4	9.4	9.6
Total fertility rate	2.1	1.9	1.8	1.6	1.4	1.4	1.3	1.3	1.2	1.3
Female life expectancy at birth	75.3	75.7	76.4	76.6	77.4	77.5	78.1	78.5	78.9	78.9
Male life expectancy at birth	66.1	66.7	67.6	68.2	68.9	68.9	69.8	70.3	70.4	70.5
Mortality rate per 1000 males aged 25–64 years (SDR)	10.7	10.3	9.6	9.2	8.9	8.9	8.3	8.0	7.9	–
Infant mortality (per 1000 live births)	18.2	17.3	13.6	12.2	10.2	9.5	8.8	8.1	7.5	7.0

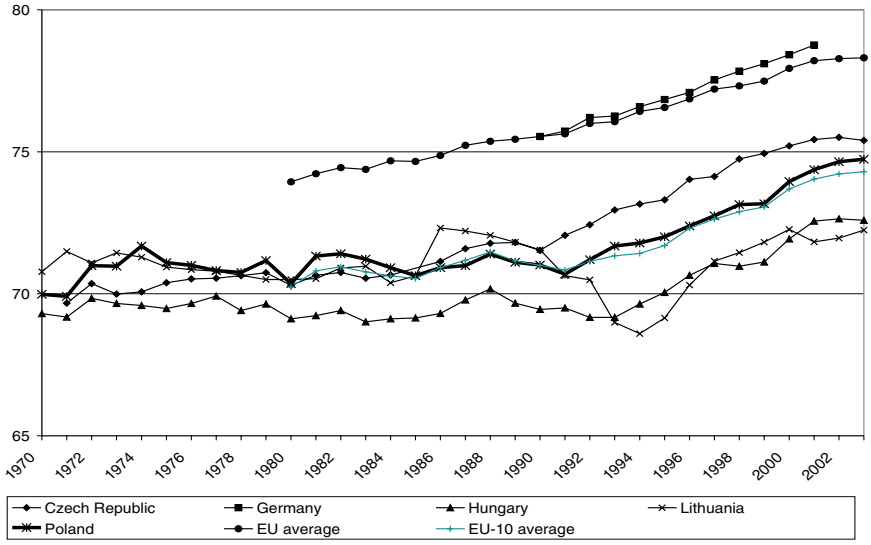
Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: SDR: standard death rate.

population. Under communist rule after the Second World War, a Ministry of Health was created in 1945 and health care was declared a public responsibility. Administration of the health care system was strongly centralized, as was the administration of the economy in general. Poland developed a health care system over the next few decades which, however, resisted some aspects of the Soviet model. For example, private practice was never formally abolished and private medical cooperatives and dental services remained, although much diminished, under communism. There were three major sets of health sector reforms before 1989. The first set of reforms aimed to develop free and universal public health care. Health care services were offered to all state employees, and in the 1950s occupational health clinics were set up at workplaces. Only limited free health care was available in rural areas, but this improved after 1972 when coverage was extended to include agricultural workers.

The second set of reforms aimed to bring together comprehensive health and social services in each district. In 1960, the Ministry of Health became the Ministry of Health and Social Welfare. In 1972, the integrated health care management units, the ZOZ (*Zespol Opieki Zdrowotnej*), were established, managing hospitals, outpatient clinics, specialist and primary health care, as well as some social services. Many experts considered the change to be premature and detrimental.

The third set of reforms aimed to decentralize public administration. Health sector reforms in the 1980s were linked to efforts to decentralize

Fig. 1.3 Average life expectancy at birth in Poland compared with selected countries and regional averages, 1970–2003



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union, EU-10: New Member States joining the EU on 1 May 2004.

the administrative structure of the country by strengthening the position of voivodships and later the gminas. In 1983, the powers of the Ministry of Health and Social Welfare were reduced and the voivodships and the ZOZ were given greater political and administrative powers.

A variety of proposals for restructuring the health care system have been debated since 1989. The major reforms of the 1990s focused on further decentralization, the strengthening of primary care, and the introduction of compulsory health insurance.

New arrangements linked to the establishment of health insurance funds started in January 1999, but after three years of "sickness fund" activities, new ideas were implemented by a new government. A centralized National Health Fund was established and has been operating since 2003. But in the same year the Constitutional Court ruled that the Law on Universal Health Insurance with the National Health Fund was "unconstitutional" and as a consequence a new Law on Health Care Services Financed from Public Sources was passed in August 2004 in parliament.

2 Organizational structure and management

Organizational structure of the health care system

Throughout the 1990s, the Polish health care system remained predominantly funded by the state. In the early 1990s, Poland proceeded with gradual public sector devolution, including reorganizing the previously hierarchical health care system. The first step away from a centralized model increased the power of the provincial administration (the voivodships). The administration of most health services was transferred in 1991 from the national Ministry of Health and Social Welfare to the provinces (voivodships) and to a lesser extent to the local (gmina) authorities. The second step, from 1993 onwards, was to devolve ownership of most public sector health facilities to the provinces and to the local governments. The gminas previously had little involvement in health care services. Further, the old level of the powiats was re-established in 1998 and took over responsibility for county hospitals (Fig. 2.1).

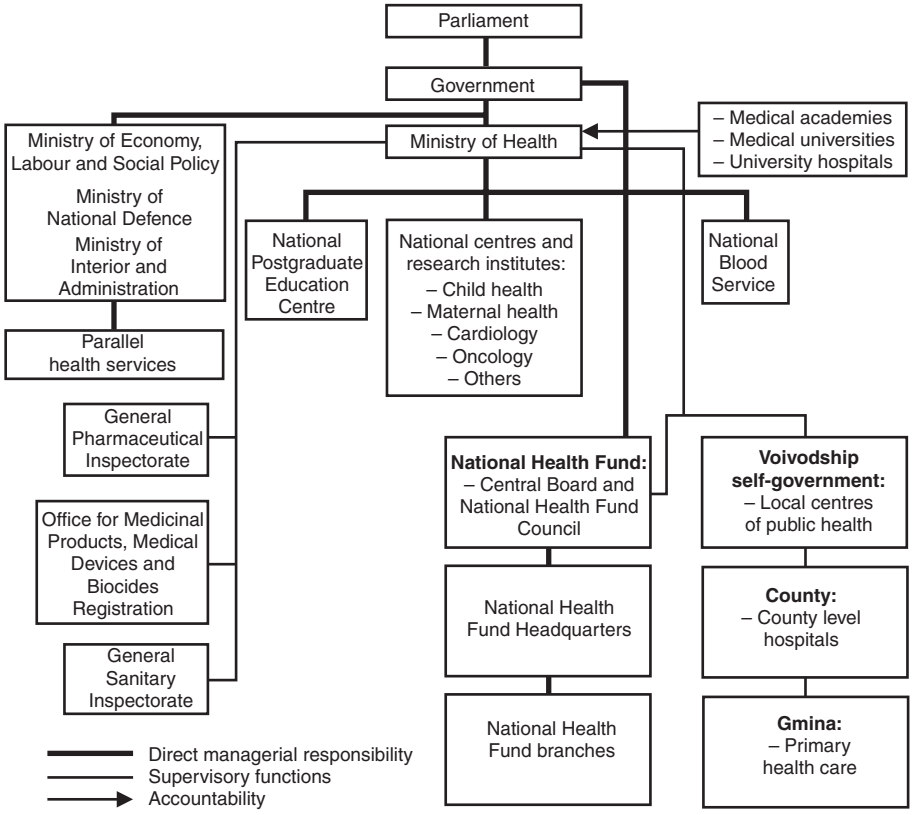
Since 1999, the health care system has undergone major structural changes, notably the establishment of 16 regional sickness funds and of a separate fund for uniformed public employees such as army and railroad workers. As a consequence of rising user discontentment with the reform, these were merged again into a single National Health Fund (NHF) in 2003. The reasons for the discontentment with the reforms were multiple. The main causes seemed to be a bad image of reforms in the press coupled with the use of health reform issues for election campaigns. Decreased access to services during this period without notable improvements in service, quality and financial problems at the regional fund level were among the other reasons.

In 2005, the stewardship, management and financing functions in the Polish health care system were divided between three different types of institutions:

1. Ministry of Health
2. National Health Fund
3. Territorial self-government administration.

An overview of the structure of the Polish health system is given in Fig. 2.1. The organization and respective roles and responsibilities of the key stewardship, management and financing institutions are discussed in detail later. This is followed by an overview of the current structure of health care provider institutions in Poland.

Fig. 2.1 Overview of the health care system



The Ministry of Health

Since 1989, the role of the Ministry of Health has progressively evolved from health care funder and provider, to policy-maker and regulator. The Ministry is responsible, in general, for national health policy, for major capital investments, and for medical science and education. It has administrative responsibility only for those health care institutions that it directly finances. In particular, these include the national postgraduate education centre and national centres for child health, maternal health and cardiology. Medical academies, university hospitals and research institutes are semi-autonomous, but are ultimately accountable to the Ministry of Health. The Ministry is also responsible for implementing national public health programmes, for training health care personnel, for partly funding medical equipment, and for setting and monitoring health care standards.

The Minister of Health has the overall responsibility for health care and its organization. For some areas, the Ministry has kept direct managerial functions, including the State Medical Emergency Service, health resort treatment, and the regulation of the medical professions. It is responsible for coordinating health policy programmes according to cost–benefit aspects.

Furthermore, the Ministry of Health has a number of supervisory functions. These include the supervision of the Chief Pharmaceutical Inspector and the President of the Office for Medicinal Products, Medical Devices and Biocides Registration, who are responsible for the safety of medicinal products, medical devices, biocides and cosmetics, as well as the marketing approval for medicinal or food products produced using genetically modified organisms. The Minister of Health also supervises the Chief Sanitary Inspector, who is responsible for hygiene and sanitation, including supervision of safety, food quality assessment in the process of its production and trade turnover, and materials and products designed for contact with food.

The Ministry of National Defence, the Ministry of Interior and Administration and the Ministry of Justice all supervise systems of parallel health services financed from their budgets.

National Health Fund

The National Health Fund started its operations in 2003 as a successor to the previous 16 sickness funds. The major task of the NHF is to finance health services provided to insured persons. Health services are aimed at maintaining, restoring and improving human health in the event of disease, trauma, pregnancy and childbirth, and at preventing disease and promoting health. To this end, the NHF, as a fundholder by virtue of the law, contracts with service providers

for the supply of health services. The conclusion of contracts is preceded by competition for public funds, or negotiations.

The NHF finances health services according to its financial resources. The NHF is prohibited from engaging in profit-making activities, it cannot operate or own health care institutions, it may have no ownership rights over the legal entities operating health care institutions or pharmacies, and it cannot be a shareholder in companies which manage health care institutions or trade drugs.

The National Health Fund is supervised by the Fund Council. The Fund Council consists of nine members appointed by the Prime Minister for a five-year term. Before October 2004, there was also a Fund Board, which was abolished by the Law on Health Care Services financed from Public Sources.

The NHF is managed and represented by its president who is appointed and recalled by the Fund Council. The vice-president for medical affairs must be a physician. The vice-presidents are proposed by the NHF president and appointed and dismissed by the Fund Council, which also determines their remuneration.

In 2003 the Constitutional Court ruled that the Law on Universal Health Insurance with the National Health Fund was "unconstitutional". The tribunal gave the government one year (i.e. until the end of 2004) to amend the law in conformity with the Constitution. As a consequence, the government prepared the new Law on Health Care Services Financed from Public Sources, which was passed in the Sejm on 27 August 2004.

There are few changes compared to the law from 2003. However, the new law does meet the Constitutional Tribunal's requirements concerning the list of health care services financed by the National Health Fund. It also introduced transparent regulations for the management of waiting lists for scheduled interventions and hospitalizations. Furthermore, the question of who bears the cost for health services for the homeless and other uninsured people has been clarified. Owing to the short time taken to prepare the law, it was impossible to prepare a list of approved health services financed from public sources as originally planned. Instead a "negative" list of services that will no longer be covered by the NHF was included. The new Law did not increase the independence of voivodship NHF branches and did not change current co-payment regulations referring mainly to drugs.

According to the Law on Health Care Services Financed from Public Sources, the homeless who undergo programmes to put an end to their homelessness are covered by the health insurance. Their premiums are paid by social care institutions, which are responsible for the programmes. Since it was necessary not to disrupt the process of service contracting, the new law did not include

all the recommendations of the experts' panel, which had been convened to prepare the new law. In this respect, it could be seen as an emergency measure to answer to the Constitutional Tribunal's ruling and it is clear that further work is needed on the regulation of the National Health Fund.

Territorial self-government administration

On 1 January 1999, a new fundamental three-tier territorial division of the country was introduced, based on gminas, powiats and voivodships. At each level of the self-government administration, health authorities are responsible for three domains: general strategy and planning based on the identified health needs in a given region, health promotion, and the management of public health care institutions.

Health care units

Establishment and management of health care units may take any form defined in the Law on Health Care Units. On the basis of this law, a health care unit is an independent facility in terms of its organization, personnel, assets and finances. It is established and managed to provide health services and promote health. A health care unit is defined as:

- a hospital, chronic medical care home, nursing home, sanatorium, rehabilitation facility, or other facility providing 24-hour or regular working-hours health care services;
- an outpatient department, health centre or outpatient clinic;
- an emergency ambulance service;
- a diagnostic laboratory;
- a dental prosthetic or orthodontic clinic;
- a rehabilitation treatment centre;
- a childcare nursery;
- another institution meeting the conditions defined in the law.

The Law on the Medical Profession defines forms of liberal medical practice other than those based on employment in health care institutions, such as individual or group medical practices. Health care services provided exclusively at the place to which a physician is called are also regulated under this law. Medical practices are not considered public health care institutions under Polish law.

Individual medical practice may be performed only by a person who has both a licence to practise a medical profession and permission to run an individual

medical practice. In addition, it is required that individual medical practices are registered with a district Chamber of Physicians and Dentists.

With regard to individual specialized medical practice, specialization in a medical discipline corresponding to the performed practice is required. Both forms of individual medical practice involve delivery of health services at the place of their registration.

It should be noted that practising a medical profession outside a health care institution on the basis of employment, or another contract, is on an equal footing with individual medical practice or individual specialized medical practice. However, in such a case, the party contracting with a physician or a nurse/midwife is obliged to notify details about the premises and equipment to be used for delivering health services.

Under a group medical practice, health services are provided exclusively by physicians or nurses and midwives who are partners in a private or partnership company. As in individual medical practices or individual specialized medical practices, they are obliged to have a licence to practice a medical profession and specialization in the relevant medical discipline. Group medical practice on the basis of a contract for delivery of health services is not allowed in a public health care institution.

Primary dental care is almost entirely provided by private dentists. It is also the only category of health services where the scope of services delivery is defined in, and based on, the Law on Health Care Services Financed from Public Sources.

Planning, regulation and management

Planning

Health services delivery plans are elaborated by the National Health Fund on the basis of national health plans approved by the Minister of Health. They define the volume and the scope of health services needed to satisfy the health needs of a given population outlined in voivodship health plans. These plans should contain:

- the characteristics of the health status and identified health needs of the population in a given voivodship;
- an outline of policy and undertakings to meet the population's health needs and consequently improve its health status, indicating priorities.

Contracts for health services can be made only with service providers who meet the requirements laid down in the law along with specific requirements defined by the National Health Fund. The NHF contracts for the delivery of health services are concluded either through a competition for public funds or through negotiations. A separate National Health Programme for health promotion and prevention was set up in 1996.

Health service delivery plans were regularly developed by voivodship self-governments. Currently they are being prepared by the National Health Funds. The health service delivery plans define essential health needs and the volume of health services needed to meet them, as well as proposed solutions to existing health problems perceived from a long-term perspective. Planning and meeting the health needs of the population are carried out along the time dimension (short-term, annual and long-term plans) and according to geographic/territorial considerations.

The National Health Programme (NHP) for 1996–2005 was adopted by the Council of Ministers on 3 September 1996. The strategic goal of the NHP is to improve the health status of the population and to enhance health-related quality of life based on the WHO Health for All concept in a multisectoral programme. The NHP is organized around three areas:

- health and health determinants
- health promotion
- public health policy.

Health policy should be built up at all levels and by the public. That is why the NHP defines the objectives of "the public health policy" not "the state health policy" as it used to be in the past, which means that the emphasis has been shifted from undertakings at the top levels of the state administration to universal activity, in which all members of the public are involved. The three key areas of activities aimed at accomplishing this strategic goal are as follows:

- creating conditions and developing personal motivation, knowledge and skills to choose healthy lifestyles, and undertaking actions for improving one's own health and the health of others;
- making the environment supportive to health, work and education;
- reducing inequalities in health and in access to health services.

Operational targets, supplemented with rational indices, have been monitored since 1998. Each year, a detailed report on the NHP monitoring is developed and presented to the Minister of Health. The report is based on relevant data provided by national institutes and reference units (e.g. the National Institute of Cardiology, the Maria Sklodowska-Curie Memorial Cancer Centre and

Institute of Oncology, the National Institute of Hygiene, and the Food and Nutrition Institute).

The NHP monitoring renders it possible to find out whether individual segments of expected outcomes and health gains are achieved at the appropriate time and whether the accomplishment of a particular target as a whole is possible by 2005. However, there are also objectives which cannot be accomplished on time; therefore more effective measures need to be taken. It will also be necessary to take account of targets not completely accomplished in designing the future National Health Programme for the years 2006–2015.

The most essential health indicators and behaviours leading to health-conducive lifestyles among the Polish population, covered by the National Health Programme for 1996–2005, have changed for the better. The following should be mentioned as good examples:

- reduced infant mortality rate to 7.2 per 1000 live births;
- decreased male mortality from diseases of the circulatory system;
- decline in the rate of increase for mortality from some neoplasms;
- dramatic decline in the incidence of hepatitis B;
- increased proportion of non-smoking men;
- positive change in consumption of fats, vegetables and fruits;
- positive change in the pattern of alcohol consumption;
- decreased number of fatal injuries owing to road traffic accidents compared with 1995.

These developments are mirrored by a continuous extension of life expectancy at birth since 1991. Unfortunately, Target 1 of the NHF, promoting physical activity among the general population, gives rise to some serious worries, especially among adults and to some extent among young people who, though taller, are less physically active. Some unfavourable tendencies are also observed in the area of mental health. This issue needs a more thorough analysis and adjustment of social and health policy.

Regulation

Article 68 of the Constitution of the Republic of Poland commits the public authorities to ensure that all citizens have equal access to health services, irrespective of their ability to pay. This means that the state is responsible for the health protection of its citizens, and thus for ensuring equal access to and quality of health services. Health care for children, pregnant women, handicapped people and elderly people are specifically mentioned in the law as the responsibility of public authorities, as are the prevention and control

of epidemic disease and environmental degradation. Physical activity among children and young people is another focus.

Both public and non-public sectors are subject to the same requirements and terms of registration. The law provides for a broad spectrum of legal entities entitled to establish health care institutions; any person or legal entity, which includes commercial partnerships, may establish a health care institution.

The essential difference between public and so-called non-public health care institutions is that they are founded by different legal entities. The public health care institutions may be established by the minister or a central body of the government administration, public medical institutions (medical university, medical academy), or other public institutions carrying out training and research activities in medicine, the voivoda or a territorial self-government.

Independent Health Care Institutions (HCIs) are the basic type of organization. At present, territorial self-governments are founders of 90% of HCIs. Other forms – budgetary entity or budgetary enterprise – are permissible only if the founder agrees to maintain HCIs in one of those forms. The main characteristic of independent HCIs is their dependence on health insurance contributions. HCIs are distinguished by their legal status, which is acquired through registration by a relevant court. However, registration by a court must be preceded by registration in the register of health care institutions. This register is opened and kept by the Minister of Health or the voivoda, depending on the organizational structure and type of legal status granted by the Minister of Health or the voivoda.

HCIs (state or self-government) are completely separate from a founder, which is a specific legal form of public ownership. They are the successors of the former ZOZ and still get their revenues in the form of budgets. The founder does not bear responsibility for the obligations of the HCIs, which thereby gain substantial autonomy but also risk. Each HCI operates on a self-financing basis and covers all the costs of its operations and obligations. If an HCI is unable to cover its loss, then the founder of the HCI is obliged to do so. HCIs do not pay income tax. The independence of each HCI with respect to its founder is also limited by the founders' supervising authority. In Poland, public and non-public health care institutions are put on an equal footing.

Other non-public health care institutions may be established by churches or religious organizations, an employer, a trade union, a foundation, an insurance company, a professional local government body or association, or an individual, who may be a Polish citizen or a foreign national.

The Law on Health Care Institutions is liberal towards the spectrum of entities entitled to establish health care institutions, but it is restrictive with respect to personnel, premises, devices and medical equipment. The law states

that premises and equipment of health care institutions should satisfy technical and sanitary requirements based on a decree by the Minister of Health. Premises and equipment used for individual medical practice should meet the requirements laid down in the regulations concerning all forms of practice. Permission to operate and practise, to be registered, and to commence the medical practice of pharmacy is conditional upon these requirements being met.

Management

Since the introduction of a social health insurance system is based on contracts between payers and providers, procedures have to be defined. The NHF places an advertisement, including the terms set forth by the Minister of Health in the Ordinance of 25 March 2003, announcing the procedure for contracting health services with the NHF. This includes: inviting interested parties to participate in negotiations, putting health services out to tender, appointing and dissolving the tender commission, and defining the responsibilities of the tender commission (Journal of Laws No. 55, item 493) and the National Health Fund Law (article 78, paragraph 5).

The key information provided in the announcement includes the name and address of a health service purchaser, the subject and the value of the contract, the required professional and technical qualifications of health service providers, taking account of Polish technical standards harmonized with European standards and statistical classifications issued on the basis of public statistics regulations.

Competitive tendering is an essential mechanism in contracting health services. It comprises two parts: one open and one confidential. During the open part of the competition, the bidding commission informs bidders about the number of offers put out to tender, decides which of the offers meet the requirements, and enters explanations and declarations made by bidders in the tendering record.

During the closed part of competitive tendering, the bidding commission may select the most favourable offer or select a number of offers if the required volume of health services cannot be provided by one bidder alone. It may also reject all offers if none of them ensures the required quality of services.

During the closed part of competitive tendering, the bidding commission may negotiate both the number of health services to be delivered and their prices. The negotiations are carried out with the bidder who tenders the most favourable offers. If there is more than one bidder, the commission is obliged to negotiate with at least two of them.

The National Health Fund may sign contracts for health services concluded through negotiations only in instances defined in the Law on Health Care Services Financed from Public Sources. To open negotiations, together with the placement of an announcement, the NHF is obliged to send invitations.

At the level of each voivodship branch, the NHF president calls into being social councils, composed of 14 members, including invited representatives from local health authorities and trade unions. The objectives of these social councils are to give an opinion on the voivodship health plans and the National Plan of Health Services Delivery with respect to relevant voivodships, and to carry out periodical analyses of complaints and suggestions raised by insured persons, except for issues subject to medical supervision.

The major tasks of the Fund Council are as follows:

- to control the current activity of the NHF in all its scopes;
- to make decisions on the NHF annual work plan and the investments plan;
- to give an opinion on the NHF financial plan and the remuneration system of NHF employees;
- to accept the annual NHF financial reports and endorse annual reports on NHF activities;
- to decide if the NHF assets and investments exceed the president's competence and purchase, sales and encumbrance of NHF real estate property;
- to control the implementation of the NHF financial plan;
- to propose to the president of the NHF recommendations and findings on controlling the procedures for entering into contracts with health providers.

The president of the NHF administers and represents the NHF. The president's tasks are as follows:

- to manage NHF finances;
- to safely and effectively administer the NHF funds and properties, including the reserve fund;
- to incur liabilities including loans and credits;
- to develop the annual NHF cost and revenue forecasts for successive years;
- to develop the project of annual budget plans;
- to develop NHF work plans;
- to implement the annual budget plans and work plans;
- to develop a project including the annual material plan of investments;

- to prepare the implementation reports of the annual budget plans;
- to prepare periodical and annual reports on NHF activities;
- to supervise the settlements of accounts under the regulations on coordination;
- to submit a plan on the remuneration system of NHF employees to the Fund Council;
- to act as the employer for the employee headquarters according to the Law on Labour;
- to appoint and recall the heads of voivodship branches after consulting the regional councils;
- to implement resolutions accepted by the Fund Council;
- to supervise implementation of the NHF voivodship branches' activities;
- to coordinate cooperation between the NHF and the governmental administration, organizations that act for health care, social insurance institutions, self-governments of medical professionals, trade unions, employers' organizations, health services provider organizations and the insured;
- to submit health programmes prepared by the Ministry of Health to voivodship NHF branches for implementation;
- to make decisions on issues listed in law;
- to work towards the unification of implementation systems of the NHF branches' activities listed in the law.

Decentralization of the health care system

The Law on Universal Health Insurance, dated 6 February 1997, with later amendments, came into force on 1 January 1999 and radically changed the system of public health care, in terms of the structure and sources of finance. The establishment of mandatory health insurance broke with the centralized system of a national health service financed from the state budget. The former system was based on the right of every citizen to health services, which was administered by state authorities (Ministry of Health and voivodas). Health services were provided by public health care institutions with the status of budgetary entities. Sixteen regional sickness funds and one sickness fund for the uniformed forces were set up under the new system. They became holders of public health care funds that were raised primarily through health insurance contributions. The right to health services was linked to registration with a

mandatory health insurance and payment of contributions. Public health care institutions changed their status to independent health care institutions obliged to cover their expenditures with their revenues from health services delivery. In April 2003, the sickness funds were replaced by a single National Health Fund, partly because of rising discontent with the new system among the insured population and partly for political reasons.

The 1997 reform together with its numerous modifications introduced two major public sources of health care financing: universal health insurance contributions and budgetary expenditures from the state budget and budgets of voivodship, county and commune authorities. Owing to its dual nature, the system is defined as an insurance-budgetary system.

3 Health care financing and expenditure

Main system of finance and coverage

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 gminas.

Expenditure on health care as a percentage of GDP and as a percentage of the state budget declined slightly during the 1990s from an already low level.

The restructuring of health care finances remained stalled, since the state could not finance reforms and the population was unable to afford adequate insurance contributions. The decline in budget allocations placed considerable strain on the health system. The aims of the new insurance scheme are to tap new sources of revenue, formalize health sector financing, further decentralize the administration of health care services, and introduce market mechanisms in order to increase efficiency.

The official statistics, however, underestimate the level of total health care financing (Chawla et al. 1998). First, the data refer only to government expenditure and do not cover other sector activities. Second, the National Health Accounts do not yet take account of the changed financing of health care. Third, out-of-pocket payments by households are not necessarily included, such as informal payments and even official co-payments for some health services. Fourth, budget figures before 1990 are not necessarily comparable since socialist countries did not include "non-material" products such as health and education in their national accounts.

Based on a random national survey of households in 1994, Chawla et al. (1998) argue that out-of-pocket payments have increased substantially. The

expectation is that in the future insurance contributions should largely replace informal payments including "envelope payments".

The 1997 Law on Universal Health Insurance, introduced in January 1999, changed the system of financing. Funds then came from two main sources. First, the insurance funds financed the direct costs of health services to patients through contracts with service providers. Second, government budgets (state, voivodships or gminas) continued to finance public health services, the capital costs of all health services, specialist tertiary care services (such as organ transplants), and very expensive drugs (such as immunosuppressant drugs).

The national government budget has historically been the main source of health care financing. The Ministry of Finance funded the health care system from the central budget, although other sources of finance became more significant after 1990. The government proportion of total health care finances dropped throughout the 1990s as private sources rose. However, as explained earlier, the figures in Table 3.1 can only provide estimates, given the lack of reliable information on private payments for health care.

Statutory health insurance

In the statutory health insurance system, the rate of the health insurance contributions, the base for their calculation and those who pay them, are determined according to the Law on Universal Health Insurance together with the legal status of insured persons, contribution payers, sickness funds and later the National Health Fund, health service providers, and other relevant bodies and institutions (e.g. Ministry of Health, Regional Chambers of Physicians and Dentists, health insurance supervision or founders of public health care institutions). The mutual relations between all those institutions were also outlined. The institution of universal health insurance, although separate, is an integral part of the entire social insurance system operating in Poland. In general, the replacement of sickness funds by the NHF has neither changed the legal base of universal health insurance nor the principles of registration for insurance or the contribution rate.

The relationship between insured persons and sickness funds/NHF has become crucial and arises from the legal obligation of citizens to participate in the public health insurance system. The Law on Universal Health Insurance defines all categories of individuals subjected to mandatory health insurance, including those covered by social insurance (e.g. employees and farmers) and those who receive social security benefits. Other categories of individuals are also distinguished, namely non-employed persons (the unemployed, students), civil servants (e.g. the military, the police) and others (e.g. political refugees).

All social groups are practically covered by mandatory health insurance. It is not possible to opt out of the system on the grounds of level of income, social group or source of means of living. The revenues from universal health insurance contributions, aggregated in the contribution fund of individual sickness funds (and later of their legal successor – the National Health Fund) form the major public source of health care financing.

To design contributions appropriately, it is essential to establish the base for their calculation and their rate. By the time the Law on Universal Health Insurance came into force, this issue gave rise to political debates, which still continue. The first health insurance bills proposed a contribution rate of 10–11% of the calculation base, similar to that used for calculating the social insurance contribution. In the 1998 version of the law, the rate was reduced to 7.5% of the base, which included almost all the income of an insured person, without upper limit. In consequence, the base for calculating the health insurance contributions became similar to the income taxable by personal income tax (PIT). It should be indicated that the base for calculating contributions varies, depending on groups of insured persons. This applies especially to private farmers whose income is not taxable by PIT. The base for calculating farmers' health insurance contributions is the price of 0.5 quintal of rye from each standard hectare of croplands on a given farm. The base for calculating health insurance contributions for the self-employed is their income, but the base cannot be lower than 75% of the average salary in the enterprise sector. With regard to insured persons who receive social security benefits, the base for calculating health insurance contributions is the gross amount of those benefits (retirement pay and pensions, social welfare allowances). In most instances, contributions are calculated, collected and transferred by payers, namely by employers or institutions responsible for providing benefits, not by the insured persons themselves. For these activities, payers get a 0.1% commission on paid contributions.

The establishment of a contribution rate of 7.5% of the base for its calculation originated from an assumption that the growth rate of public expenditure on health care has to be limited and maintained at a level similar to that adopted in the former system. Thus it appeared that the achievement of a noticeable increase in public expenditure was not in fact the goal of the 1999 reform of public health care. This gave rise to critical opinions presented by numerous reformers, especially representatives of medical circles who had hoped that the reform would contribute to a substantial increase in public sources of health care financing. The pressure from opponents continued to grow. In 2000, the contribution rate increased to 7.75% and in 2003 to 8% of the calculation base. An annual increase in the contribution rate by 0.25 percentage points was adopted to reach a 9% base for contribution calculation in 2007. Farmers

and their families are insured in the special social insurance institution (FSIF) which transfers money for health insurance to the NHF.

Health insurance contributions are deductible from PIT and reimbursed on the basis of an annual tax declaration. During the initial years, whole contribution payments were deductible, but in 2003 the rate of compensation was limited to 7.75%. Thus in 2003, the sum equal to 0.25% of the base for calculating contributions could not be deducted from PIT, becoming a type of out-of-pocket payment covered by insured persons. In 2004, the insured person's non-tax-deductible share of contributions increased to 0.5%.

The decision on the base for calculating contribution and its rate, as well as the way the contributions are paid and compensated, have given rise to much criticism. First of all, it is stressed that this structure of public sources of health care financing creates strong interdependence between the amount of public funds for health care financing and citizens' personal incomes. Low indices of the population's income growth have a direct bearing on the financial capacity of public fundholders who are not able to contract the required volume of health services. It also indirectly affects the financial situation of public health care institutions, which is changing for worse.

Owing to the fact that health insurance contributions are directly linked to personal income tax, a health insurance contribution cannot be regarded as typical for a social health insurance system, but rather as a "quasi-tax". There are other aspects of this Polish model of health insurance contribution that are unusual, such as payment of contributions calculated on the basis of all revenues from employment and non-agricultural economic activity, lack of a defined ceiling level of revenues, different bases for calculating contribution rates, and neglect of the relation between health risk and the insurance coverage under one health insurance contribution for members of a family. These are often used as arguments to support the thesis that this practice contributes to an inequitable financial burden imposed on citizens, whereas the adopted legal regulations clearly distinguish taxes from health insurance contributions. This has practical consequences: to evade payment of health insurance contributions is not regarded as a tax offence. Due contributions and running interests can be collected by means of administrative constraint only. Sickness funds were previously fundholders via the Social Insurance Fund (SIF). Now this responsibility has been taken over by the National Health Fund.

The contribution rate, the base for its calculation, the way contributions are collected and compensated for by tax deductions, and some other issues still evoke much debate, so that further relevant modifications can be expected.

State budget and self-government budgets

In the reformed health care system, the involvement of the state budget and self-government budgets in health care financing is very limited. Now, expenditures from those budgets play only a supplementary role. In general, the public health targets, health insurance contributions for specific groups of the population (the unemployed receiving social security benefits, persons receiving social pensions, farmers, war veterans and others), and investments in public health care institutions are financed from those budgets. The major part of funds allocated for the implementation of health programmes is transferred to the National Health Fund. The list of so-called "highly specialized procedures", financed from the Ministry of Health budget on the basis of contracts signed with service providers, has been cut down. The responsibility for contracting numerous procedures, formerly placed on that list, has been taken over by the National Health Fund and its branches.

The funds from the state budget are used to cover the costs of health services provided in life-threatening situations, in case of accidents or childbirth, to persons who are not insured and thus do not pay health insurance contributions. The Minister of Health may give consent for covering the costs of treatment or diagnostic procedures not available in the country to be performed abroad.

Health care benefits and rationing

From 1952, the Polish state had provided universal access to health services. Health sector reforms in the 1990s sought to maintain this commitment. The 1991 Health Care Institutions Law and subsequent regulations set out a range of basic services which must be provided. Only a few health services were excluded, such as alternative therapies and cosmetic surgery. It also excluded some services in health resorts (spas), but those who are entitled to health care can still obtain free dental care and balneotherapy at these spas. There have been a number of controversial changes to the entitlement of women to abortions. A policy of relatively open access in communist times was changed to almost complete prohibition with the advent of multi-party democracy. The 1993 Abortion Law now permits abortion in certain circumstances, such as where the health of the mother is at risk.

The 1997 General Health Insurance Law and later amendments propose universal coverage of the population and full entitlement irrespective of risk, as discussed later. Certain treatments are excluded, as before, including cosmetic surgery and non-disease related treatments in health resorts.

Both the Law on Universal Health Insurance and the Law on Health Insurance with the National Health Fund, dated 23 January 2003, in force until the end of 2004, defined a wide range of health services under the insurance scheme. These included health services aimed at maintaining and restoring human health and preventing diseases and injuries; early diagnosis; medical treatment; and prevention and alleviation of disabilities. Insured persons were entitled to medical examinations and consultations, diagnostic examinations, preventive care, outpatient health care, hospital care, medical emergency services, medical rehabilitation, nursing, supply of drugs and medical devices, supply of orthopaedic devices and aids, perinatal care during pregnancy, childbirth and the puerperium, palliative care and certification of temporary or permanent disability. For dental care, a precise system of point pricing with respect to a standard "basket" of dental procedures and dental materials was established, as defined in a decree by the Minister of Health.

The following health services were excluded from the guaranteed package of services:

1. services financed on the basis of separate regulations, including occupational medicine and highly specialized medical procedures financed directly from the state budget;
2. health certificates for drivers and other medical certificates at the request of the insured person if these are not connected with further treatment, rehabilitation, work disability within the meaning of regulations on social insurance of employees and farmers, continued studies, participation of children, pupils and students of teachers' training centres and university students in sport events and organized leisure unless these certificates are to be presented to welfare institutions or in order to obtain nursing allowances;
3. health care services at health resort hospitals and sanatoria not related directly to a health problem being the reason for referring the insured person to these medical institutions;
4. non-standard dental services;
5. non-standard vaccinations;
6. other non-standard services determined in a list issued by a decree of the Minister of Health.

The decree of 4 April 2003 issued by the Minister of Health as executive provisions to the Law on Health Insurance with the National Health Fund (article 47) defined the following list of non-standard health services:

- plastic surgery and cosmetic procedures if these are not connected with disease or its consequences, congenital malformation or injury;

- sex reassignment surgery;
- acupuncture, except for pain relief.

The range of exclusions that may be regarded as very limited was not changed during the change from sickness funds to the National Health Fund, nor by the most recent Law on Health Care Services Financed from Public Sources, dated 27 August 2004.

Postulates on further exclusions, leading to the retrenchment of the so-called "basket of guaranteed health services" financed from health insurance contributions as recommended in a report by the OECD in 2000 (Girouard & Imai 2000), have not yet been put into practice.

Limits in the volume of health services set in contracts concluded between services providers and the National Health Fund branches (formerly sickness fund), which are a typical feature of the present insurance system, are mostly responsible for restricted access to health services. Limits aimed at imposing strict financial discipline on health fundholders result in refusals or postponement of admissions and visits (especially towards the end of each year – a basic accounting period), and lengthen waiting lists. As a result, patients are forced to purchase services in the private health sector or seek informal ways ("envelope payments") that might facilitate access to health services (Watson 2004). Waiting lists for some conditions, notably cancer operations, are long and probably detrimental to the health of the individuals concerned.

It may be concluded that despite the wide range of health services guaranteed by law, the present contracting rules, adopted because of financial constraints, lead in practice to limited access to services and impose extra expense on patients who have to purchase services in the private or public sector.

Complementary sources of financing

Private expenditures on health care

The studies of household budgets, carried out by the Central Statistical Office on a representative study group, are the major source of information about private expenditures on health care. The results of these studies are presented in two annual publications: "Living conditions of the population" and "Household budgets" (Central Statistical Office 2002). Household expenditures on health care are direct expenditures in cash on medical devices and health services, including non-registered expenditure (gifts for medical staff or informal gratuities).

Table 3.1 summarizes average monthly private expenditures on health per capita in the following categories: pharmaceuticals and medical devices, health services, including non-conventional medicine, hospital care and health resort treatment.

Table 3.1 Average private expenditures on health per capita and month, 1998–2002

Years	1998	1999	2000	2001	2002	Change 1998–2002
Average private expenditure on health per capita and month (in PLN)	21.35	23.69	26.63	27.58	28.32	+33%
of which:						
– Pharmaceuticals and medical devices	12.25	14.92	17.71	19.33	20.39	+66%
– Health services including non-conventional medicine	8.48	8.08	8.37	7.67	7.44	–12%
– Hospital care and resort treatment	0.63	0.69	0.55	0.58	0.48	–24%

Source: Household budgets, 2002, 2001, 2000, 1999 and 1998. Central Statistical Office. Statistical studies and information, Warsaw, 2003, 2002, 2001, 2000 and 1999.

Between 1998 and 2002, private expenditures increased by 32.6%, owing to a rise of 66.4% in spending on pharmaceuticals and medical devices. During the same period household spending on health services and hospital care (including resort treatment) decreased by 12.3% and 23.9%, respectively. However, the share of private expenditure as a percentage of total expenditure decreased slightly in this period: from 29.9% in 1998 to 27.6% in 2002 (own calculations based on household budget data).

Apart from the household data presented, no other reliable data on expenses on private health insurance are available. Nor are the costs of insurance policies for protection against various health risks, including accidents or sudden illnesses and life insurance with extended medical care options taken into account. A relatively small number of insurers cover health services in kind; the services provided mostly take the form of financial allowances connected with illness or other health needs.

Out-of-pocket payments

Over the years, out-of-pocket expenditures on drugs have been prevailing. They make up 60% of all private expenditures in cash on health care, and also on aids and medical devices. Direct expenditures on health services range between 20% and 25% of all out-of-pocket payments. A relatively small part of those expenditures includes payments and co-payments for health services provided

by public health providers, whereas the major part of expenditures is on services in the private sector and in the so-called "grey zone" of the public sector.

Private expenditures on specialized outpatient services and examinations, dental care, hospital care, medical rehabilitation and health resort treatment prevail. Contrary to general opinion, part of those expenditures is formal (services provided in the private sector, payments or co-payments for services supplied under the health insurance system). However, quite a substantial part of those expenditures, especially that on hospital care (mostly in public hospitals) is informal, e.g. "gratuities" in kind to physicians and other personnel. The share of primary health care in those expenditures is very small, which implies that there is easy access to this fundamental link in the system of health service supply.

The structure of out-of-pocket expenditures on health services reflects to a great extent the difficulties in accessing certain categories of health services in the public sector, as well as the opinion expressed by at least some patients that the standard of "free of charge" services provided by the public sector is low (e.g. long queues, long waiting lists, lack of specialists, limited referrals to specialists).

By virtue of the Law on Health Insurance with the National Insurance Fund and the Law on Health Care Institutions, the following services are provided for out-of-pocket payments and co-payments by insured persons:

- the costs of food and accommodation at chronic medical care homes and nursing homes;
- the costs of food and accommodation at medical rehabilitation facilities providing 24-hour health care services;
- a flat price for basic drugs and drugs produced by pharmacies, and 30% or 50% of the price for supplementary medicines provided on the basis of prescriptions;
- a flat price for diagnostic examinations;
- partial or full costs of orthopaedic devices and aids due to insured persons as prescribed by a physician;
- the costs of travel to and from a sanatorium and a partial payment for food and accommodation at the sanatorium;
- the costs of travel on ambulances if there is no need for urgent treatment in a health care institution or the need for continuation of undertaken treatment.

The level of co-payments is limited and depends on incomes of insured persons, which is the main basis of the limitation. The monthly charge for food and accommodation at chronic medical care homes, nursing homes, and

rehabilitation facilities is fixed at a level equal to 200% of the lowest retirement pay with respect to children and 250% to adults, and cannot be higher than 70% of the monthly salary of one person in the child's family, or the monthly salary of an adult under treatment. A flat price for a packet of a basic drug is PLN 3.20, and PLN 5.00 for a prescribed drug produced in a pharmacy, which in total cannot be higher than 0.5% of a minimum salary for a basic drug, and 1.5% for a prescribed drug. In addition, limited prices (reference prices) for drugs included in the reference drug list are introduced, thus if the price exceeds the limit, co-payment by insured persons is required to cover the difference.

The insured are charged 30% of the costs of orthopaedic devices and aids. In the case of hearing aids, insured persons cover, from their own pockets, 50% of the costs. The Minister of Health can also introduce price limits for orthopaedic devices and aids, and for their repair. The costs for food and accommodation in sanatoria vary depending on the accounting season (spring–summer and autumn–winter), and the standard of accommodation (8 categories). The highest cost per day in a single room with a bathroom in the spring–summer season is PLN 23.30 and the lowest payment is PLN 6.50 in rooms with several beds, without a bathroom, in the autumn–winter season. The full costs of travel in health transport vehicles is covered by patients who can move around without the help of another person and can make use of public transport. Otherwise, if the patient's disorder entails an inability to move freely or requires a special mode of public transport adjusted to the needs of his or her disability, the NHF covers 60% of the costs of the travel in ambulances. The patient however, would have to cover all costs connected to the transport.

It should be added that besides the aforementioned statutory limitations concerning the service range, payments and co-payments in the public health care system, there are provisions in contracts concluded between the National Health Fund and service providers that define medical standards of individual categories of health services. By virtue of those provisions, service providers may offer other technologies, but the difference in price between standard and non-standard services has to be met by patients.

Private expenditures in the form of pre-payment schemes

Precise data on expenditures for pre-payment schemes are not available. In June 2004, 30 companies were offering private accident insurance, 23 companies offered full health insurance plans, and 32 companies offered additional accident and health insurance packages. The total amount of premiums paid in additional insurances was PLN 2000 million in 2003, of which accident insurance premiums amounted to PLN 631 million and health insurance premiums to PLN 145 million (Stachura 2004).

This group of expenditures includes insurance policies and so-called "medical subscriptions".

The number of people with medical subscription coverage is estimated at about one million. These are mostly employees who are offered expanded packages of health services by their employers. The costs of packages are incorporated into employers' costs. The packages usually include services which the employers are obliged to provide by virtue of provisions of the Law on Occupational Medicine (periodical check-ups and workplace prevention programmes). Expanded packages facilitate access to services and guarantee their higher standard, being at the same time an effective incentive used by employers. It is worth mentioning that subscriptions mostly cover outpatient health services (consultations provided by primary health care physicians and specialists, diagnostic procedures, prevention and, albeit to a smaller extent, dental care). Individual clients may also subscribe to packages with varied ranges and prices. However, their proportion amounts to less than several per cent of all beneficiaries and they are mostly employees of private companies and institutions. Subscription packages are usually offered by private and public health care institutions. This system, also termed "quasi insurance", follows the American example of Health Maintenance Organizations (HMOs), where financing is integrated with health services provision. As mentioned earlier, the subscription system offers easier access to, and a higher standard of, health services than those which are theoretically guaranteed by the public sector. Monthly costs of subscriptions are not high, ranging from twelve to several hundred PLN, depending on the range of services in the package. The most expensive packages (VIP category) are aimed at top executives and rich individual clients. They also include other services like coordination of hospital care, home visits, or sanitary transport.

Different insurance policies, protecting against risk of expenditures on health care, are offered by relevant insurance companies. These are, for example, sickness or accident insurance, or insurance with "medical" options such as a supplement to life insurance. Insured persons are offered benefits in cash or in kind. Short-term travellers' accident and sickness insurance against expenditures on health and other services during international travels are most frequent. Among personal accident or sickness policies valid within the country, those with extended medical options are quite common. The development of the system of additional health insurance, offering a wider range of health services, is still in its initial stages. This kind of insurance is offered only by a small number of insurance companies, and the number of beneficiaries is estimated at approximately ten thousand. In the opinion of the representatives of insurance companies, there are two major factors that hinder the development of additional private health insurance. First, a wide range of public sector services are

guaranteed by law. Second, there is lack of transparent operation of the public health care system (e.g. lack of waiting list management, lack of guaranteed deadlines for provision of services, or limited volume of health services in contracts signed with service providers because of financial constraints).

Health care expenditure

Until 1998, the public health care sector in Poland was financed from the state budget (mainly via the Ministry of Health and collective budgets of voivodas – the state administration bodies), and budgets of territorial self-governments (gminas). The financing system, including both its structure and sources, largely changed in 1999 when health and administration reforms were simultaneously initiated. In consequence, mandatory universal health insurance was introduced; the rate of insurance contributions and contribution payers were fixed, and 17 sickness funds were established. Sickness funds received financial resources mainly from health insurance contributions. These resources have become the major public source of health services financing. The state budget financing was limited only to targets of particular significance to the health care system. It should be noted that the range of these targets has been constantly modified since 1999.

The administrative reforms resulted in a new three-tier territorial division of the country based on gminas, counties and voivodships with territorial self-government administration equipped with competencies and financial resources for health services. The first step away from a centralized model was to increase the power of regional and local authorities by switching to local administration for most health care institutions. In consequence, in the period from 1999 to the first quarter of 2003, health services were financed from three main sources:

- sickness funds
- state budget
- self-government budgets.

Since 2003, the National Health Fund has taken over the sickness fund functions. Financial coverage of the costs of health services by sickness funds accounted for over 80% while the contribution of the state budget was limited to around 10%. Funds for health services were transferred from the state budget to local budgets, and there were also transfers between individual self-government institutions at different levels. This mechanism has not changed since the introduction of the National Health Fund.

Structure of financing

Departure from predominance of the state budget source of financing health care towards financial resources of sickness funds based on the universal health insurance contributions has not contributed to a considerable increase in public finances for health services.

In 1999–2000, public expenditure on health as a percentage of the gross national product (GNP) ranged slightly between less than 4.2% in 1998 to almost 4.5% in 1999. However, a slight decrease to 4.2% was again observed in 2002 (Table 3.2). In the years of high economic growth (1995–2000), a similar or even higher percentage was allocated from the state budget. In 2004, public expenditure on health care as a percentage of GNP exceeded 5% in the 15 EU Member States before May 2004 and a similar share was found in the majority of the new EU Member States since May 2004 (Fig. 3.6a and Fig. 3.6b).

Table 3.2 summarizes data on the extent and structure of public expenditures on health during the period 1998–2004 as well as the share (%) of these expenditures of GNP. Overall public expenditures were defined as the sum of the sickness funds' expenditures (financial adjustments excluded), expenditures from both the state budget and budgets of self-governments (after excluding funds flow from the state budget to self-governments as well as between them,

Table 3.2 Public expenditures on health, 2000–2004, total amount, sources and percentage of gross national product (GNP)

	2000	2001	2002	2003	2004
Total (PLN million)	27 586.9	30 605.5	327 757.7	33 313.6	34 937.7
of which:					
– Sickness funds (PLN million)	23 009.3	26 415.4	28 675.9	29 213.6	30 487.4
– (% of total)	83.4	86.3	8.7	87.7	87.3
– State budget[a] (PLN million)	3622.3	3266.1	3078.8	3146.1	3191.5
– Self-government budgets[b] (PLN million)	955.3	924.0	1021.0	953.9	1258.5
– Percentage of GNP	3.81	4.02	4.20	4.08	3.95
– Public expenditure on health (PLN per month per capita)	50.0	61.6	62.1	71.5	74.4

Source: Ministry of Health data (2005).
Notes: [a] Transfers of funds from the state budget to self-governments, as well as between them, and health insurance contributions and the cost of health services for individuals not covered by the mandatory health insurance are included; [b] After excluding transfers of funds between self-government units; in 1998, expenditures from budgets of self-government units were regarded as expenditures from budgets of gminas.

and health insurance contributions together with the cost of health services for individuals not covered by the mandatory health insurance).

An analysis of the growth rate of public expenditures on health, observed during 1998–2003, shows a considerable increase in funds (in nominal terms) during the first year of the new system compared with the year preceding the health reform (rate of increase 23.2%). This shows that while public expenditures in health increased in nominal terms from PLN 23.2 billion (1998) to 34.1 billion (2002), when taking inflation into account the increase in public health care expenditure has been very small, from PLN 27 billion in 1999 to 28.7 billion in 2002 (using 1999 as the base). The increase in funds was connected with the need to increase the input in order to cover the start-up costs of sickness funds (setting up, equipment, employment, training, reserves, etc.). In 1999, expenditures of sickness funds themselves slightly exceeded the overall 1998 public expenditures on health care. The increase in public expenditures in the following year was very low (2000/1999, 0.7%), which reflects the reduced rate of GNP growth. Financing of health care from the state budget did not offset the absence of noticeable growth of resources from health insurance contributions. The growth rate of the public funds for health services, considered in nominal terms, oscillated in consecutive years between over 14.1% in 2001/2000 and below 4% in 2002/2001. The growth rate of sickness funds resources was close to that of overall public expenditures. However, it was most pronounced in 2002 as the sickness funds' share of financial resources, as a proportion of total public expenditures on health care, continued to increase, reaching 87% in 2002. Surprisingly, a proportion of expenditures from the central budget, expressed by both a decline in nominal values and a drop in state budget expenditures on health, decreased in overall expenditures from the state budget. In 1999, the proportion of expenditures on health care from the state budget was close to 4.6%, and it was reduced to almost 1.9% in 2002. Those changes resulted from the fact that the state had stopped financing the direct costs of health care and tasks in the area of public health and transferred funds to sickness funds and self-governments. After a stepwise decline observed in 1999, self-government expenditures on health care grew for two consecutive years, but they decreased again in 2002 (4.2% in 2001; 2.4% in 2002).

In assessing the level of public expenditures on health, it is advisable to compare their dynamics with the average annual rates of growth in the section on goods and services, particularly with the dynamics of prices in the health sector. Table 3.3 gives the growth rates for the years 1999–2002. The growth rate of public expenditures on health, in nominal terms (Table 3.4), was considerably marked by oscillations in the years following the health reforms. The rates of increase in the price of materials and services in the health sector

Table 3.3 Growth rates of public expenditures on health care compared to growth rates in prices of consumer goods and services, and prices of goods and services in the health sector (%), 1999–2002

Growth rates (%)	1999	2000	2001	2002
Public expenditure on health (nominal)	23.2	0.7	14.1	3.9
Prices of consumer goods and services	7.3	10.1	5.5	1.9
Prices of materials and services in the health sector	15.9	10.6	6.5	11.5
of which:				
-– pharmaceuticals	15.6	12.6	7.5	13.8
– services of conventional and non-conventional medicine	11.2	7.9	4.7	7.1

Source: The authors' own analysis based on data derived from the Polish Statistical Yearbook, 2001 and 2002 and Small Statistical Yearbook of Poland, 2003, published by the Central Statistical Office.

were consistently much higher than the rates of increase in prices of consumer goods and services.

Prices of pharmaceuticals were characterized by a particularly high growth rate. In 2002, the growth rate of prices for materials and services in the health sector started to grow again, and the disproportion between the growth rate of prices of all consumer goods and services (1.9%) and that of materials and services in the health sector (11.5%) was particularly striking.

To facilitate international comparisons, public expenditures on health per single inhabitant are given in US$ according to the average annual exchange rate and purchasing power parity. The comparison according to purchasing power parity is more reliable as it takes no account of the effect of the exchange rate policy and eliminates the differences in the price levels of individual countries (Table 3.4).

Table 3.4 Public expenditures on health care per capita (nominal) and US$ according to the exchange rate and purchasing power parity

Public expenditures on health per capita	1998	1999	2000	2001	2002
In PLN (nominal)	600	740	756	851	893
In US$ (mean annual exchange rate)	172.4	186.9	172.2	208.5	213.1
In US$ (PPP)	355.1	396.7	404.4	452.3	–

Source: The author's own analysis based on data derived from the Statistical Yearbook and the 2003 OECD database.

The structure of sickness funds' expenditures

As already mentioned, in 1999–2002 sickness funds were the major public source of financing health care in Poland. In 2003 the National Health Fund replaced the sickness funds. They covered health services for insured persons, including primary health care, outpatient specialized medical procedures, dental care, inpatient care, mental health and addictions, long-term medical care (therapy, care and nursing), palliative care, emergency services and sanitary transport, health resort treatment (sanatoria), medical rehabilitation, prevention programmes (health education and health promotion), drug reimbursement, orthopaedic supplies, technical supplies and other therapeutic devices. It should be noted, however, that not all funds from health insurance contributions were used to cover the costs of health services for insured persons. The deductions included the costs of registration and the collection of contributions paid by the insured (0.1%), the Social Insurance Fund (SIF) (0.5%) and the Farmers' Social Insurance Fund (FSIF) (0.25%) as well as costs of sickness funds' operations and other compulsory allocations. In 2002, the SIF and FSIF shares decreased to 0.25% and 0.2%, respectively. Thus the costs of health services paid for by sickness funds were lower than their overall expenditures, and increased gradually from PLN 21.54 billion in 1999 to PLN 28.82 billion in 2002. In 2003, the costs for health services slightly decreased to PLN 27.92 billion.

The share of expenditures on individual categories of services changed during subsequent years of the sickness funds' operation, reflecting the changes in their policies, plans and their distribution of financial resources. This also resulted from the introduction of different forms of payment for purchased health services as well as from changes in prices of medical devices, particularly pharmaceuticals.

In the structure of expenditures, hospital care predominates. It is followed by drug reimbursement for insured persons, primary health care and outpatient specialized care. These four areas of services consume over 90% of all financial resources for health care. In the period 1999–2003 a considerable increase in the proportion of expenditures associated with drug reimbursement was observed. Each year, the real costs of pharmaceuticals actually exceeded the planned expenditures by several percentage points.

This was to the detriment of primary care, which saw a sharp decrease of its share of expenditure from 19.9% to 11.6% during this period. Overall costs for hospital care also showed a slight decline, although an exact analysis is difficult as the definition of hospital care had been changed during this period (Table 3.5).

Table 3.5 The structure of expenditures on health services incurred by Health Insurance Funds (% of total)

	1999	2000	2001	2002	2003
Primary health care	19.9%	13.6%	12.9%	12.2%	11.6%
Outpatient specialized care	6.6%	7.2%	7.2%	6.9%	6.4%
Hospital care	50.4%	46.8%	46.7%	42.5%	41.9%
Emergency service	3.5%	3.6%	3.4%	3.3%	3.2%
Supply of pharmaceuticals	15.7%	19.6%	19.6%	19.1%	21.8%
Other costs[a]	3.9%	9.2%	10.2%	16.0%	15.1%

Source: Costs of health services financed by sickness funds. The National Health Fund's estimated data, 2004.

Note: [a] The increase in the total expenses in this group is caused by separation of financial resources from expenditures on hospital care, e.g. selected groups of specialized services such as psychiatric treatment, rehabilitation and other separately contracted services (for example, dialysis etc.) to the pool of separate financial resources.

The structure of expenditures on health care in the state budget and self-governments budgets

In the structure of the state budget, the largest proportion (over 90%) of expenditures on health care, concerns the "health" section within the competence of the Minister of Health and the "voivodship budgets" section managed by voivodas. The remaining expenses were covered from the budgets of the Ministry of National Defence, the Ministry of Interior and Administration, the Social Insurance Fund, the Farmers' Social Insurance Fund, the Ministry of National Education and Sport, and the Ministry of the Treasury.

The financial sources managed by the Minister of Health were mostly used to finance highly-specialized medical procedures (diagnostic and therapeutic), health policy programmes, postgraduate courses and medical specialty training, public blood banks, occupational medicine, prevention and control of AIDS, drug addiction and alcoholism, inspection of hygiene standards (since 2002), investments in institutions supervised by the Ministry of Health (health care institutions at top reference levels), and health services for non-insured individuals and those entitled to health services by virtue of regulations on the control of so-called "social diseases" (e.g. tuberculosis, venereal or infectious diseases). Since 1999, the expenditures on highly-specialized medical procedures gradually decreased as the provision of those services was assigned to sickness funds.

Voivodship budgets were used to finance pharmaceutical and hygiene inspections (until 2002), regional methodological health care teams, restructuring programmes, health insurance contributions for certain groups of the population (e.g. children, school children not covered by health insurance on the basis of separate regulations, the unemployed who are not entitled to unemployment

benefits), subsidies for self-government units for investments in supervised health care institutions, and implementation or sponsoring of assigned tasks in the area of occupational medicine and health promotion programmes (e.g. AIDS or drug addiction control). Health care expenditures financed from the budgets of the Ministries of National Defence and Interior and Administration were mainly used to finance investments in health care institutions supervised by them, out-of-pocket payments in military health service centres, health services provided to the military, recruits and trainees as well as their families, and mountain and water rescue teams. Other fundholders' budgets were used to cover health insurance contributions for certain groups of the population (farmers, war invalids, the military or persons entitled to children's allowances). In total, subsidies were higher than direct expenditures in the state budget expenditures.

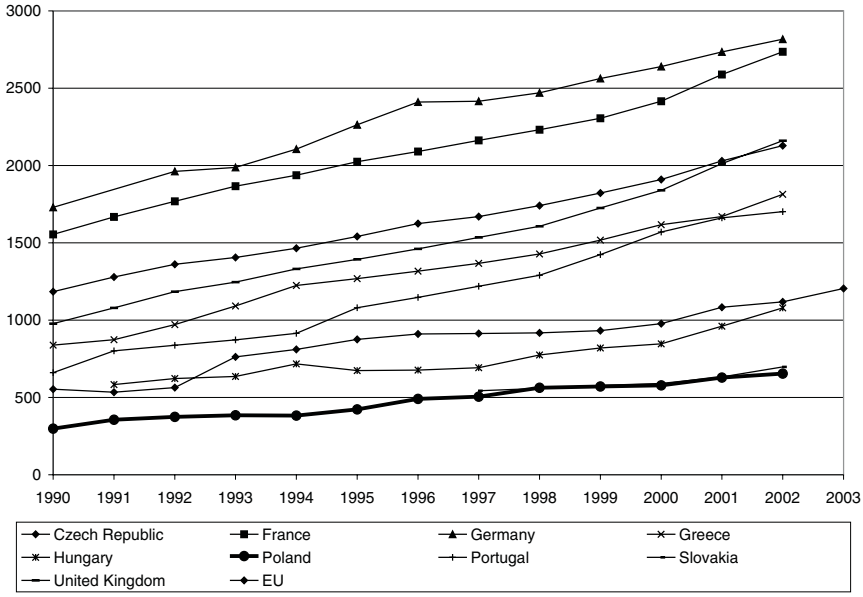
Expenditures on health care from self-government budgets comprised funds owned by individual units and subsidies from the state budget. These funds were spent, according to competencies and tasks of self-governments at different levels, on health promotion and health policy programmes, varied public health tasks, investments in public health care institutions, nurseries, and the operation of sobering rooms or health insurance contributions.

Total expenditures on health care in international comparison

In Poland, the level of expenditures on health care (in US$, adjusted for purchasing power parity) is rather limited in comparison with other European countries. However, with a growth of 55% in the period 1995–2002, the degree of growth in Poland was similar to that observed in Great Britain, Portugal and Hungary. In Fig. 3.1 and Table 3.6, Poland's total expenditure on health is compared to selected European countries. Fig. 3.2 depicts the dynamics of public and private expenditure in a number of European countries in the period 1995–2002. It is noteworthy that in Poland as well as in the Czech Republic and Slovakia, public expenditure has not increased in line with total expenditure, which reflects a higher burden of health care costs carried by users of health care in transition countries in CSEE. Fig. 3.3 shows the development of total expenditure on health care as a share of GDP from 1990 to 2003.

In 2002, total expenditure on health in Poland as a percentage of GDP only reached 6.1%, which is 2.6 percentage points lower than the EU average of 8.7%, and 0.3 percentage points below the average of new EU Member States (Fig. 3.4B). Health expenditure in US$ adjusted for purchasing power parity gives a similar picture, with US$ 654 spent on health in Poland in 2002 compared to US$ 2129 for the EU average and US$ 800 in the new EU Member States (Fig. 3.5A and Fig. 3.5B).

Fig. 3.1 Dynamics of total expenditures on health care, 1990–2003, in US$ PPP per inhabitant



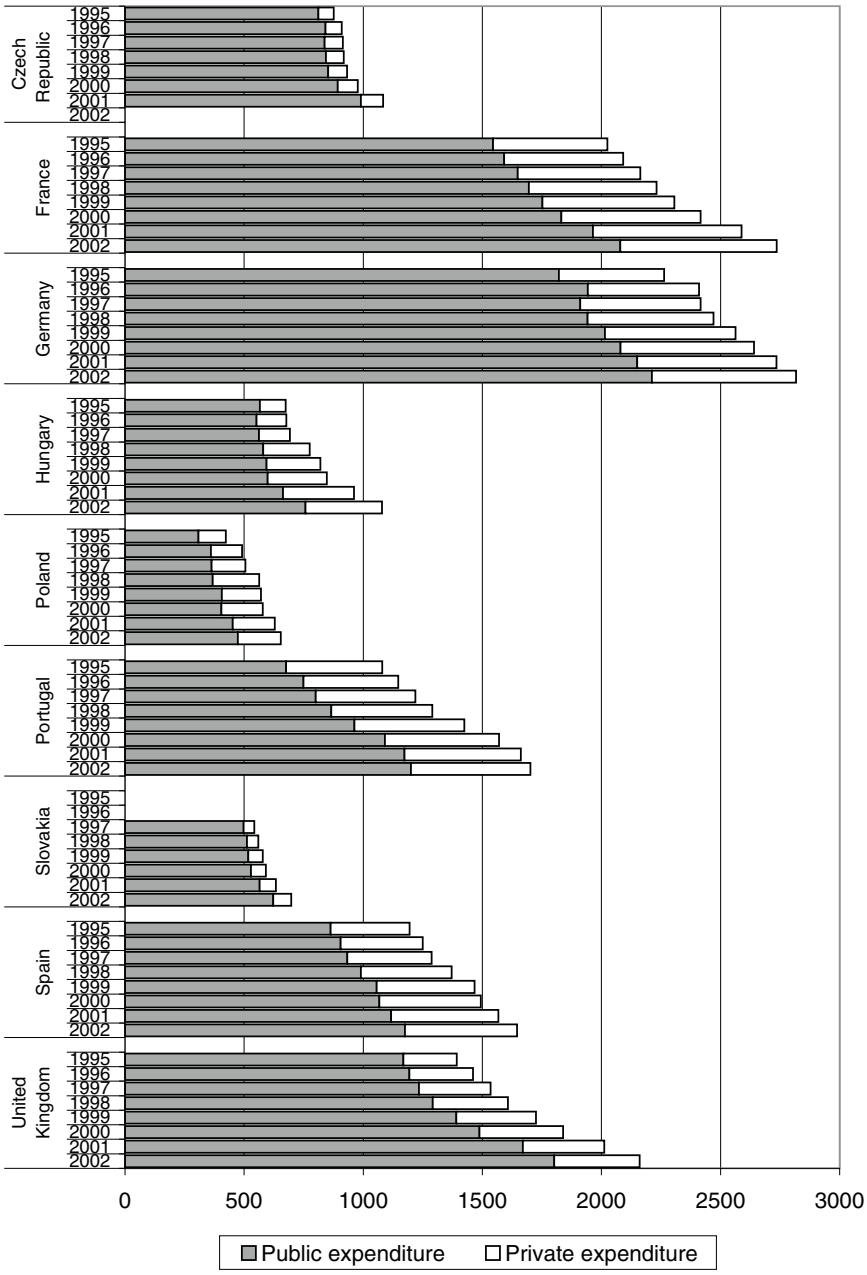
Source: OECD health data, 2004.
Note: EU: European Union.

Table 3.6 Total expenditures on health care, 1995–2002, in US$ PPP per single inhabitant in Poland and in selected European countries

	1995	1996	1997	1998	1999	2000	2001	2002	% Change 1995–2002
Czech Republic	876	910	914	918	932	977	1083	1118	28
France	2025	2091	2163	2231	2306	2416	2588	2736	35
Germany	2263	2410	2416	2470	2563	2640	2735	2817	24
Greece	1269	1317	1367	1428	1517	1617	1670	1814	43
Hungary	674	677	692	775	820	847	961	1079	60
Poland	**423**	**491**	**505**	**563**	**571**	**578**	**629**	**654**	**55**
Portugal	1080	1147	1219	1290	1424	1570	1662	1702	58
Slovakia	n.a.	n.a.	543	559	578	591	633	698	29[a]
Spain	1195	1250	1287	1371	1467	1493	1567	1646	38
United Kingdom	1393	1461	1535	1607	1725	1839	2012	2160	55

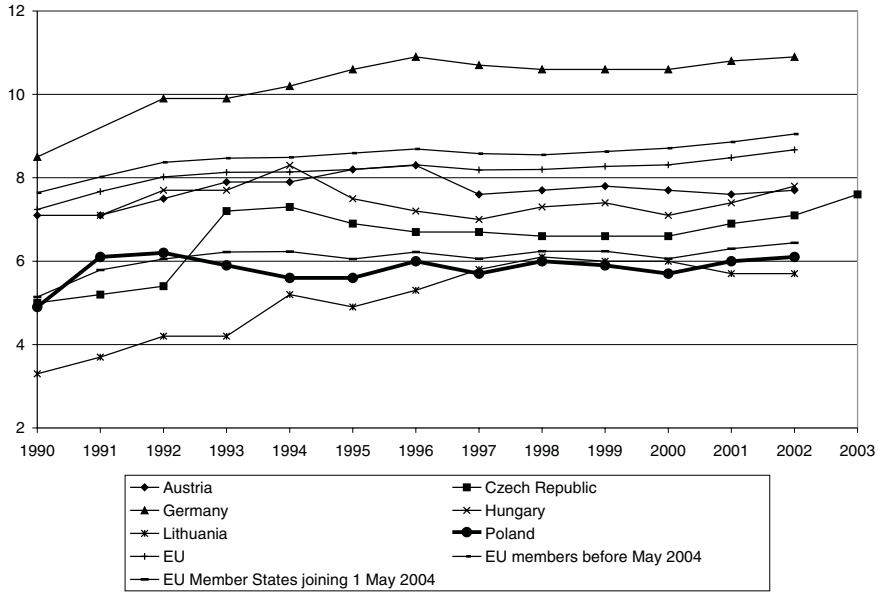
Source: OECD health data, 2004.
Note: [a] (1997–2002)

Fig. 3.2 Trends in public and private expenditure on health care, 1995–2002, in US$ PPP per capita



Source: OECD health data, 2004.

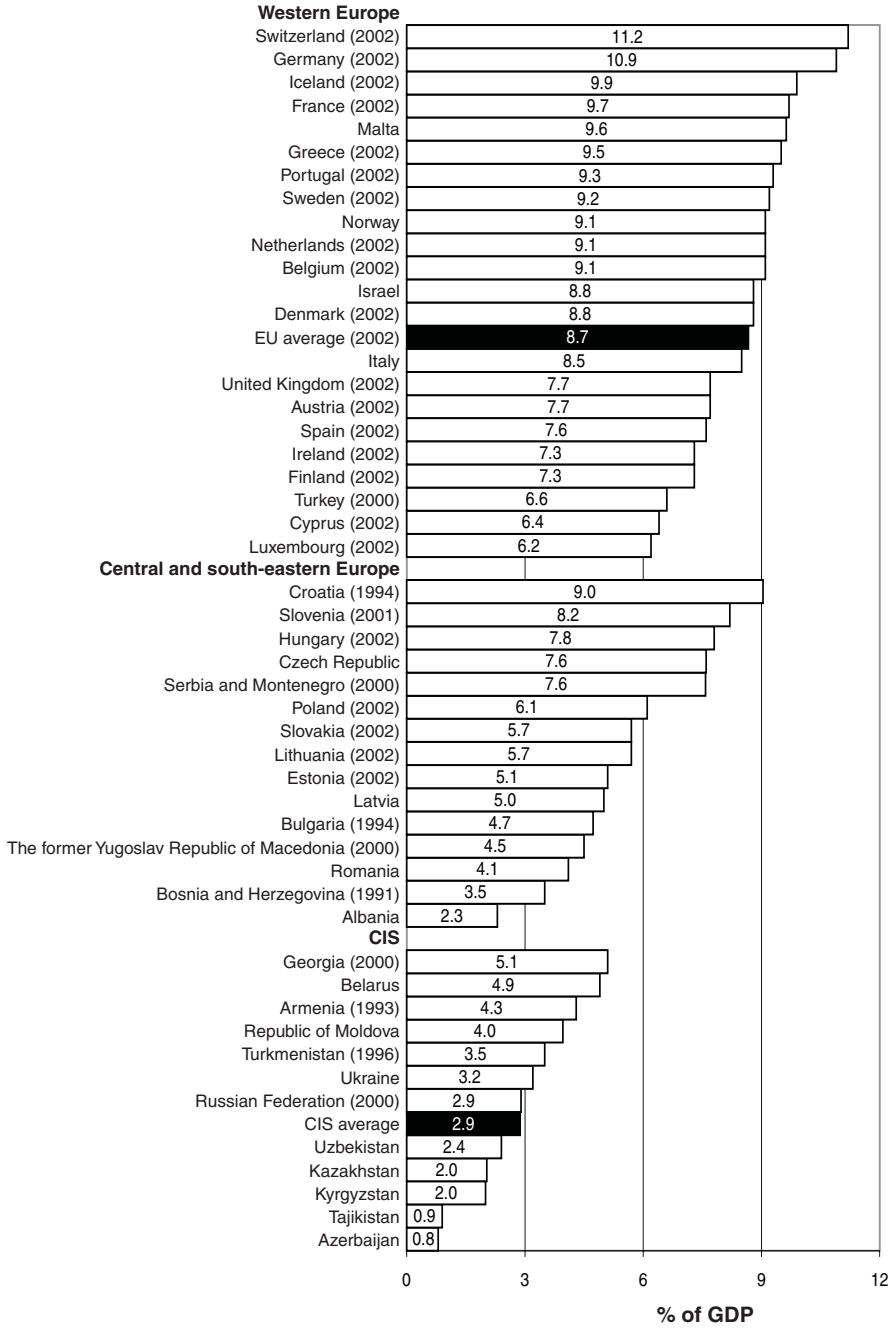
Fig. 3.3 Total expenditure on health as a share of GDP (%) in Poland and selected European countries, 1990–2003



Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: EU: European Union.

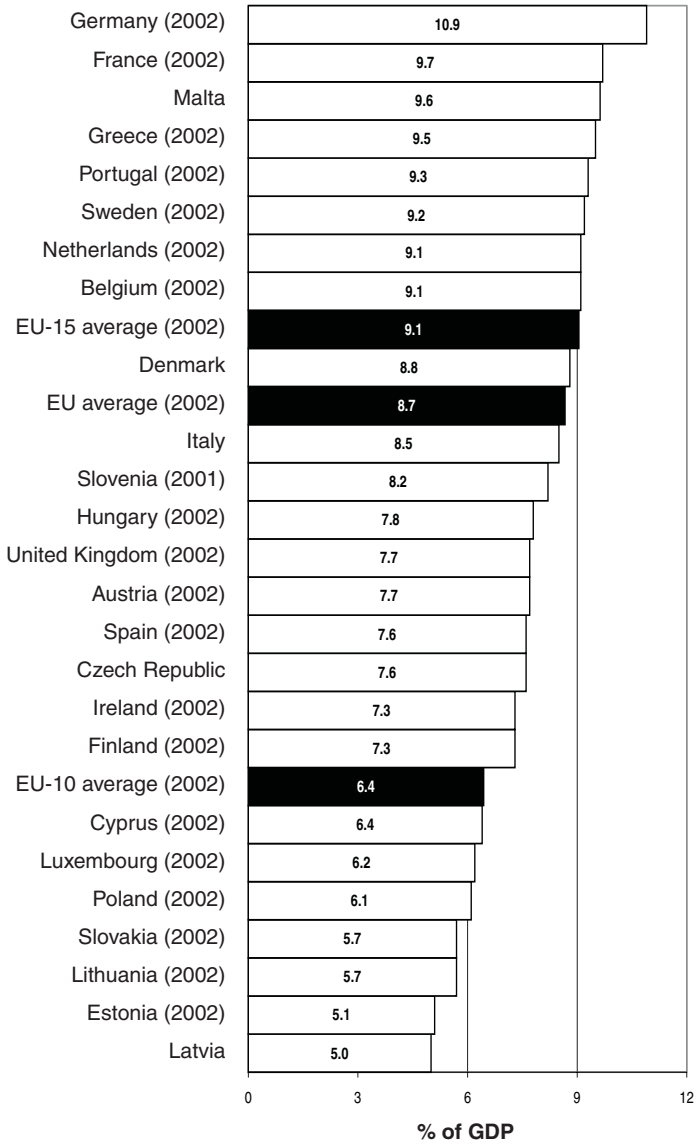
In Poland, private expenditures accounted for 28–30% of total expenditures on health care. Poland thus spends more private money on health care than most countries in central and south-eastern Europe (Fig. 3.6A and Fig. 3.6B). However, some countries in Western Europe such as the Netherlands, Switzerland and Greece finance even higher proportions of their health care systems from private sources (Fig. 3.6A and Fig. 3.6B). As already mentioned, the growth rate of expenditures on health care, both public and private, is rather small (cf. Fig. 3.2), which has been recently associated with a low rate of economic growth, the policy on the control of health expenditures financed from public sources, high unemployment rates, and low average household incomes and their low growth rate.

Fig. 3.4A Total expenditure on health as a % of GDP in the WHO European Region, 2003 or latest available year (in parentheses)



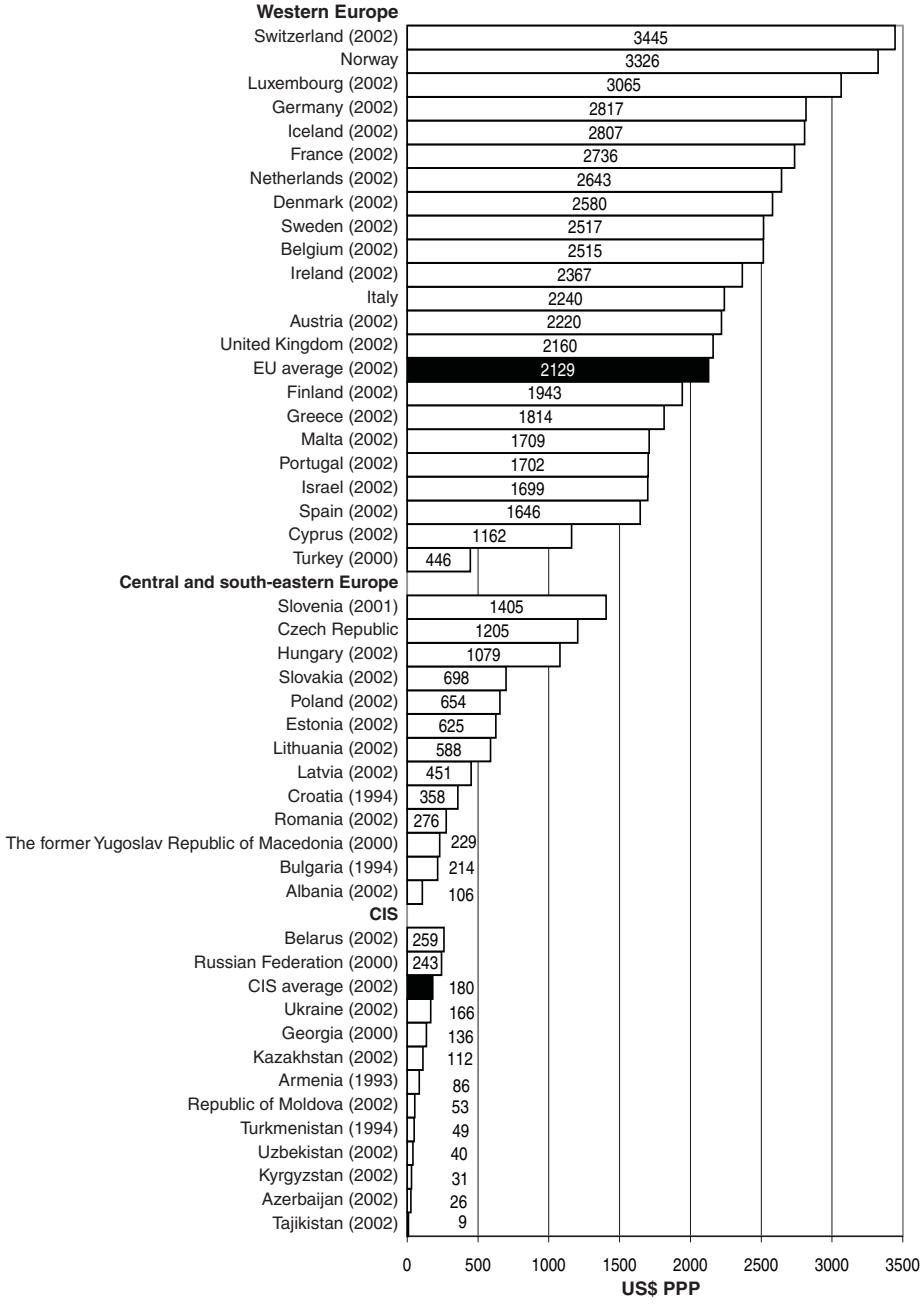
Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.

Fig. 3.4B Total expenditure on health as a % of GDP in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004.

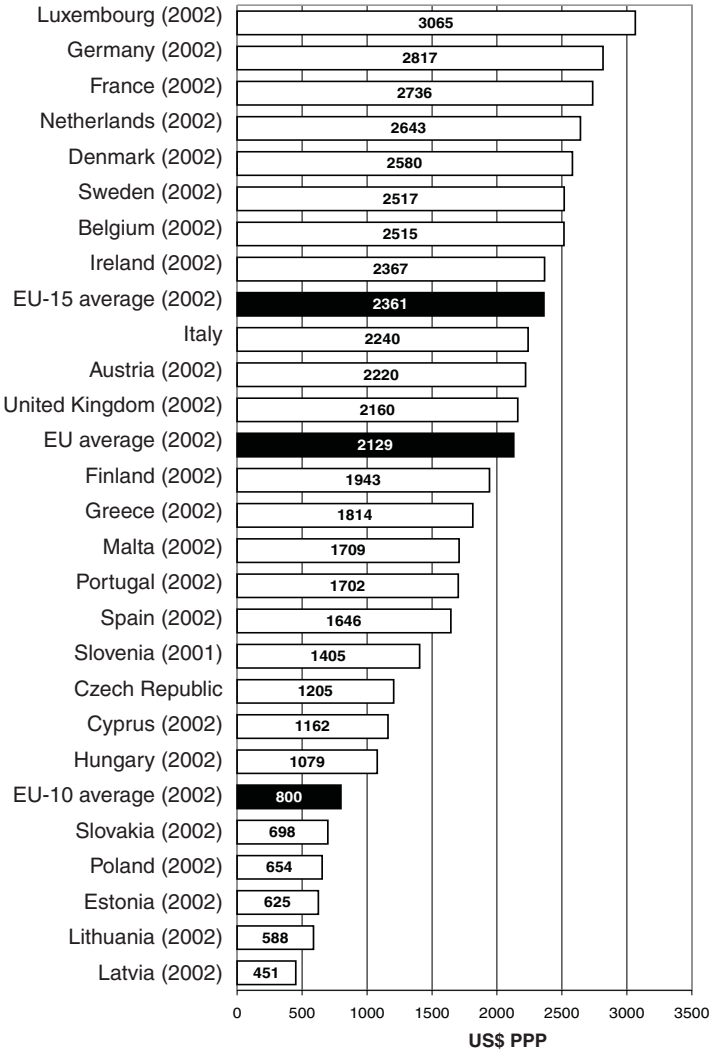
Fig. 3.5A Health care expenditure in US$ PPP per capita in the WHO European Region, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.

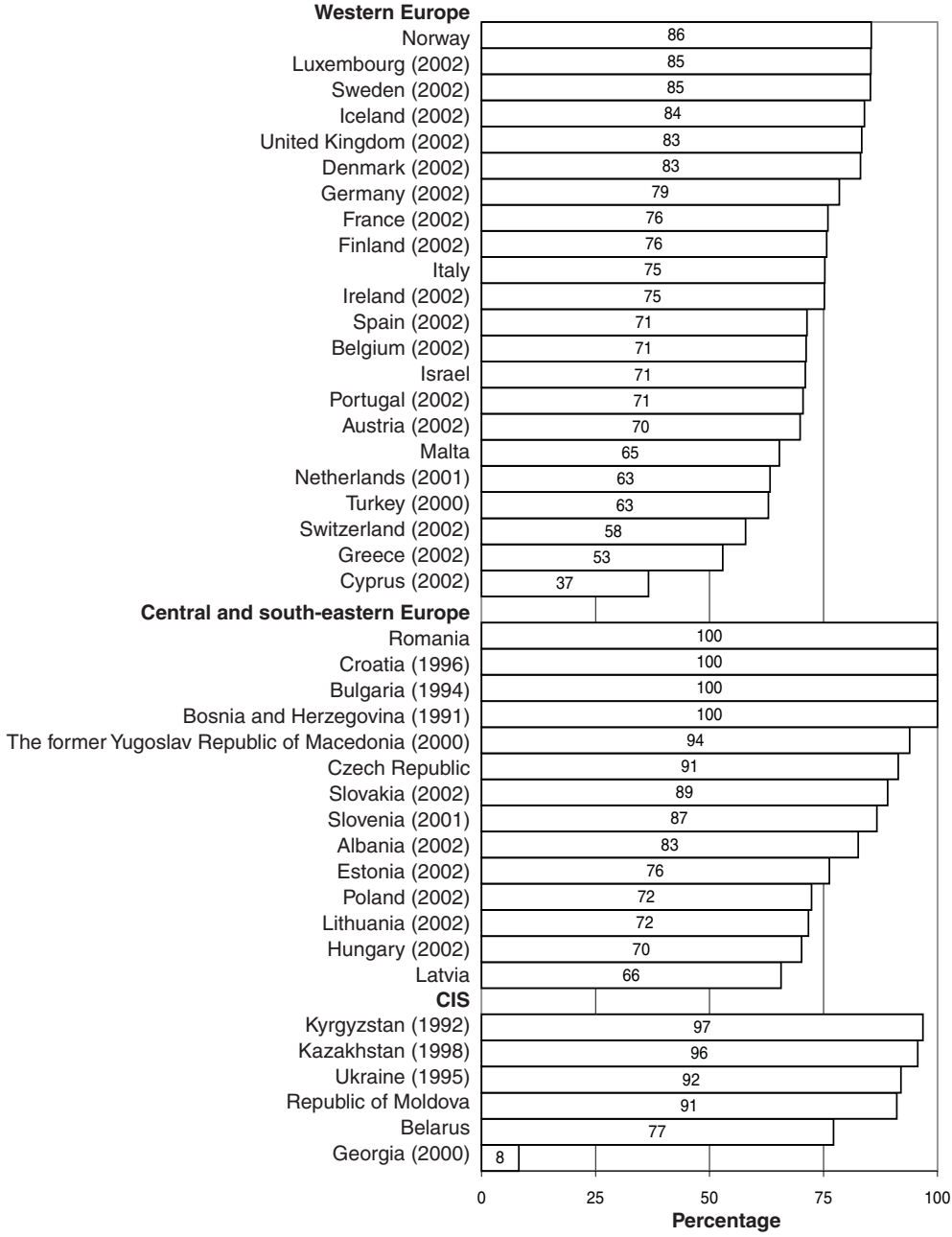
Fig. 3.5B Health care expenditure in US$ PPP per capita in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004.

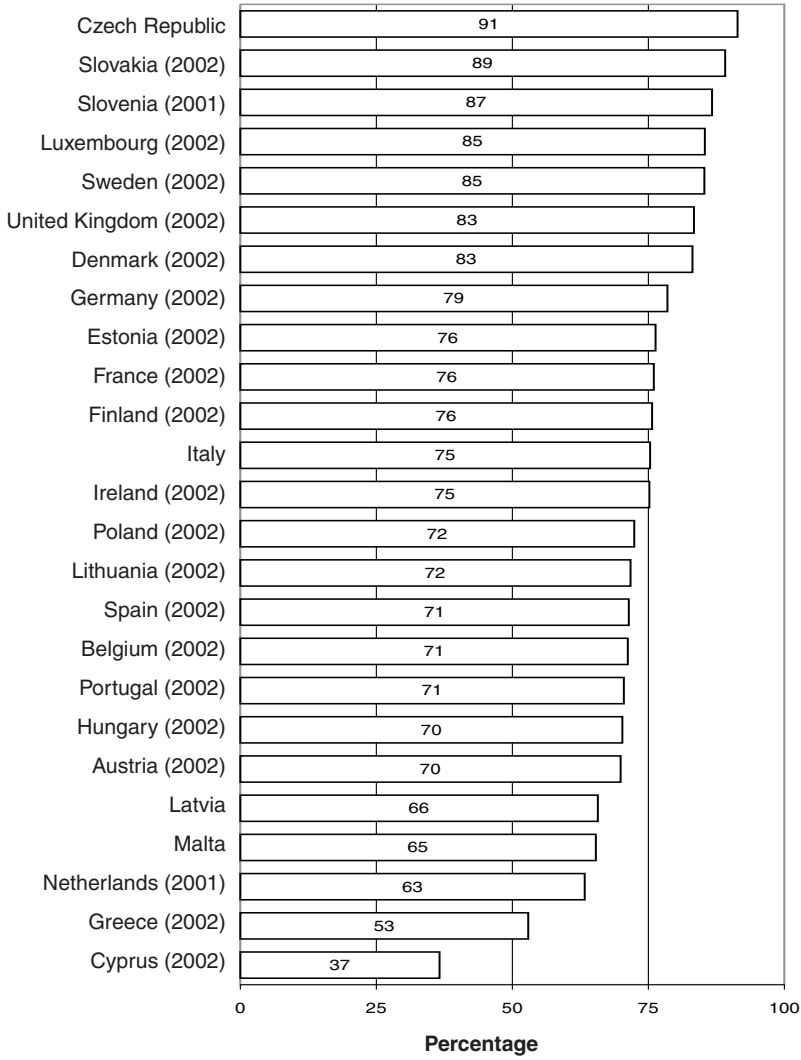
Fig. 3.6A Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: CIS: Commonwealth of Independent States; countries without data not included.

Fig. 3.6B Health care expenditure from public sources as a percentage of total health care expenditure in countries in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

4 Health care delivery system

Since the institution of sickness funds in 1999, which instigated the system of contracting with providers and the creation of the National Health Fund in 2003, health service delivery has changed in many respects. In 1998, health care was mainly delivered through a three-tier regional system. The Ministry of Health and Social Welfare administered tertiary hospital care including teaching hospitals, institutes and one outpatient clinic for higher-ranking civil servants and diplomats. The second tier included mainly voivodship specialist physicians and integrated hospitals, which provided both inpatient and outpatient services. Primary care was mainly provided by health care management units (ZOZs), which covered most primary care physicians, specialist outpatient departments and general hospital care. ZOZs included at least four specialties: internal medicine, surgery, paediatrics, and obstetrics and gynaecology. In the third tier, local government provided primary and secondary care according to their capacity. Smaller gminas provided primary care facilities staffed by doctors and nurses.

Public health services

The public health services system, which was developed in the 1950s and 1960s with considerable success for the control of infectious diseases is, with some modification, still in place in 2005. Each voivodship has sanitary inspectors and inspection stations with their own laboratory facilities. These inspectors are ultimately accountable to the Chief Sanitary Inspector in the Ministry of Health. In addition, the National Institute of Hygiene has responsibilities in the area of illness prevention.

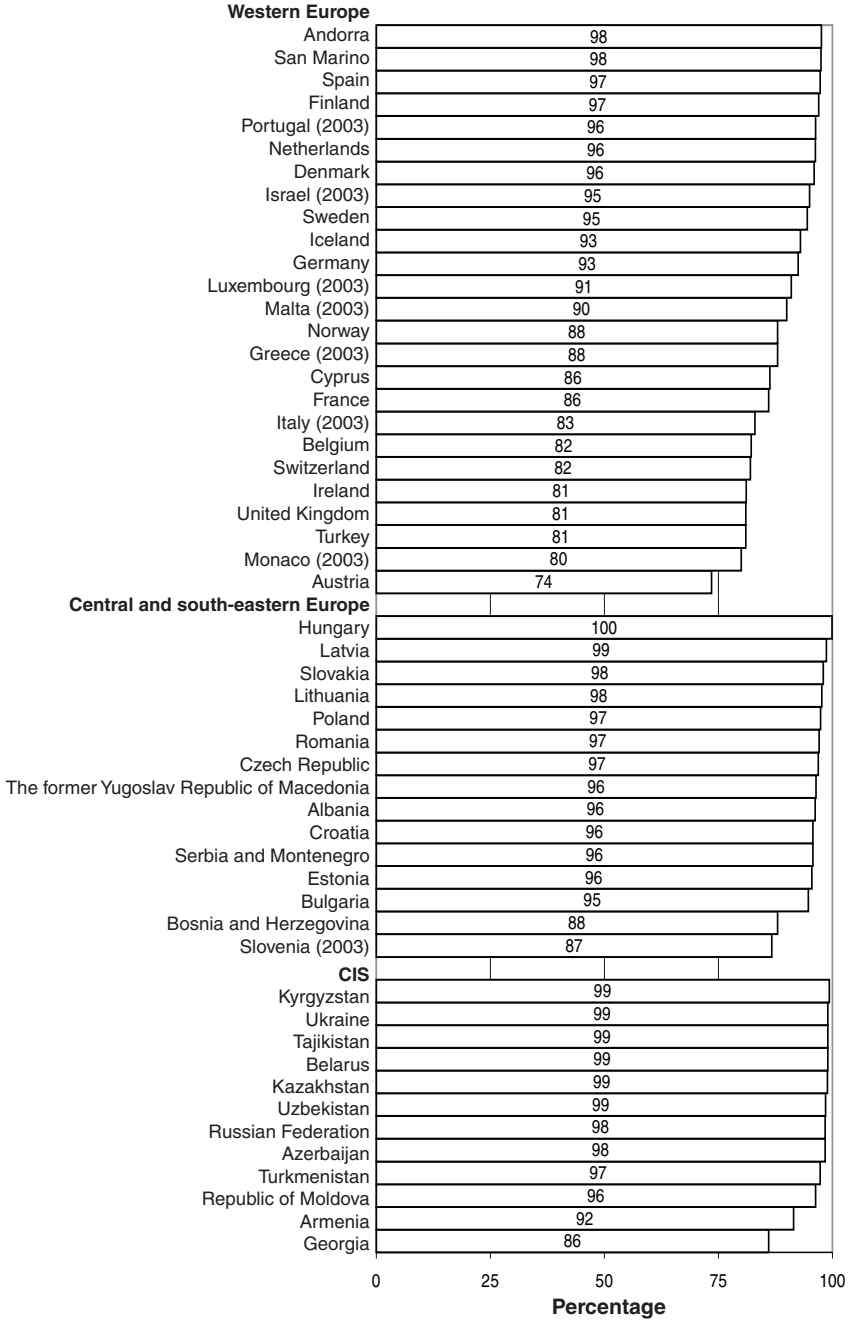
Immunization and screening of children involves the institutes of maternal and child health together with the National Institute of Hygiene, the ZOZ paediatric departments, and the sanitary inspection stations. Poland has a high level of immunization against measles, as do most CSEE countries compared to western European countries (Figs 4.1A and 4.1B).

The cornerstone of Polish public health services is the National Health Programme, which is based on the "Health for All" strategy developed by the World Health Organization. Parts of the "Health for All" strategy were implemented in the 1980s, but the NHP was only adopted by the Polish Government in 1990. Since then, the NHP has been greatly modified. In practice, the health authorities encountered enormous difficulty in involving other sectors in its implementation.

After numerous modifications, the National Health Programme for 1996–2005 was finally adopted in 1995. Apart from the strategic target to improve the health status of the population, 18 operational targets have been defined. They mainly focus on efforts aimed at changing the population's lifestyles into health-conducive behaviours. The first six operational targets concentrate on promoting physical activity and healthy diet, reducing tobacco smoking, alcohol consumption and abuse of other psychoactive substances. The objective of two targets is health promotion, including mental health. It comprises health education in all groups of the population and training of health promotion educators. Two other targets deal with environmental health and improvement of sanitation throughout the country. It should be stressed that the expected outcome and health gained by 2005 are precisely specified for each NHP target by using relevant indicators. A separate document defines a detailed timetable to be followed in the NHP implementation, and accurately formulated tasks for all sectors of the state and local authorities.

Some NHP targets are directed towards health problems of a broader nature and reaching out to primary and secondary care. They address such issues as improvement of primary health care, emergency services and diagnostic procedures, especially with respect to cardiovascular and neoplastic diseases. It should also be stressed that the decision to adopt better prevention of communicable diseases as one of the operational targets has proved to be useful, especially with regard to chronic diseases and emerging infections. An operational target aimed at providing better opportunities for people with disabilities is closely related to the population ageing process and the growing number of traffic accidents, and also to the fact that disability pensions involving substantial funds from the state budget are not always justified. The eighteenth operational target relates to improving prevention of dental caries in children and young people.

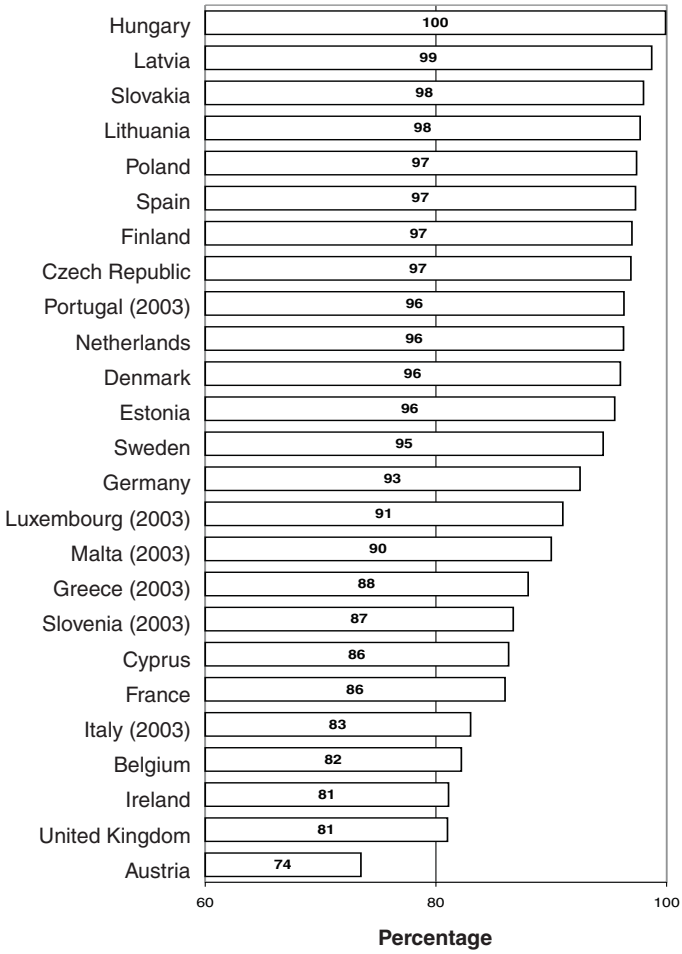
Fig. 4.1A Levels of immunization for measles in the WHO European Region, 2004 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: CIS: Commonwealth of Independent States; countries without data not included.

Fig. 4.1B Levels of immunization for measles in the European Union, 2004 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

The National Health Programme provides for establishing governmental intersectoral working groups chaired by officers of high rank (deputy prime ministers) to coordinate all activities involved in its implementation. Despite financial constraints, much progress has been made in accomplishing individual NHP targets. This applies in particular to such issues as premature births, control of low birth weight, and environmental health. Average life expectancy has also developed positively in recent years, with a reduction in the gap between Poland and the average of the EU Member States.

Primary health care

Until 1991, the concept of a family physician or general practitioner did not exist. Primary care physicians were mainly specialists in internal medicine, obstetrics–gynaecology or paediatrics who provided care in polyclinics. Primary care was historically undervalued. Narrow specialties dominated the system and undergraduate medical education did 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 equipment. 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.

In 1991, a strategy to improve the status and quality of primary care was developed under the name of "family medicine" and was followed by the creation of the College of Family Physicians in Warsaw in 1992 to support this new model. Postgraduate specialist training in family medicine was also started. Up to 2004, 7000 doctors obtained a specialist degree in family medicine. However, this falls short of the 15 000 family medicine specialists needed according to Ministry of Health estimates. This shortage is covered by the former primary care physicians, most of whom have a specialist degree in internal medicine. In addition, 5000 paediatricians and 3000 gynaecologists deliver health care services in primary care according to their specialty areas.

The development of so-called "home hospitalization" is now strongly supported. In this scheme, services that have traditionally been provided in hospital are now provided by family physicians in patients' homes. Besides having economic advantages, it serves chronic patients and children well, by protecting them against the stress usually associated with inpatient treatment.

The former preference of Polish doctors to work in hospitals rather than in primary health care has now been reversed. All primary health care physicians are obliged to provide services in patients' homes in instances when emergency ambulance services are not necessary. With 5.6 outpatient contacts per person per year in 2002, Poland's outpatient services intensity was somewhat lower than the EU average of 6.3 for countries belonging to the EU before May 2004, and substantially lower than the average of new Member States with 8.4 outpatient contacts per person per year (Fig. 4.2A and Fig. 4.2B).

It was expected that the systems of accreditation and registration of hospitals would cause small hospitals to close and at least a 10% bed reduction. Paediatric and infectious beds, which had the lowest occupancy rate, were the first beds to

be reduced. Other acute beds were attributed to psychiatry, one-day paediatric surgery, and some other specialties such as oncology. Other acute wards were transformed into rehabilitation wards, long-term wards or palliative care structures and hospices.

Secondary and tertiary care

Outpatient specialized health care

Outpatient specialized health care is strictly separated from inpatient health care structures. The outpatient specialized sector is mostly based in private medical practices, except in large cities, where outpatient specialized care has developed on the basis of the former specialized health care centres, operating now as independent health care institutions.

Inpatient health care, including hospitals

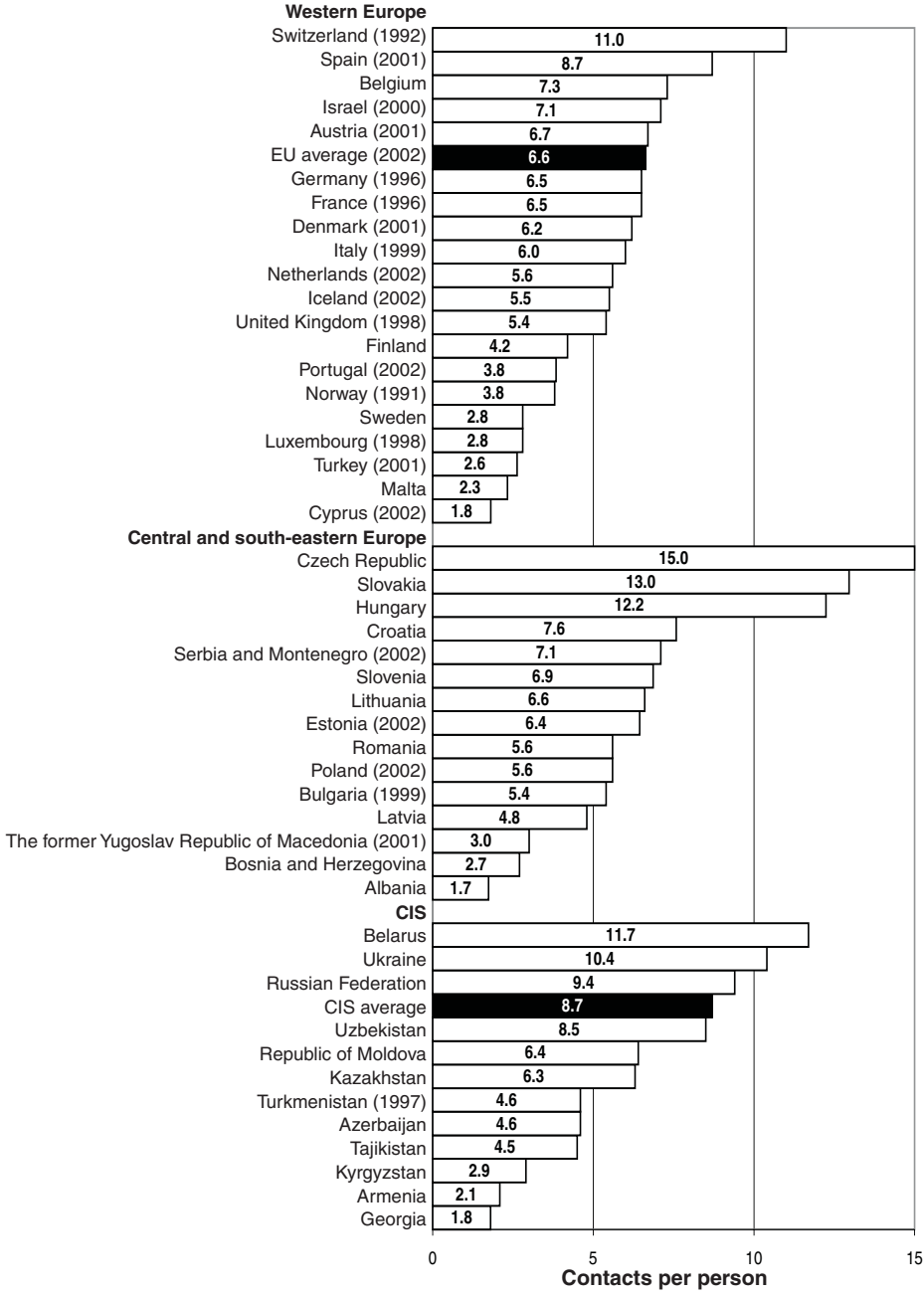
The organization, operation, administration, management, establishment, transformation, financing and closing down of hospitals are regulated by the 1991 Law on Health Care Institutions and its executive provisions. Hospitals established by territorial self-governments are commonly termed county hospitals. In 2004, 90% of independent public health care institutions were established by territorial self-governments. Health care institutions established by ministers are called ministerial hospitals, e.g. hospitals of the Ministry of Health, the Ministry of Interior and Administration or the Ministry of National Defence.

According to provisions of the Law on Health Care Institutions the name of specialized health care institutions should correspond to the scope of services offered by a given hospital.

Hospitals established by medical academies and involved in research, education, medical care, and health promotion are called clinical or university hospitals. The referral levels of hospitals are not formally described.

Briefly, hospitals provide health care services in four basic departments: internal medicine, surgery, obstetrics and gynaecology, and paediatrics. The departments are used to classify hospitals according to referral levels. Hospitals that only have the four basic departments are known as first referral level hospitals and they are mainly established by county self-governments. Second referral level hospitals, mostly established by voivodship self-governments,

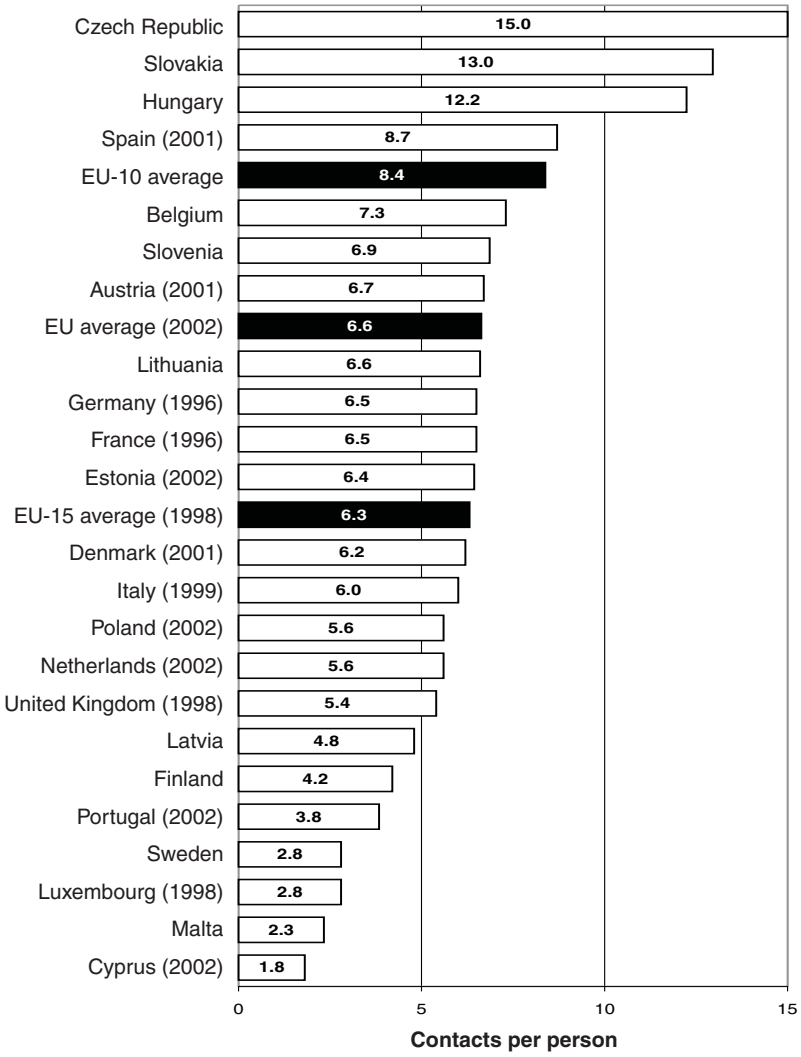
Fig. 4.2A Outpatient contacts per person in the WHO European Region, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: CIS: Commonwealth of Independent States; EU: European Union; countries without data not included.

Fig. 4.2B Outpatient contacts per person in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004; countries without data not included.

provide services in other specializations, e.g. cardiology, dermatology, oncology, urology or neurology, and are called voivodship specialized hospitals. The third referral level hospitals, mostly university or ministerial hospitals, provide highly

specialized medical care by top medical specialists. The National Institute of Cardiology, the Maria Skłodowska-Curie Memorial Cancer Centre and Institute of Oncology or The National Mother and Child Institute are examples of this category of hospitals. Referral level refers to a period when separate regional sickness funds existed. Although at present there are no such divisions in force, the term is still in use. The number of public hospitals at each level is depicted in Table 4.1. The number of hospitals under private, confessional or NGO ownership in Poland is low. In 2003 there were 72 non-public hospitals in total compared to 732 public hospitals.

Table 4.1 Number of public hospitals, 2002–2003

	2002	2003
General hospitals	429	427
Specialized hospitals	231	226
University hospitals	42	41
Institute hospitals	15	14
Other hospitals	22	24
Total number of public hospitals	739	732

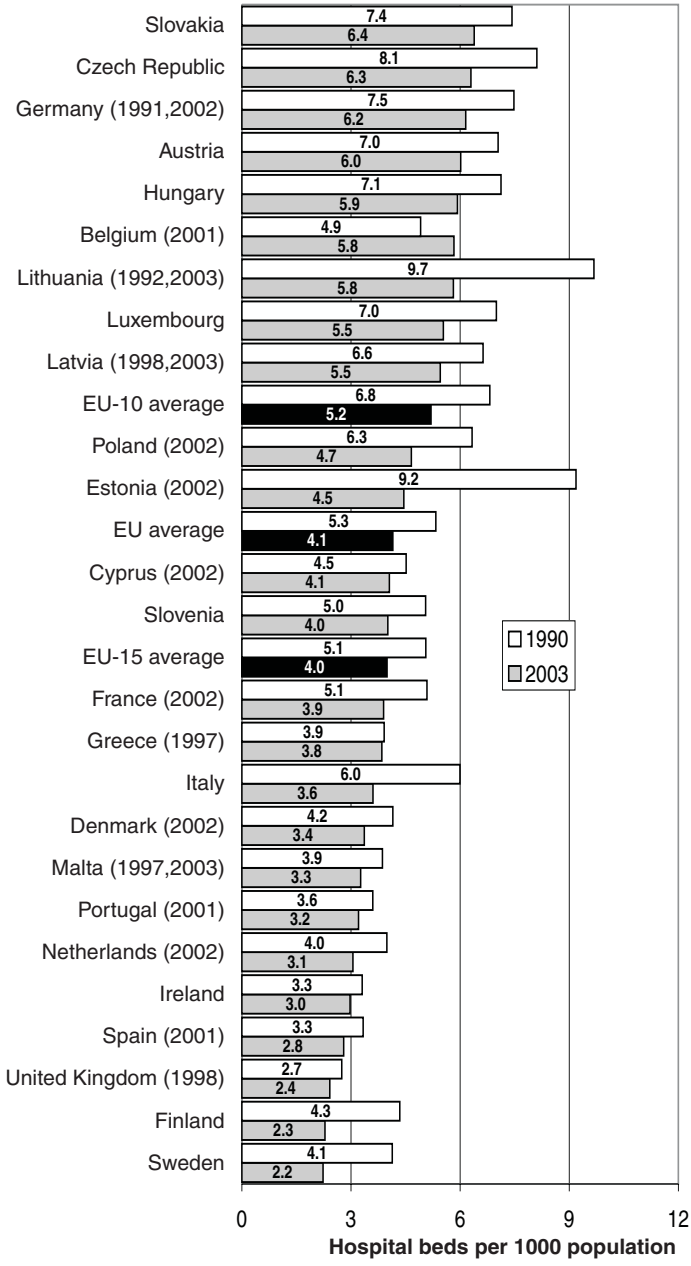
Source: National Institute of Hygiene, 2005.

With 4.7 acute care hospital beds per 1000 population in 2002, Poland provides fewer hospital beds than the average of new EU Member States (5.2), but still more than the EU average of 4.1 (Fig. 4.3). For the longitudinal analysis only the total number of hospital beds is considered here for Poland, because the definition of acute care hospital beds has changed during the 1990s and longitudinal analyses of acute care hospital beds are, therefore, misleading.

Like many other European countries, Poland has decreased its total hospital bed capacity substantially in the last decade, down from 6.3 per 1000 population in 1990 (Figs 4.3 and 4.4). The average hospital stay in general hospitals has decreased from 9.3 days in 1999 to 7.9 days in 2002. The indicator that describes how many patients used one hospital bed during one year increased from 34.7 in 1999 to 38.8 in 2001. The occupancy rate of hospital beds was 74.5% in 2001 and was thus similar to many other European countries (Table 4.2). At the same time, the utilization of hospital beds has sharply increased in parallel with the reduction in beds since 1999 (Fig. 4.5).

The changes in the health care market and in the demographic structure of Poland, and the reforms of the country administration resulted in a relatively small reduction in the number of hospitals but caused substantial changes in their internal structure. The number of hospital beds in paediatric and infectious diseases wards, which had the lowest occupancy rates, was reduced. Other beds were transferred to the care of chronic diseases, rehabilitation, long-term care

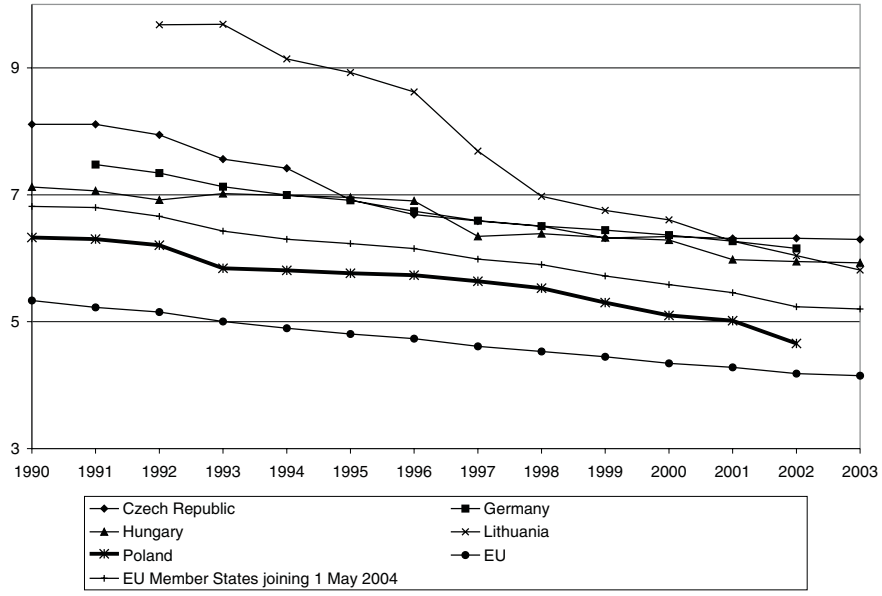
Fig. 4.3 Hospital beds in acute hospitals per 1000 population in the European Union, 1990 and 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004.

Fig. 4.4 Hospital beds per 100 000 population in Poland, selected countries and regional averages, 1980–2003



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004.

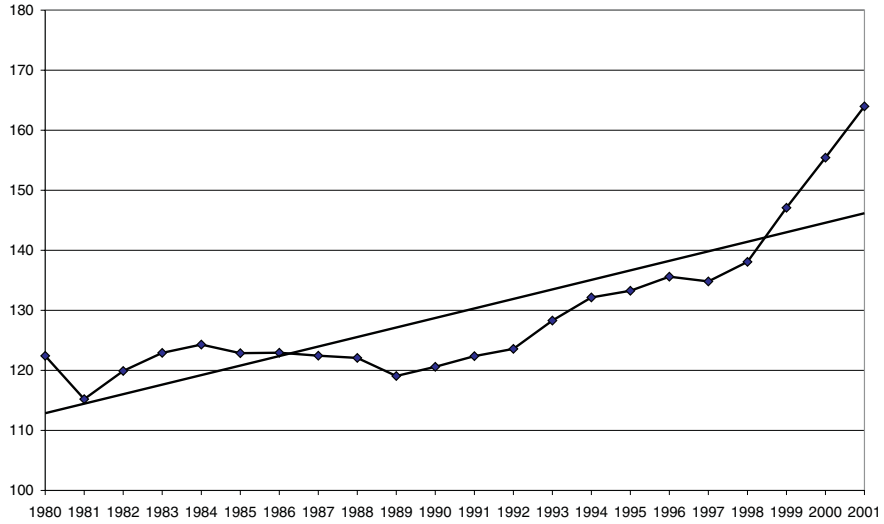
for dependent people, palliative care, hospices and psychiatric care. The small number of new private hospitals usually specialize in general medical care and surgery. Some of them have contracts with the NHF.

Emergency medical service and emergency medicine

In Poland, the emergency medical service has been in existence for almost 100 years. It has always been independent under the name of Emergency Ambulance Service. Its organization has been territory-based (voivodship, powiat and gmina). There is an ongoing process of establishing a new system of emergency medical services by setting up hospital emergency departments. The major aim of the new system is to improve facilities for saving human lives, mainly by reducing the timelag between an accident and hospital admission to 8 minutes within cities and to 15 minutes outside cities, for 75% of emergency calls, and by developing close cooperation between the emergency services of the fire brigades and the police.

To accomplish these aims it is necessary to improve major segments of the system, namely:

Fig. 4.5 Number of hospitalizations per 1000 population, 1980–2001



Source: CIOS Warsaw, 2003.

- to increase the number of dispatch centres and improve their distribution;
- to increase the number of emergency ambulances;
- to locate and equip hospital emergency departments;
- to set standards for receiving emergency calls and ensure the accessibility of ambulances under the supervision and coordination of a physician.

A national network of 270 hospital emergency departments were planned to be operational by the end of 2005. In May 2004, 110 departments were operational and 208 facilities are currently being restructured. Fig. 4.6 illustrates the new emergency system as currently planned.

Health resort treatment

Poland has a long-standing tradition of spa rehabilitation and has many well-known health resorts. Health resort treatment is provided under contracts with the National Health Fund, concluded on terms defined in the Law on Health Care Services Financed from Public Sources. The majority of patients referred to health resorts are offered rehabilitation services based on natural therapeutic resources, such as thermal water, as well as on the environmental and climatic benefits of a given area.

Table 4.2 Inpatient utilization and performance in acute hospitals in the European Union, 2003 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Austria	6.0	28.8	6.4	76.2
Belgium	5.8[b]	16.9[d]	8.0[d]	79.9[e]
Cyprus	4.1[a]	8.0[a]	5.8[a]	73.5[a]
Czech Republic	6.3	20.4	8.4	74.1
Denmark	3.4[a]	17.8[b]	3.6	83.5[c]
Estonia	4.5[a]	17.2[a]	6.9[a]	64.6[a]
EU average	4.1	18.0[a]	6.8[a]	76.9[b]
EU-10 average	5.2	20.3	7.5	72.6
EU-15 average	4.0[a]	17.9[b]	6.9[b]	77.6[e]
Finland	2.3	19.9	4.3	74.0[h]
France	3.9[a]	20.4[d]	5.5[d]	77.4[d]
Germany	6.2[a]	20.7[a]	8.6[a]	79.4[a]
Greece	3.8[f]	14.5[e]	6.4[e]	66.6[e]
Hungary	5.9	23.2	6.7	77.2
Ireland	3.0	14.1	6.5	84.2
Italy	3.6	15.2[a]	6.8[a]	76.9[a]
Latvia	5.5	18.3	–	–
Lithuania	5.8	21.5	7.9	73.6
Luxembourg	5.6	18.4[i]	7.7[e]	74.3[i]
Malta	3.3	10.8	4.6	83.4
Netherlands	3.1[a]	8.8[b]	7.4[b]	58.4[b]
Poland	4.7[a]	–	–	–
Portugal	3.2[b]	11.7[e]	7.3[e]	75.5[e]
Slovakia	6.4	17.7	8.5	64.8
Slovenia	4.0	16.2	6.1	68.1
Spain	2.8[b]	11.8[b]	7.0[b]	77.2[b]
Sweden	2.2	15.0	6.2	77.5[g]
United Kingdom	2.4[e]	21.4[g]	5.0[g]	80.8[e]

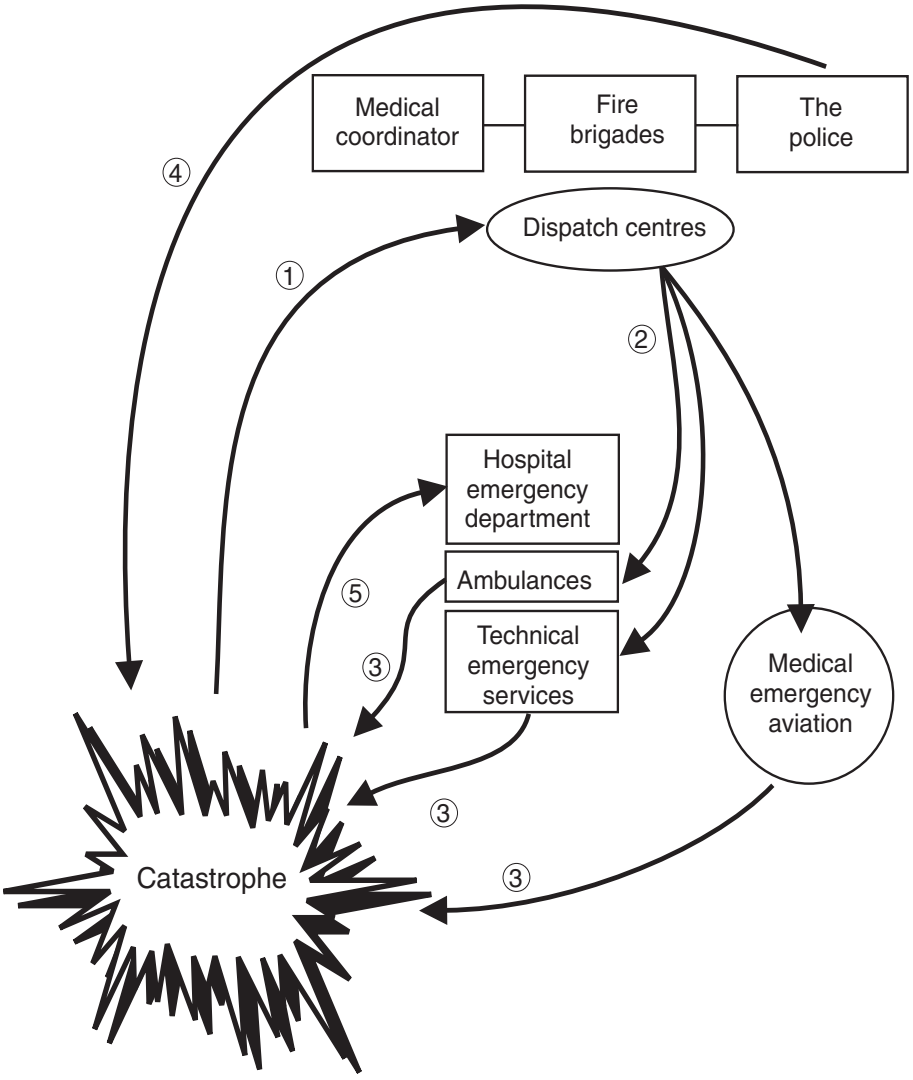
Source: WHO Regional Office for Europe Health for All database, June 2005.

Notes: [a] 2002; [b] 2001; [c] 2000; [d] 1999; [e] 1998; [f] 1997; [g] 1996; [h] 1995; [i] 1994; EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004.

The transformations in the health care system do not impose any radical changes on the functioning of health resort treatment institutions (sanatoria). They will still maintain the character of health resort hospitals aimed at providing patients with post-hospitalization medical rehabilitation. Nevertheless, there is a need for improvement in order to ensure comprehensive rehabilitation services, to reduce waiting times, to ensure better use of funds allocated for purchasing this category of services, and to increase the effectiveness of rehabilitation services to prevent disability and related pensions.

A legal Act on health resort treatment came into force on 1 October 2005. The law regulates issues concerning health resort treatment at large and provides

Fig. 4.6 Organizational chart of the medical emergency service system



the basis for defining the status, function, competencies and financing of health resorts. Standards for early and late rehabilitation also have been laid down. In addition, it is planned to regulate the status of health resort companies as public service institutions. It is also planned to strengthen the role of the Ministry of Health in the medical supervision of health resort activities.

Social care

Social care was poorly developed under the "Semashko" model and much non-medical care took place in hospitals. Social care includes the non-medical care of dependent people, such as the very elderly or the disabled, which can instead be provided in nursing or residential homes, in community day centres and other venues, or as domiciliary care in a person's own home. Health sector policy generally aims to shift non-acute health care previously provided in hospitals to community-based care. The policy intention, as in many western European countries, is to substitute the medical care model with a social care model where appropriate.

The voluntary or nongovernmental sector grew substantially during the 1990s. These nongovernmental organizations are playing a greater role as providers of nursing homes, hospices and rehabilitation services, and as providers of long-term residential care and care in the community.

In 2005, there are still insufficient beds in nursing homes and hospices to cater for dependent people, despite a growth to 983 homes and facilities up to 2001, of which 216 (excluding sub-branches) are for the care of the elderly. There are 86 600 places in homes, including 14 800 for elderly people (National Statistical Offices 2004). The cost of long-term care financed by the National Health Fund totalled 1.5% of all NHF expenses in 2002. It is planned to convert some existing health care institutions into social care institutions to meet the remaining needs.

Since community services and residential care are still not well developed, many patients are cared for in hospitals. Patients may be waiting for a place in a nursing home, or discharge may be delayed because of poor housing conditions, or the lack of community services. In practice, their families look after most elderly people in need of care. Community care services have been the responsibility of the voivodships and the ZOZ. Voluntary organizations and domiciliary nursing agencies have begun to develop community services such as home nursing and home help, but these services are still very scarce.

The care of children with learning disabilities is the responsibility of the Ministry of Education.

The long-term mentally ill are cared for in regional psychiatric hospitals supervised by the Institute of Psychiatry and Neurology. The present policy is that acute psychiatric care should be transferred to new psychiatric wards in voivodship hospitals, rather than continuing the past practice of admitting patients to regional psychiatric hospitals, often far from where they lived. The intention is also to increase the provision of community-based long-term psychiatric and social care, which remains the responsibility of the voivodship.

In 1999, the contracting of services in nursing homes began. Most of these homes are managed by nurses educated in the care of this group of patients. There is currently a debate in parliament about a possible role for mutual insurance in health and social care and for a separate insurance for nursing or long-term care for the elderly.

Human resources and training

Medical professionals can be divided into two categories: professionals covered by the EU sectoral system on the recognition of professional qualifications, and professions covered by the EU general system on the recognition of professional qualifications. The first category concerns five professions: doctors, dentists, nurses, midwives and pharmacists. The second category concerns the following regulated professions: laboratory diagnosticians (medical or clinical biologists), speech therapists, physiotherapists, dental assistants, dieticians, feldshers, opticians, hearing prosthetitians, dental hygienists, school hygienists, orthopaedists, child care workers, medical rescue workers, occupational therapists, medical laboratory technicians, dental technicians, pharmacists' technicians, electroradiology technicians, medical massage therapists, orthopaedic technicians and radiation protection officers.

Doctors and dentists

The number of doctors, nurses and other health care staff per capita in Poland is lower than that in most western European countries. Poland had 2.3 doctors per 1000 population in 2002, which is about one third below the EU average for countries belonging to the EU before 2004 of 3.6 (although these countries vary considerably), and lower than most CSEE countries, the new EU Member States (2.8 doctors per 1000 population), and certainly the CIS countries (Fig. 4.7, Fig. 4.9A, Fig. 4.9B). Despite the new development of family medicine, Poland is still regarded as having too many specialists with more than three specialists for every primary care doctor.

The number of doctors per 1000 population has risen slowly since 1970 (Fig. 4.7), as has the supply of pharmacists, qualified nurses (Fig. 4.8), midwives and dentists. However, the latest drop in the number of qualified nurses since 1997 might give rise to concerns (Fig. 4.8), although the supply of health care personnel is generally still regarded as adequate despite shortages among some occupational groups and urgent retraining needs. Pay levels, working conditions

and morale remain problematic among health care personnel in Poland. The 1992 government budget crisis caused job losses among health personnel, but employment has stabilized since. 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. In order to control inflation, the government has held down public sector wages throughout the 1990s. As a consequence, a number of Polish doctors have sought work in better paying countries in western Europe, notably the United Kingdom and neighbouring Germany. Since there is no compulsory registration of doctors and nurses who leave the country to work abroad, their number is unknown. However, according to data provided by the Polish Chamber of Physicians and Dentists, between 4 May 2004 and 30 April 2005, 2533 certificates confirming qualification to practise as a doctor, and 797 certificates confirming qualifications to practise as a dentist, were issued, which are required in order to obtain registration as a doctor or dentist in another EU Member State. Therefore, this number can serve as an estimate for the number of doctors and dentists who left Poland for work abroad in the 12 months following its accession to the EU in 2004. According to the General Medical Council of the United Kingdom, 1211 doctors with a Polish primary medical qualification were registered in the UK alone in August 2005 (personal communication, General Medical Council 2005).

In 2003, the average monthly pre-tax salary of a doctor from his work in the public health sector was €750; the salary of a nurse was €400 (Table 4.3). With many doctors and other health care professionals now aspiring to salary levels closer to their western European counterparts, many are thought to offset these relatively low salaries by an increase in informal "envelope" payments. In a 2003 survey conducted by the Stefan Batory Foundation, 57% of interviewees stated that they have paid bribes to health workers (Watson 2004). However, it must be kept in mind that the current salaries for doctors are about 5–10 times lower than in neighbouring western European countries, but living costs are only 2–3 times lower. Thus the only sustainable option to eliminate informal payments and the exodus of qualified health professionals is to raise salaries in the public health sector to an acceptable level.

Health sector reforms aimed at strengthening primary health care are also intended to produce a better geographic distribution of health care professionals who, as in many countries, tend to be concentrated in urban areas. Although less than two-thirds of the Polish population live in urban areas, nearly three-quarters of health care professionals in ambulatory care were employed in urban areas in 2004, and nearly three-quarters of all doctors. Health sector reforms must, therefore, consider inducements for health professionals to work in primary care in rural areas.

Table 4.3 Average gross public health services wages per month without medical staff duties which are paid separately, in PLN

Average wages	1998	1999	2000	2001	2002	2003[a]
in Poland	1 233	1 707	1 924	2 062	2 098	2 201
doctors	1 945	–	–	2 920	2 960	2 989
dentists	1 412	–	–	1 966	1 820	1 838
nurses	1 158	–	–	1 536	1 568	1 584
midwives	1 136	–	–	1 487	1 546	1 562

Source: Ministry of Health; Report: Health Care Financing in Poland – Green Book, 2004. Data of Central Statistical Office, different surveys.

Notes: [a] estimated. Conversion rates in August 2005 were 1 Polish zloty (PLN) = €0.25, €1 = 4.04 Polish zloty.

Medical supervision

The Law on Health Care Institutions (1991) clearly defines requirements to be met by personnel employed in health care institutions, and thus health care services can be delivered only by persons with a licence to practise a medical profession. It also precisely defines the scope of controls and institutions or persons authorized to exercise control. The control of health care institutions and of all founders of health care institutions is within the competence of the Minister of Health, whereas the Prefect (Voivoda) is authorized to exercise control of public and non-public health care institutions operating on the territory of a given voivodship.

To this end, a national specialized supervisory body was established. It is composed of national consultants appointed by the Minister of Health. At the voivodship level, consultants are appointed by the voivodas in consultation with relevant national consultants.

Another form of supervision referred to in the law is exercised by founders of health care institutions. This form of supervision also embraces medical supervision termed monitoring of "the implementation of statutory tasks, accessibility of health care services and assurance of their quality".

The major aim of each self-government organization, including professional self-government organizations, is to implement statutory tasks. Article 17, paragraph 1 of the Constitution of the Republic of Poland states: "By means of a statute, self-government organizations may be created within a profession in which the public repose confidence, and such self-governments shall concern themselves with the proper practice of such professions in accordance with, and for the purpose of protecting the public interest." At present, over a dozen self-government organizations operate in Poland, among them self-government organizations of physicians, dentists, laboratory diagnosticians (medical biologists), pharmacists, nurses and midwives.

Undergraduate medical and dental education

In Poland, there are eleven Medical Academies, from which 2473 physicians and 901 dentists graduated in 2002. Since then, the number of graduates has continually declined with 2387 physicians and 753 dentists graduating in 2004. All graduates of Medical Academies are obliged to participate in postgraduate education. This obligation was imposed by the Law on the Professions of a Physician and Dentist of 5 December 1996. According to this law, postgraduate education of physicians and dentists is carried out under two newly established systems:

- a compulsory postgraduate one-year internship ending with the state exam;
- an optional medical/dental specialization.

Compulsory postgraduate 1-year internship

The compulsory one-year internship is undertaken by newly qualified physicians, who serve in a hospital as an addition to their undergraduate training. The internship is based on the following principles:

- it is carried out in hospitals selected and listed by the Voivodship Marshal;
- the employment status of an intern is equal to that of a permanent physician in aforementioned hospitals; internship contracts are financed from the state budget via Voivodship Marshals;
- the internship can be started on one of two dates each year either on 1 October or 1 March;
- it lasts 13 months for physicians and 12 months for dentists;
- to complete the internship, a physician trainee has to get the approval of an internship coordinator and has to pass the state examination. If both conditions are fulfilled, a licence to practice as a physician is issued.

The content of the state examination does not reach beyond the scope of the internship programme, and thus renders it possible to evaluate the quality of the training programme carried out by the assigned hospitals. The examination is a multiple-choice test, which is uniform for the whole country, set for each examination session (twice a year), separately for physicians and dentists.

Specialist training

A physician can begin specialization in a chosen discipline once he or she obtains the licence to practise as a physician or a dentist in the territory of the Republic of Poland and passes an entrance exam for specialty training. Foreign physicians and dentists, who do not follow this path, need to obtain the consent

of the Minister of Health. The new system of single-level specialization applies to basic (internal medicine, emergency medicine, family medicine) and other medical disciplines. Moreover, only physicians who have completed specialty training in one of the basic disciplines may apply for admission to specialization in another discipline.

Residency training

Medical specialist training status, also called "residency" is financed from the state budget via the Minister of Health, who distributes financial resources allocated for this purpose among medical institutions responsible for the organization of specialization programmes. Physicians who apply for resident status have to pass through a qualification process, which mainly consists of the entrance exam already mentioned. If they succeed they are employed on a contract basis for the whole period of the specialty training. Each year about 800 physicians begin their specialization with resident status. In 2004, more than half of these resident positions were allocated to the three basic disciplines: internal medicine, emergency medicine and family medicine. The Ministry of Health plans to expand the residency training scheme to about 2000 places per year in the coming years.

Specialization can be organized only in accredited institutions. Accreditation is a procedure aimed at assessing whether a given medical institution and its educational standard meet the specified criteria. Once the accreditation is granted, the medical institution is authorized to carry out specialization programmes. Criteria are defined for the number and training of medical personnel, organizational structure, equipment and research basis, and the profile and range of health services provided. The accreditation process is linked with placing a given medical institution on the list of the authorized units approved by the Minister of Health who allocates to them a specified number of specialization contracts. Voivodship public health centres keep registers of physicians and dentists who are currently in specialization programmes in a given voivodship.

Specialization examination and EU-wide recognition of medical qualifications

In the new system, each specialization programme is concluded with the state specialization examination. After passing the state exam, a physician is awarded a diploma of specialist in a given discipline. The Centre for Medical Examinations (CEM) is responsible for the organization and performance of state examinations as well as for other examinations related to postgraduate education and professional advancement courses addressed to physicians,

pharmacists and other health professions. The state examinations, which are composed of three parts – practical, written and oral – are organized twice a year: during the spring and autumn sessions. The licences to practice medicine or dentistry are issued by the regional branches of the self-government organizations of physicians or dentists.

Regional medical councils issue licences to practice as a physician or dentist for citizens of other Member States of the European Union, if they meet the aforementioned requirements (with reservations regarding specific regulations adopted for some EU countries), and if he/she:

- presents a certificate issued by relevant authorities of a given EU Member State showing that he or she has been given permission to practise medicine on the territory of that state;
- presents a diploma confirming his or her qualifications in the physician/dentist profession;
- has full legal capacity;
- is fully and mentally able to practise as a physician or a dentist;
- is a person of impeccable ethics;
- presents a written declaration stating that he or she has a good command of the Polish language in both writing and speaking.

Continuing education

By virtue of the Code of Medical Ethics, each physician or dentist is obliged to acquire new skills and advanced professional qualifications. To this end, the chamber of physicians and dentists has adopted a resolution that provides a basis for meeting this obligation through self-education and participation in various forms of postgraduate education. Also, according to the regulations of the 5 December 1996 Law on Professions of a Physician and Dentist, a physician has a right and duty to improve his/her qualifications. This includes different forms of postgraduate training.

Practising medicine

To practise the medical profession means to provide health services, in particular to:

- examine patients' health status
- diagnose diseases and prevent them
- apply appropriate therapy and rehabilitation
- carry out consultations
- issue expert opinions and health certificates.

Dentists provide services in the area of dental care, which includes, among other things, diagnosis and treatment of oral cavity diseases, maxillo-facial disorders and other related pathologies.

Scientific research and teaching are other forms of practising medicine but only when it is related to medical education, medicine or health promotion. It is the duty of each physician to practise medicine in accordance with his or her best current medical knowledge, using available methods, procedures and means to prevent, diagnose and treat illnesses in line with the principles of medical ethics and with professional accuracy.

Chamber of physicians and dentists

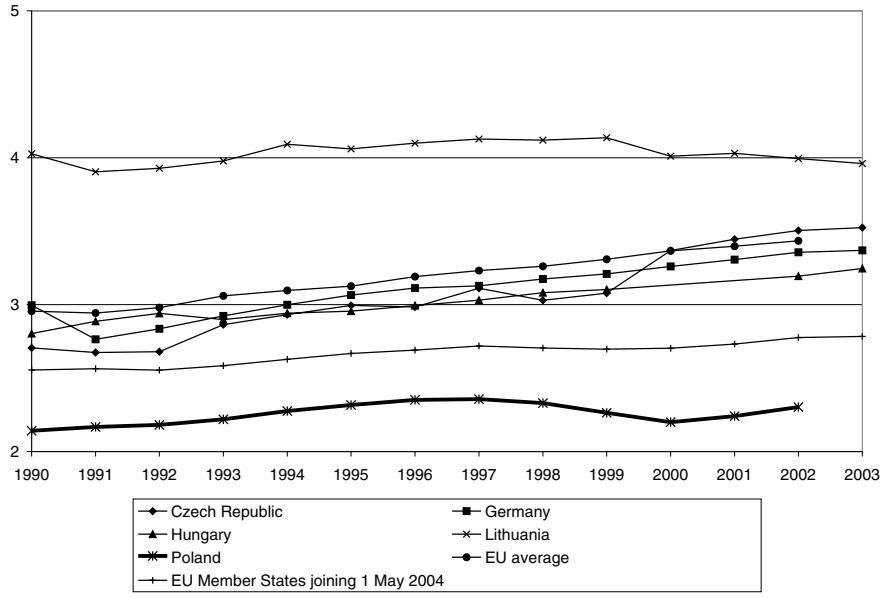
The Polish Chamber of Physicians and Dentists and its regional branches are organizational entities of the self-government of physicians. At present, there are 24 regional chambers and one Military Chamber of Physicians and Dentists. Membership is compulsory for physicians and dentists. The operation of self-government of physicians is regulated by the Law on the Chamber of Physicians and Dentists.

One of the domains that the chamber and its regional branches are involved in is medical jurisdiction in the area of medical responsibility and arbitration. On the basis of the Law of 17 May 1989 on Chambers of Physicians, members of the self-government of physicians and dentists are liable to medical professional responsibility before medical courts for performance contradictory to principles of medical ethics and deontology as well as for violation of regulations on performance of medical practice.

Nurses and midwives

According to legal regulations now in force (Law on the Professions of Nurse and Midwife, 1996), the professions of nurse and midwife are independent professions. The term "independent profession" means that nurses and midwives are entitled to provide health and particularly medical services on their own, rather than being entirely dependent on the doctor's orders. Until now, nurses and midwives were regarded as auxiliary medical personnel. On the basis of the aforementioned law, the duties and responsibilities of nurses and midwives have been largely expanded, which in consequence has not only increased the range of requirements concerning their knowledge and qualifications, but also entailed some reforms in the health care system and organization. The principal change that has been introduced is that nurses can now practise in their own nursing practices.

Fig. 4.7 Physicians per 1000 population in Poland compared to selected countries and regional averages, 1990–2003



Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: EU: European Union; EU-10: Member States joining the EU on 1 May 2004.

Education of nurses and midwives

The education of nurses and midwives is now in the process of transformation, as traditional nursing schools are being closed down and a new licence and Master's degree-based system is being established. Currently medical universities offer two types of studies for nurses: 3-year licentiate studies and complementary studies for those who do not have a licentiate degree. After obtaining a licentiate degree, there is a possibility of 2-year Master's studies. This change is aimed at increasing the number of personnel with higher education in these two occupational groups. At present, of the 200 000 employed nurses and midwives, only about 4000 are graduates of higher educational institutions.

Licence to practise as a nurse or midwife

On the basis of the aforementioned law, only those people who hold a licence issued by a regional council of nurses and midwives are permitted to practise one of these professions. All nurses who had previously received a nursing diploma from a nursing school in Poland have been granted licences to practise under the new law.

Postgraduate education of nurses and midwives

By virtue of the Law on the Professions of Nurse and Midwife, nurses and midwives have not only the right, but also the duty to advance their qualifications through participation in different forms of postgraduate education in order to acquire new skills and update their knowledge. Postgraduate education can only be carried out by institutions with a special entitlement or by individual professionals who have been granted permission to organize postgraduate education by the regional councils of nurses and midwives.

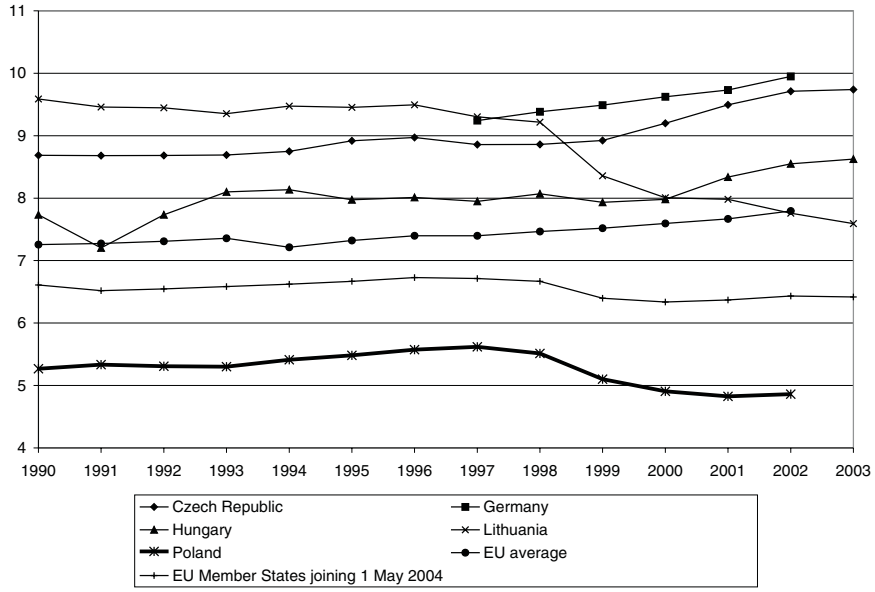
Practising nurses and midwives

Like physicians, nurses and midwives are obliged to perform their professions in accordance with the principles of medical ethics, his or her best current medical knowledge, using available means and methods, and with professional accuracy. The nurse and midwife practice also includes teaching and research in the area of nursing and midwifery, and management and supervision of nurses and midwives. It is the responsibility of both nurses and midwives to keep information about patients' conditions and other profession-related information confidential. A nurse or midwife is entitled to expect from physicians information on the patient's condition, diagnosis and proposed diagnostic, therapeutic and rehabilitation procedures as well as on possible consequences of the treatment undertaken. They are obliged to follow the doctor's orders documented in the patient records.

The professions of nurses and midwives as well as their interests are represented by self-government, established and based on organizational entities, such as the main Chamber of Nurses and Midwives and its district chambers. The district chambers are operated on the basis of compulsory membership of nurses and midwives practising in this field.

The major tasks of the self-government of nurses and midwives are to ascertain documents showing permission to practise, and to keep the register of nurses and midwives. In addition, the Chamber of Nurses and Midwives issues opinions on matters related to under- and postgraduate education, including specializations, as well as on legal regulations concerning health care and practices of nurses and midwives. The professional self-government supervises the performance of nurses and midwives as well as adjudicating on professional responsibility, and arbitrating.

Fig. 4.8 Nurses per 1000 population in Poland compared to selected countries and regional averages, 1990–2003



Source: WHO Regional Office for Europe Health for All database, June 2005.
Note: EU: European Union; EU-10: Member States joining the EU on 1 May 2004.

Other medical professions regulated by law

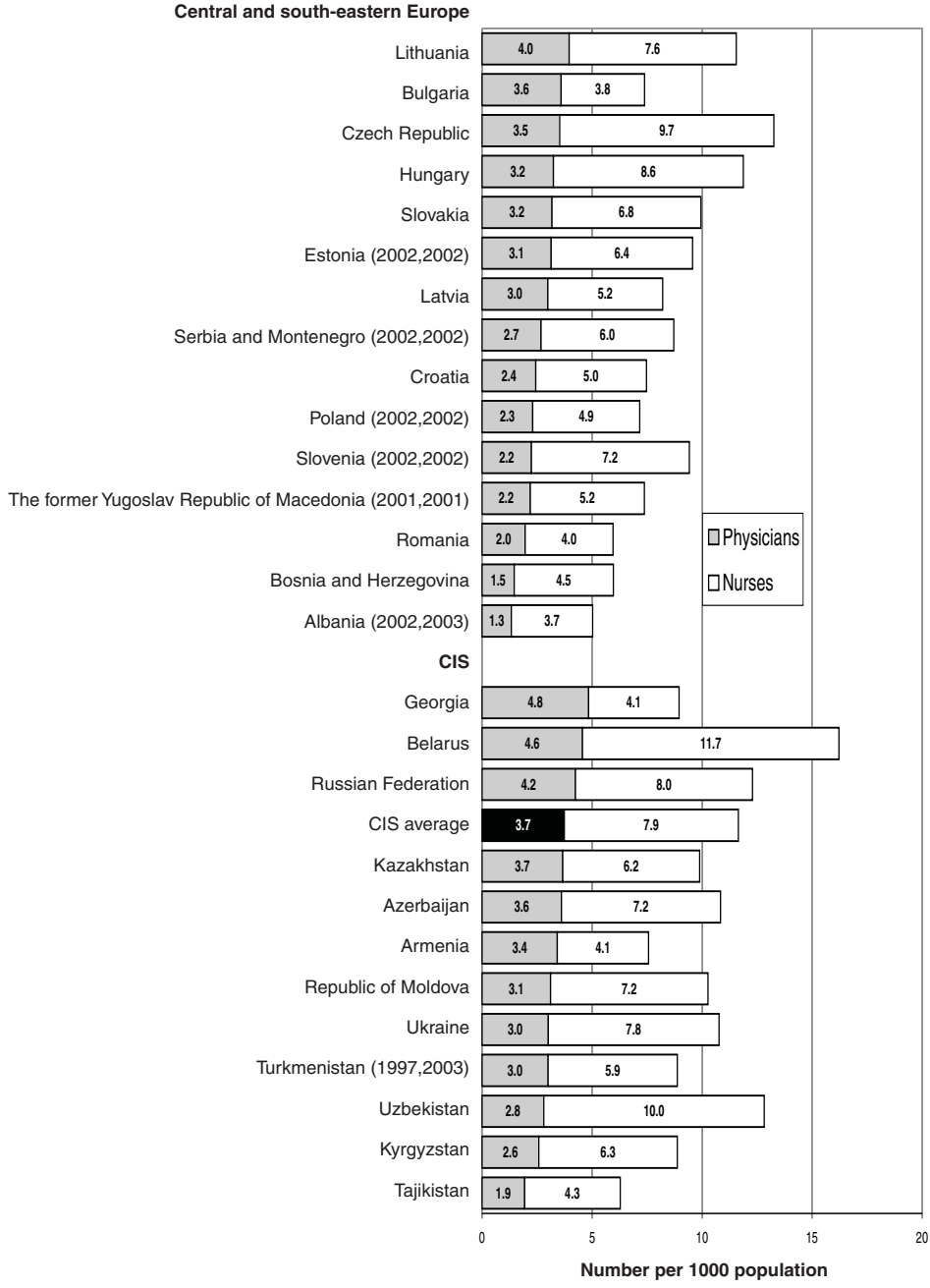
Pharmacists

According to the Law on Pharmaceutical Chambers of 19 April 1999, a person who is a graduate of at least a 5-year course of university-level study in pharmacy with a minimum of a 6-month traineeship earning the professional title of an MSc in Pharmacy or a diploma granted by an EU country, considered to be an equivalent in the Republic of Poland, is permitted to practise as a pharmacist, provided the person is in good health and has full legal capacity.

Permission to practise as a pharmacist on the territory of the Republic of Poland is ascertained by a regional chamber of pharmacists competent for the region where the practice is located and performed.

A separate legal instrument regulates the recognition of professional qualifications of citizens of EU Member States. It includes the list of diplomas, certificates and other documents issued in those states, which ascertain the necessary qualifications to practise as a pharmacist on the territory of the Republic of Poland. The list has been elaborated and published by the Minister of Health.

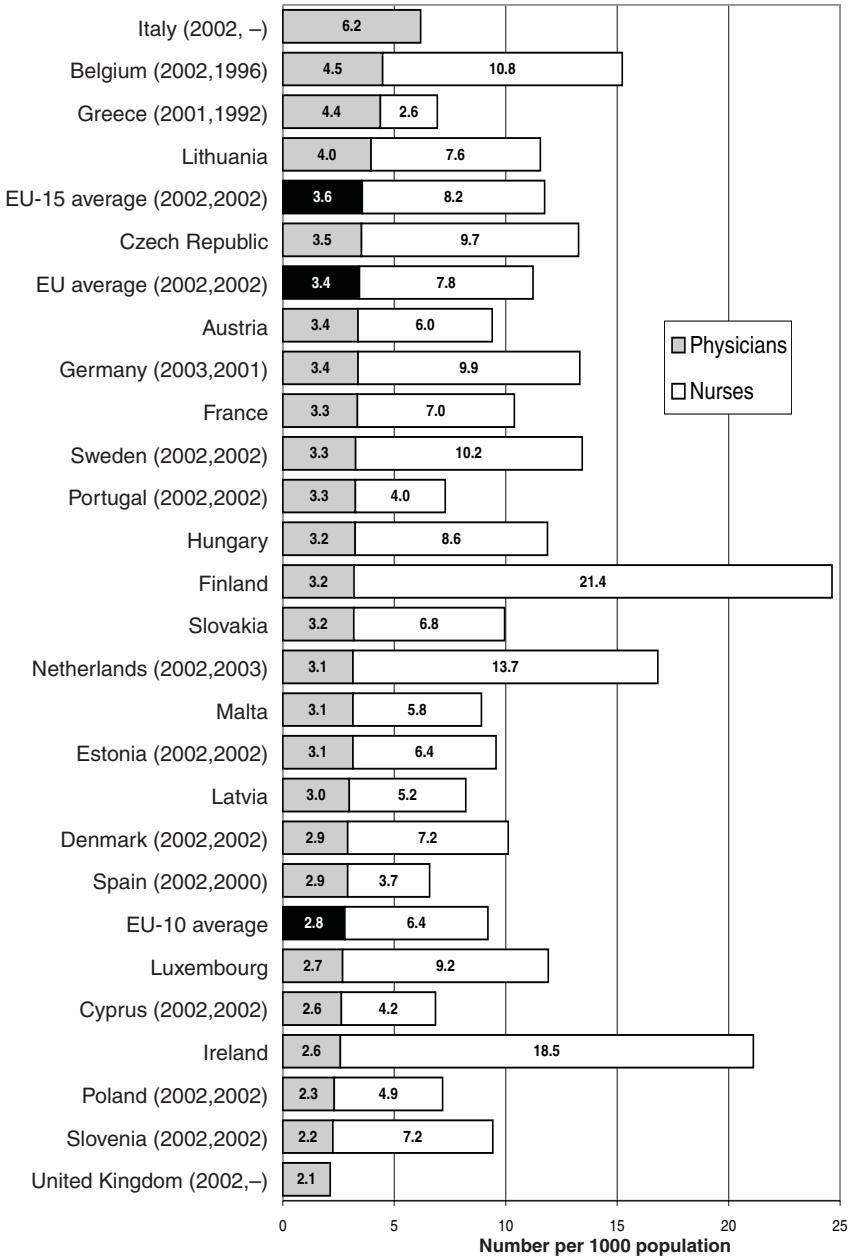
Fig. 4.9A Number of physicians and nurses per 1000 population in central and south-eastern Europe and CIS, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: CIS: Commonwealth of Independent States; countries without data not included.

Fig. 4.9B Number of physicians and nurses per 1000 population in the European Union, 2003 or latest available year (in parentheses)



Source: WHO Regional Office for Europe Health for All database, June 2005.

Note: EU: European Union; EU-10: EU Member States joining EU on 1 May 2004; EU-15: EU Member States before 1 May 2004.

A person who practises as a pharmacist is not entitled to practise as a physician, dentist or veterinary surgeon at the same time. The practice as a pharmacist is aimed at protecting human health and embraces the following tasks:

- to provide medicinal products and medical devices subject to trade turnover in pharmacies and pharmaceutical warehouses and to supervise their trade turnover, storage and use;
- to produce and dispense medicinal products;
- to assess quality and integrity of drugs composed in pharmacies and of over-the-counter drugs;
- to provide information and consultations on the effects of medicinal products and application of medical devices subject to trade turnover in pharmacies and pharmaceutical warehouses;
- to manage a pharmacy, hospital pharmaceutical outlet or pharmaceutical warehouse;
- to participate in the supervision of the medicinal products management, especially in health care institutions;
- to participate in clinical investigations carried out by hospital staff;
- to participate in studies of drugs, monitoring of undesirable effects of drugs and to inform relevant bodies about the results of these activities.

The activities of the self-government of pharmacists are regulated by the Law on Pharmaceutical Chambers, which was passed on 21 July 2001. On the basis of this law, it is the responsibility of the pharmaceutical chamber to establish the catalogue of tasks to be implemented by the self-government of pharmacists according to its statute. The pharmaceutical chamber also plays the role of an advisory body, presenting its opinions on matters related to the performance of the pharmaceutical profession and trade turnover of medical devices. It is also entitled to issue expert opinions and to submit motions on under- and postgraduate education of pharmacists as well as to grant permission to practise as a pharmacist and to keep the register of pharmacists. Like other self-government bodies, the self-government of pharmacists is involved in ensuring the disciplinary responsibility of its members and thus supervises the performance of pharmacists, adjudicates on professional responsibility, and arbitrates.

Laboratory diagnosticians (medical or clinical biologists)

Permission to practise as a laboratory diagnostician is given to a person with a higher education diploma, good health and agility, who takes a vow and is placed on the list of laboratory diagnosticians.

There are two ways of becoming a laboratory diagnostician. One is by obtaining a Master's degree at the medical school while studying at the analytical faculty. The other is through graduation at a faculty that is recognized as providing the solid background knowledge required by the laboratory diagnostician in order to perform the duties of the profession. The recognized faculties are listed by the National Chamber of Laboratory Diagnosticians. However, this path also requires postgraduate studies within the laboratory analytical field and an examination.

Laboratory diagnosticians practise in laboratories. By virtue of the Law on Laboratory Diagnostics, passed on 20 April 2004, laboratory diagnosticians are assigned the following tasks:

- performance of laboratory tests and examinations aimed at defining physical, chemical and biological properties as well as compositions of organic fluids, secretions, excrements and tissues collected for preventive, diagnostic, therapeutical or sanitary-epidemiological purposes;
- performance of microbiological examinations of organic fluids, secretions, excrements and tissues collected for preventive, diagnostic, therapeutical or sanitary-epidemiological purposes;
- performance of tests aimed at determining histocompatability;
- evaluation of diagnostic quality and usefulness of the aforementioned tests and laboratory interpretation and authorization of test results.

Scientific research and teaching in the area of laboratory diagnostics and management of laboratories are also within the competence of laboratory diagnosticians. In addition, a laboratory diagnostician is entitled to perform procedures and activities (defined by the regulation) involving the collection of biological materials from a patient to be tested in a laboratory.

Laboratory diagnosticians are organized in a self-governmental organization. The National Chamber of Laboratory Diagnosticians is a legal, organizational entity, being at the same time the organ of the self-government. The self-government is supervised by the Minister of Health according to the principles and scope set forth in the Law on Laboratory Diagnostics. The chamber is entitled to control and evaluate the performance of laboratory diagnosticians. To this end, the chamber assigns this competence to appointed inspectors.

On the basis of the law, the job title "laboratory diagnostician" is under legal protection. The Chamber of Laboratory Diagnosticians makes the decision on who can or cannot be placed on the list of laboratory diagnosticians. A laboratory diagnostician is struck off the list on written personal request, upon death, and in case of the disciplinary court's judgement to withdraw his or her permission to practise, or when membership fees have been overdue for a period of 12 months.

Medical rescuer and medical dispatcher

The medical emergency system, based on the Law on the State Medical Emergency, has been established in Poland to ensure the safety of its citizens. By virtue of this law two new medical professions have been established, medical rescuer and medical dispatcher. Candidates for medical rescuers have to pass the state examination to obtain permission to practise this profession in addition to possessing a diploma of university-level study in medical rescue (or its equivalent). This requirement is introduced to provide them with a uniform scope of knowledge and skills, regardless of the type of schooling completed. Curricula of higher vocational schools and medical post-secondary vocational schools for medical rescuers cover knowledge which prepares their graduates to perform tasks independently or under supervision of medical emergency physicians.

Psychologists

Services provided by psychologists are an important link in the diagnosis and treatment of certain illnesses. The Law on Psychologist Profession and self-government of psychologists came into force on 1 January 2006. On the basis of its provisions, a psychologist will provide psychological services, including psychological diagnoses, opinions and decisions concerning psychotherapy and psychological support.

Other medical professions that are regulated are: speech therapists, physiotherapists, dental assistants, dieticians, feldshers, opticians, hearing prosthetitians, dental hygienists, school hygienists, orthopaedists, child care workers, occupational therapists, medical laboratory technicians, dental technicians, pharmacist's technicians, electro-radiology technicians, medical massage therapists, orthopaedic technicians and radiation protection officers.

Pharmaceuticals and health care technology assessment

Legislation

In Poland the pharmaceutical industry responsible for supplying drugs and medical devices is regulated by the following legal instruments:

- Pharmaceutical Law, dated 6 September 2001;
- Law on the Registration of Medicinal Products, Medical Devices and Biocides, dated 6 September 2001;

- Law on Medical Devices, dated 27 July 2001;
- Law, dated 6 September 2001, introducing the Pharmaceutical Law, the Law on Medical Devices, and the Law on the Registration of Medicinal Products, Medical Devices and Biocides;
- Law on Prices, dated 5 July 2001.

The aim of the amended laws was to harmonize Polish legislation with the binding instruments of international law, taking account of European Union directives on production, marketing approval, advertisement, trade turnover of medicinal products, quality control and supervision.

In Poland, regulations on the protection of patent active substances have been in force since January 1993. From 1 May 2004, the EU period of data exclusivity became obligatory in Poland (10 years plus 1 year with respect to application of technology of remarkable significance).

Drug registration

The production of drugs in pharmacies has lost its importance. Nowadays, medicines produced by the pharmaceutical industry are more common in Poland than those produced in pharmacies. Safety, quality and efficacy are the three basic criteria taken into account in the process of registration and marketing approval of medicinal products and medical devices.

Article 8 of the Pharmaceutical Law provides that the decision to register a drug is issued by the Minister of Health. The decision is based on a report produced by the President of the Registration Office for Medicinal Products, Medical Devices and Biocides.

Recently, more than 15 000 pharmaceuticals have been registered and given marketing approval in Poland. To meet EU requirements, over 8000 Polish drugs have to be subjected to repeated investigations. The list for the transitional period was closed in May 2004 as Poland joined the EU. The transitional period for Poland continues until 2008. However, Poland has put forward a motion for a 15-year transitional period for drug re-registration to enable authorities to adjust their drug registration regulations to meet the requirements for new Member States. All drugs submitted to registration after the Pharmaceutical Law came into force have to comply with these requirements. An applicant is obliged to provide evidence that the medicinal product submitted for registration meets the requirements in terms of its safety, quality and efficacy. Should the need arise, the evidence must be based on the results of quantitative, pre-clinical and clinical studies. The performance of studies should meet the requirements of Good Manufacturing Practice (GMP) and Good Clinical Practice (GCP). The process of marketing approval should follow precisely specified guidelines. In

addition, on the basis of the Pharmaceutical Law, a pharmacotherapy safety monitoring system has been introduced. Since Poland's accession to the European Union, this system is to be integrated with the systems in other EU Member States.

The pharmaceutical industry

The Polish pharmaceutical industry consists of 238 enterprises, including 15 leading ones with over 1% market share. In recent years, a substantial number of main pharmaceutical enterprises have been transferred to private ownership, partly through the investment of international capital or admission to the stock market. At the moment, there are only three plants owned by the state, others are privately owned with domestic capital. In 2002, the total value of the domestic production accounted for PLN 4.8 billion in producer's prices (about €1.2 billion).

Prices of domestically produced drugs vary to a much greater extent than those of imported drugs. Drugs whose domestic production began at least ten years ago are low priced; however, those prices are comparable with those of generics imported from some European countries. The price difference between drugs whose production started in very recent years and original imported drugs ranges only between 12% and 30%. Prices of certain imported drugs are higher in Poland than in some western EU countries. The largest Polish domestic pharmaceutical enterprises are: Polfarma – Starogard, Polfa – Warszawa, Polfa – Tarchomin and Polfa – Pabianice. GSK Pharma, Servier, Novartis and Eli Lilly lead the market among foreign pharmaceutical companies in terms of revenue.

The pharmaceutical market

The Polish pharmaceutical market occupies the nineteenth place in world rank in terms of revenue (IMS Health data). In 2002, the value of the domestic market reached PLN 12.24 billion (about €3.1 billion) in producers' prices, and PLN 18.55 billion (about €4.68 billion) in prices of purchase by patients and hospitals. In terms of quantity, domestic drugs are in the majority (mostly generics), accounting for about 67%, whereas the share of imported drugs is about 33%. In terms of revenue, domestic drugs accounted for 36.5% and imported drugs for 63.5% of the market, respectively. Patented medicines represented 47.2% of the market compared to 52.8% for generics.

The Polish pharmaceutical market can be split into three major segments, according to turnover, with the following value shares: general access pharmacies

(80%), hospital pharmacies (15%), and other retail outlets (5%). Market share in terms of revenues was PLN 16.12 billion for pharmacies, 1.46 billion for hospital pharmacies (in producers' prices) and 0.83 billion in retail outlets. Of this total of PLN 18.41 billion, the National Health Fund only reimbursed 5.75 billion (31%).

Reimbursement

Drugs on the pharmaceutical market are divided into the following categories that indicate drug availability to patients, including their value shares in 2002:

Reimbursed drugs	53%
Prescribed drugs fully paid by patients	18%
Over-the-counter drugs fully paid by patients	29%

At least twice a year, the list of drugs with reimbursement coverage is published by the Minister of Health. A Drug Management Team has been set up at the Ministry of Health. It gathers experts representing the Minister of Finance, the Minister of Economy and Labour, the Minister of Social Policy and the National Health Fund. The main objective of the Team is to assist the Minister of Health in making decisions on the list of reimbursed drugs and in setting statutory wholesale and retail prices of drugs.

Reimbursed drugs are divided into two major categories:

A. drugs available to all insured persons

B. drugs available to patients with specified chronic disorders.

Category A includes three lists of drugs available to patients at different co-payment levels:

- a flat fee; at present equivalent to PLN 3.20 (€0.70) per package
- 30% of the cost of drugs
- 50% of the cost of drugs.

Category B includes four lists of drugs, three of them include drugs with defined levels of co-payments (as above in Category A) and the fourth includes drugs that are free of charge. Changes in co-payment levels are proposed by a special commission established by the Minister of Health. It is composed of specialists representing different medical disciplines.

Once the lists of drugs are determined, drug producers submit price proposals with their justification. The Drug Management Team analyses the submitted proposals and then arrives at statutory retail and wholesale prices per package of each drug included in individual lists. If a producer proposes too high a price, the

Minister of Health assigns a price limit with maximum wholesale and maximum retail prices, constituting a reference price system. Lists of reimbursed drugs and prices are reviewed by relevant governmental bodies and representatives of physicians and pharmacists, in consultation with drug producers. It is vital to determine an appropriate price limit, since the prices are crucial in deciding the scale of expenditures on drug reimbursement provided by the National Health Fund. If price limits are lower than statutory ones then patients pay the difference, and thus the patient's share in the expenditure (co-payment) becomes higher than the level determined on the lists of reimbursed drugs.

There are two kinds of reference prices. The first is most frequently applied to preparations containing the same active substance converted into a specified amount of a given substance, taking account of its different pharmaceutical forms. The use of a group limit is rather rare. It embraces all drugs of a given category classified in the fourth Anatomical Therapeutic Chemical (ATC) group set by WHO, that is, the group of drugs having a similar therapeutic effect. The fixed price limit corresponds to the daily therapy costs for the cheapest drug of a given group with allowance made for the amount of the defined daily dose (DDD) published by WHO.

Since 2003, a wholesale price has been set by adding a 9.9% margin to the agreed producer's price, and a retail price, by adding a decreasing margin within a 40% range for the cheapest package up to PLN 12 for drugs with a wholesale price higher than PLN 100. Statutory margins do not apply to drugs without reimbursement coverage, and prices for this group of drugs are not controlled. Hospitals purchase drugs at prices negotiated with wholesalers or drug producers. The Drug Management Team can also set official prices for drugs, but only for those used in hospitals. Owing to the application of limits in setting statutory prices for reimbursed drugs, the share of expenditures on drugs from the NHF budget is about 20%, and patients' co-payment about 34% of their value. If one adds the costs of non-reimbursed drugs purchased by patients, their total share in the value of the pharmacy market is about 65%, which is very high in comparison with western European countries. Therefore, the government aims to reduce this share to 50% during the coming years.

During the past three years, the consumption of all drugs measured in DDD has decreased to a level of about 1300 DDD per 1000 inhabitants per day. In 2002, drugs in group C – the cardiovascular system – made up the largest proportion (25.6%). They were followed by drugs in group A – the digestive system and metabolism (23.7%), and in group N – the nervous system (8.1%).

Total expenditures on drugs account for about 2.4% of the country's gross national product and are among the highest in Europe. Per capita consumption by volume is second in Europe with 29 packs of pharmaceuticals consumed

per citizen, only topped by France with 50 packs per citizen in 1995 (London School of Economics 2000). For comparison, citizens in Italy, Sweden, Finland, Denmark, Norway, Belgium, Switzerland and the United Kingdom all consumed fewer than 10 packs per citizen and per year (Yuen 1999). The combination of high prices for imported drugs and irrational prescribing behaviour of doctors as reflected in these high consumption figures are the main drivers of the exceptionally high expenditures on drugs compared to other European countries.

Distribution

The present system of distribution is good enough to ensure permanent access to drugs. The system embraces pharmaceutical warehouses, pharmacies and pharmaceutical outlets outside pharmacies, and plays a key role in the supply of drugs. It should be also stressed that both the retail and wholesale markets are almost completely privatized and regulated by rules laid down in the Law on Prices and the Pharmaceutical Law.

Compared to other European countries, Poland has a large number of pharmaceutical wholesalers compared to the number of drug producers and retail sales units. At present, there are about 500 wholesalers, most of them small ones with local or regional outreach. Nevertheless, 88% of the whole pharmaceutical market is served by 20 wholesalers.

In 2002, 10 200 general access pharmacies and 668 hospital pharmacies operated in Poland. The former are almost entirely under private ownership. There are 3700 inhabitants on average per pharmacy. This ratio places Poland among EU countries with the densest network of pharmacies. The number of inhabitants per pharmacy varies from 1000 inhabitants in one district to over 5000 in another.

According to regulations in force, any business person can own a pharmacy. Nevertheless, there are some limitations with respect to pharmacy chains, which mean that one chain cannot embrace more than 1% of pharmacies in one region of the country. Several wholesalers have bought up to 400 pharmacies each. However, of an estimated 10 900 retail pharmacies, about 86% are still owned by pharmacists. There are also price differences between pharmacies. Mail or internet trading of pharmaceuticals is not permitted.

Future strategy

The expenditures on drugs will be further rationalized, *inter alia* by implementing education and information policies in the area of pharmaco-economics and

developing training courses addressed to physicians. Attempts have already been made to promote a systemic approach towards better utilization of generic drugs, to promote training in pharmaceutical economics, and to make the prescribing of highly specialized pharmaceuticals more rational and consistent. It is also planned to implement a national system aimed at monitoring tendencies in drug prescription among physicians, and to develop, in consultation with the medical profession, a therapeutic guidebook containing evidence-based recommendations on drug efficacy and treatment costs. However, these measures will have to be aligned with financial incentives for prescribers and pharmacists that are conducive to rational prescribing behaviour.

5 Financial resource allocation

Third-party budget setting and resource allocation

The 1999 health reform initiated an "internal market" in the health care system by introducing universal health insurance and establishing sickness funds with managerial independence, including greater freedom of access to, and use of, public resources for health care. Owing to these undertakings, the responsibility for purchasing health services was separated from that which supplies services so that two major actors emerged on the scene – health service purchasers and health service providers.

In the health care budget system that existed until 1999, health care was largely financed from government resources and major health care providers with the status of budgetary units, or establishments were allocated funds from the budgets of the Ministry of Health, or voivodship (province) and gmina (commune) authorities. Expenditures on health care from the budget were planned and distributed according to sections and subsections, corresponding to the kind of costs and categories of service providers, which strongly hindered the flexible management of funds. In a few provinces only, and on an experimental basis, budget resources were aggregated, and on behalf of the voivoda (province governor), the voivodship health authority was granted power to disburse the global health budget. Those voivodships played a leading role in the transformation of the health care system; they changed the status of health care centres from budgetary units into independent public health care institutions so that voivodship self-governments could conclude contracts with health services providers. Thus under a modified budget system a "managed health service market" has been established following the British example.

The 1999 reform has brought about fundamental changes. Within less than one year, all health care institutions had to earn the status of independent

institutions so as to be able to contract with sickness funds. They had to depart from the former budget financing as well as from the budget accounting and reporting system and instead base their activities on general rules of accountancy binding for economic entities. As a consequence of the reform, institutional debts formerly financed from the budget had to be covered, and cleared, by the state budget in order to facilitate the start of their operations in the new system.

The 1997 Law on Universal Health Insurance set forth the principles of allocation of resources by sickness funds based on competitive tendering of health services. The contracting terms and procedures, including requirements addressed to health service providers, rules of health service competitive tendering, and other terms, were defined in separate regulations. By the end of 1998, sickness funds began to review tenders made for contracts, enter negotiations, and conclude them. During the first year of the reform, sickness funds were committed to conclude contracts with each public or private health services provider who met the necessary requirements (qualifications of medical staff, infrastructure, including standard of equipment or diagnostic facilities) and expressed willingness to enter into contract. The terms and conditions of health funds management and health services contracting were laid down in executive regulations to the Law on Universal Health Insurance and recommendations of the Plenipotentiary to the Government for Health Reforms. Seventeen sickness funds were given the freedom to determine the proportions of funds allocated for individual categories of services, define services to be contracted and negotiate prices for individual services. Different accounting periods (monthly, quarterly or annual) were applied with one general rule of monthly initial payments. The majority of mechanisms of service financing were generally straightforward; most prices were fixed for individual categories of services (e.g. consultation by specialists, hospital care) and for day care in a hospital or in another inpatient health institution. Sometimes a global budget was also defined. With regard to primary health care, the capitation system prevailed, most frequently without taking account of factors distinguishing the population by health risks and the frequency of visits paid to primary health care physicians (family doctor or general practitioner). As in the former system, a primary health care physician acted as a gatekeeper, referring patients to other service providers operating in the public health care system.

The review and evaluation of the system carried out after the first financing year resulted in numerous conclusions and recommendations. Requirements and standards of premises and equipment, and the extent of competencies of individual categories of service providers were reformulated to make them more precise. At the same time, efforts of sickness funds, responsible for fund management by virtue of their position as fundholders, were focused on formulating more accurate definitions of particular services. Trying to improve

the contracting of hospital services, some sickness funds introduced their own systems of diagnosis-related groups (DRGs) in the year 2000. According to the DRG system, hospitals were obliged to present the lists of diagnoses as well as applied diagnostic tests and therapeutic procedures. The analysis of actual costs incurred by hospitals with relation to treatment of patients in individual diagnostic groups was used to generalize prices for individual DRGs. The majority of sickness funds started to use new categories of services such as "short-term hospitalization" and "day-surgery", and distinguish hospitalizations according to the procedures performed.

In the area of specialist consultations, a requirement was introduced to define essential examinations and procedures within categories of comprehensive consultations. They were more expensive than routine consultations based on prior diagnostic tests. With respect to hospital care, accessibility of services was more often considered in contract negotiations, and waiting time became a major measure of accessibility. In dental care, the definition of point scales was verified, e.g. procedures of lower clinical effectiveness were of lower price. In the area of rehabilitation, together with the point system and fixed prices for individual categories of procedures, contracting for comprehensive rehabilitation packages became common.

While negotiating prices, sickness funds did not need to consider the real costs of a given service calculated by service providers. Their position was that of a monopolist and they often took advantage of it by imposing prices and limits on the number of services provided (volume agreements). From the perspective of fundholders this was a rational approach because of the need to contract health services within the limits of available resources. However, this practice of contracting services led to serious financial problems faced by numerous service providers. The need to pay for additional services beyond negotiated limits proved to be a major problem. Several factors are responsible for the generation of debts by health care institutions, mostly by hospitals, that commenced at the inception of the new system of operation. These include contracts that did not reflect the structure of services provided, or the limited capacity of service providers and the burden of costs that had to be covered, owing to fixed prices and limits imposed by sickness funds, frequent passive attitudes of founders during the public hospital restructuring process, and a low rate of growth of financial resources managed by sickness funds. Attempts were made to gradually standardize contracts, primarily by introducing uniform definitions of services, quality and waiting time standards, as well as criteria for settling the differences between the number and categories of contracted services and their actual performance. At the same time, sickness funds tried to improve the system of monitoring and control of service delivery and performance, in terms of medical personnel qualifications, infrastructure, accuracy of medical

documentation, reliability of data on delivered services, quality and accessibility of health services.

The share of private health care providers in contracts signed with sickness funds continued to grow, both in terms of quantity and value, especially in primary health care and dental care. In 2000, the share of contracts for primary health care services with private providers had already reached over 90% in three sickness funds, and only in five sickness funds it did not exceed 50%. A similar situation was observed for dental services. Because of the limited number of private hospitals, contracts with public hospitals prevail.

The new system of health services financing has evolved from the very beginning of its operation and it is still being improved. In 2003, the National Health Fund developed terms of contracts with service providers, formulating very precisely the scope and general and final provisions of contracts, as well as specifying the requirements for individual categories of services, including:

- primary health care
- outpatient specialized care
- hospital care
- mental health and addictions
- medical rehabilitation
- long-term care
- dental care
- health resort treatment
- emergency services and sanitary transport
- prevention and health promotion
- services under separate contracts
- orthopaedic and medical devices.

Payment of hospitals

Acute, short-term hospital care represents the domain of services that was subject to the most profound changes in the financing system. As already mentioned, in consecutive years sickness funds tried to improve financing mechanisms, e.g. through incorporating separate fees for medical procedures, distinguishing hospitalizations by lengths of stay, financing separately hospital admission rooms, and introducing, but to a limited extent, systems organized according to diagnosis-related groups. The year 2003 brought in a uniform

classification (embracing more than 1000 categories) of hospital services, mainly based on defining individual groups of procedures and prices for basic units. This helped to end the limitation of hospitalization numbers, and to improve accessibility without bringing into effect cost-induced inflation. Nevertheless, limited financial resources still remain a problem – hence decreasing incomes of hospitals despite an increasing volume of services. This is another factor contributing to hospitals' growing debts.

Payment of physicians

Financing per capita on the basis of patient lists (capitation) was generally accepted by sickness funds and this system is now also approved by the National Health Fund. A basic rate is usually adopted and differentiated by age for three age groups (0–6 years, 7–64 years, 65 years and older) with different benefits (for nurses and community midwives, school children and pensioners of social welfare homes or children's homes). The level of the basic rate is generally a problem, e.g. in 2003 the rate remained at the 2002 level, whereas physicians were required to provide, additionally, 24-hour health care services. This resulted in a mass protest of primary health care physicians, mostly in the private sector, operating under the so-called "Zielenogórskie agreement". Negotiations with primary health care physicians on strike who refused to sign contracts on those terms were finally concluded with the decision to increase the capitation rates. However, the rates still lack uniformity and vary throughout the country.

6 Health care reforms

Aims and objectives

The health care system in Poland has been systematically reformed since 1989. These reforms developed in parallel with the orientation of the overall economy towards a market-based economy. The initial stage of the reforms has been described in the first HiT profile for Poland (1999). To sum up briefly, it contained:

- transformation of the national health care system into a public system and subsequently giving independence to hospitals;
- development of the private sector in ambulatory and primary health care (currently 58% of ambulatory health services are delivered by the private sector);
- improvement of primary health care through a new focus on family medicine;
- decentralization of the system by founding health care units (mainly hospitals) at local government level;
- financing of health care by independent sickness funds and subsequently by the National Health Fund;
- development of an intersectoral National Health Programme focused on the prolongation of life expectancy and improving the quality of life;
- introduction of a hospital accreditation system;
- rationalization of the medical statistics system (about 80% of hospitalization cards are collected on the National Institute of Hygiene server);
- introduction of health care services plans provided by local governments in regional self-governments.

The aim of these reforms was to establish a health care system which is adequate to meet the needs and the economic capabilities of the country. However, despite a decreasing number of hospital beds, the development of primary health care and the introduction of a health information system, this aim has not been achieved. Too little in the way of public financial resources (4% of GDP), a concomitant increase in life expectancy by 4 years in men and 3 years in women, uncontrolled growth of expenditures on drugs, a reduction of hospitalization time, but accompanied by a significant growth in the number of hospitalizations (up from 4 million in 1999 to 6.5 million in 2002) caused a growth in out-of-pocket costs estimated at approximately 30% of total health care costs.

During the last 50 years the opinion prevailed that all health services should be provided free at the point of use. This attitude results in patients' reluctance towards legal co-payments, while at the same time illegal co-payments are still a problem. Briefly it can be said that theoretically all modern diagnostic and therapeutic techniques are available but too little funding from public sources from the social health insurance system gives the impression of limited access. This has caused a general feeling of dissatisfaction with the reforms.

The adjudication of the Law on Universal Health Insurance by the Constitutional Tribunal in 2003 presented another opportunity to modernize the health care financing mechanisms in Poland. A new law, the Law on Financing Health Services from Public Resources, was passed by the parliament in August 2004, introducing new rules for the contracting of health services, which came into force at the beginning of 2005. It contains a number of specific obligations to be met by the National Health Fund:

- it has to gather, monitor, supervise and make accessible data from waiting lists to the public at large;
- there is to be some exclusion of services from the benefit catalogue, i.e. to be provided only through out-of-pocket payments (but very restricted exclusions, e.g. cosmetic surgery);
- it introduces a system of waiting lists but not for emergency services;
- a common system of health service fees based on their average costs has to be gradually implemented;
- creation of a Polish Health Technology Assessment Agency, which will prepare the services and reimbursement drug lists according to evidence-based medicine and cost-effectiveness analyses to inform the Minister's decisions;
- a higher representation of the insured and health services providers in the National Health Fund Council is required;

- the health planning system has to be rationalized;
- it made possible the decentralization of responsibility for financial and service plan realization to voivodship NHF branches.

Preparatory studies on the role of a supplementary insurance system and the change in status of independent public health care organization units into legal entities are also being carried out.

The main target of these changes is to improve financial management of hospitals and, it is expected, a limitation of further liabilities. In fact, this is also expected to limit the number of hospitalizations and to increase their cost per unit so that the whole range of diagnostic and treating procedures can be carried out at a satisfactory level that would limit readmission of the same patients to the hospital.

A return to a fully electronic registration of all health services, especially prescriptions, is expected. Such a system had started to be introduced in 1996–1997 and was stopped in 1998. It is based on a system of electronic registration of all health service procedures in primary and outpatient specialized health care by means of doctors' and patients' e-cards, which confirm the provision of the service or prescription in this way. The main aim of this system is to limit spending on drugs.

In addition the government accepted the National Drug Policy, which is aimed at transferring the market share from branded to generic drugs. The Insurance Law mandates that the insurance contribution is to be gradually increased from 8.25% in 2004 to 9% in 2007.

The hospital restructuring should lead to a further decrease in the total number of beds and help to maintain the balance between short- and long-term care beds. Over the whole health care transformation period (1990–2005) the number of beds was reduced by about 75 000. Changes in the number and structure of hospital beds have been accompanied by a gradual development of new forms of service delivery, day-care treatments and hospitalization in patients' homes, among others. This is reflected in the reduction of public hospitals in the period 2001 to 2004 with a concomitant increase in the number of other health care institutions (Table 6.1).

In view of current epidemiological and demographic data, it is necessary to develop long-term care. The incidence rates of chronic diseases are growing, mostly owing to population ageing, as well as to advances in medical technologies. These processes necessitate an increase in rehabilitation and nursing services in the overall hospital sector. The development of the national network of hospitals is one of the elements of the health care system, which is essential for ensuring emergency health care for the population.

The following numbers of hospital beds per 10 000 population are planned:

- short-term care 35 beds
- long-term care 14 beds
- psychiatric care 7 beds

Hospitals within a hospital network will have to fulfil defined conditions and will form the basis for providing health care services in case of emergency, disaster or epidemics or for taking over the duties of other health care institutions should the need arise. The public hospital network will embrace only public health care institutions. Highly specialized hospitals and those playing a strategic role for the whole country will be the first to be included in the network. Other segments of the network will be agreed upon between the Minister of Health and voivodship self-governments. The health plans will be based on population health needs in a given voivodship according to clearly specified terms of quality and quantity (especially the demand for hospital beds with relevant profiles). It is the responsibility of local self-governments to provide the Minister of Health with data showing the condition of hospitals in individual gminas, counties and voivodships, so that it will be easier to meet the defined health needs in particular regions of the country.

The hospital network will be based on the following criteria:

- medical indications – individual medical disciplines essential for meeting local needs;
- the volume of resources;
- the geographical distribution of institutions;
- links with the emergency medicine system;
- supply of diagnostic and therapeutic facilities in individual hospitals;
- possibility of meeting quality criteria combined with accreditation mechanisms;
- presence of large industrial plants, highways and heavy traffic routes in the vicinity of hospitals.

By October 2005, however, no decision had been taken to introduce the hospital network.

Table 6.1 The number of health care institutions

Hospitals	2001	2002	2003	2004
Public	691	678	667	–
Other	45	61	203	–
Total	736	739	870	871

Source: Statistical Central Office, 2004.

Reform implementation

Sickness funds and the National Health Fund systems

Ever since the inception of sickness funds, contracts for health services concluded with their providers have been subject to criticism. Service providers argued that sickness funds disregarded costs borne by health care institutions and health needs of the population. On the other hand, sickness funds stressed their responsibility for the distribution of funds within the limits of the available financial resources in the interest of their insured populations and not in the interest of individual service providers or their associations. Unfortunately, their limited experience contributed to numerous mistakes being made during the contracting process. These were mostly because of inaccurate and maladjusted financial mechanisms, and inefficient monitoring and evaluation, but were also due to inflexibility in negotiations and terms imposed on participation in public health care financing. An objective variation in the amount of financial resources which the sickness funds had at their disposal was an additional adverse factor. Accumulation of financial resources from insurance contributions is always determined by the level of income of insured persons, hence the vast differences in contributions paid for the benefit of sickness funds in voivodships with a higher average income per capita compared to those with lower incomes and high unemployment (Table 6.2).

The algorithm of resource redistribution among sickness funds did not compensate for the large differences in the level of health care financing per inhabitant and which were even more pronounced in the amount of funds allocated for individual categories of health services.

Table 6.2 Costs of services covered by sickness funds per insured inhabitant, 1999–2002 (in PLN)

	Average	Maximum	Minimum
1999	562	612	501
2000	600	644	573
2001	689	763	591
2002	752	844	666

Financial situation of health care institutions

Before introducing the health care reform in 1999 the Ministry of Health cleared all the liabilities of health care institutions, which amounted to about PLN 8 billion. The initial years resulted in a slower increase in debts. Since 2002, however, an acceleration in debts has been observed: between January

2002 and June 2004, the accumulation of debts doubled and can be correlated with statutory wage rises for health professionals that occurred in the early 2000s (Table 6.3). Currently about 65% of all public health care institutions are indebted: 31% of these debts are owed to the public sector, mostly for local taxes, real estate taxes, and social insurance contributions on behalf of the employees; 20% of these debts are owed to suppliers of drugs and medical consumables and 18.5% of debt is owed to employees. Some 83–85% of all debts are located in health care institutions founded by local governments, which reflects their share in health services delivery.

While 65% of the public health care institutions are indebted, there are regional differences in the amount of debt owed and in whom the debt is owed to: 80% of matured debts originate from 15% of establishments. The most indebted facilities are in the Wroclaw Region (20% of all debts) and the least indebted facilities are in the Opole region (PLN 1097.8 million compared to PLN 84.1 million). This can only be partially explained by the link between expenditures on health infrastructure and total debt owed.

Since the debts amount to about 30% of local governments' budgets it is hardly possible for health care institutions to pay them back in the short term. So the new Law on Public Help and Reorganization of Public Health Care Institutions was introduced and HCIs are supposed to prepare restructuring plans. After approving the plans at voivodship level the public liabilities (the debts in public institutions like social insurance companies and tax offices) will be extinguished and civil liabilities will be renegotiated. Hospitals will receive low-interest long-term loans (3% for 10 years) and on completion of the restructuring programme, half of the loan will be cleared.

These financial liabilities are a great burden on hospitals and hinder their proper functioning. All these difficulties are reflected in the standard of health services, and the working conditions of physicians and other personnel employed in those institutions. The present constraints on public finances do not allow another clearing of debts. Independent health care institutions struggle with the high costs of servicing outstanding debts and with the obstacles faced in covering current expenditures. On the other hand, a possible clearing of

Table 6.3 Debts of health care institutions, 2000–2004

Liabilities	2000	2001	2002	2003	2004[a]
Total (PLN Million)	1 521 (without central health care institutions)	2 744	3 245	4 730	5 509

Source: Ministry of Health; Report: The Health Care Financing in Poland – Green Book, 2004.

Note: [a] on 30 June 2004.

debts would be unjust to those health care institutions which function more efficiently. Moreover, clearing of debts with present structures and terms of contracting health care services would appear to be inefficient and irrational. For example, out of the 16 regions, only two were able to stop the escalation of debts in 2004.

In view of the magnitude of problems encountered, attempts are being made to find appropriate solutions. The new Law on Public Help and Reorganization of Public Health Care Institutions, which has been passed in April 2005, should in theory facilitate the allocation of additional funds to improve the cash flow of independent public health care institutions by their founders. This includes the payment of their obligations. Currently, some local self-governments have a legal basis for supporting their hospitals financially.

A number of proposed solutions will contribute to the elimination of mechanisms responsible for the accumulation of debts.

Another constraint in pursuing a consistent health reform programme is the lack of political stability at the central level of the health system. During the last few years (2001–2005), six different ministers headed the Ministry of Health. This had major implications for the health reforms. For example, a change of government and Minister of Health in 2001 was the main reason for the recentralization of the 17 sickness funds into one National Health Fund in 2003 – not technical arguments. This move not only increased the central control of the health system, but it also made possible the introduction of new executive managers in the new fund.

7 Conclusions

The ongoing reforms of the health care system, initiated in 1989, developed in parallel with the reforms of the national economy. However, levels of public funding for health care have not kept pace with GDP growth, falling slightly as a proportion of GDP since 1995. Health reforms have also been accompanied by high rates of unemployment. An increase in life expectancy by four years during this time period, alongside a birth rate below the reproduction level, and the continuous increase in expenditure for pharmaceuticals and medical technologies contribute to an increasing financial burden imposed on health care institutions. The symptoms of underfunding of the public health system, like waiting lists, avoidable deaths, and informal payments to health professionals, ultimately led to widespread dissatisfaction with health services among Polish citizens.

Some positive effects of the reforms are manifested, among other things by a restructuring of hospitals, including a decrease in the number of hospital beds, shorter hospitalizations, the strengthened role of family medicine, and a new focus on health prevention and promotion with the National Health Programme. However, the aforementioned problems, notably the limited access to care, perceived low quality of care and high private spending on health, prevented the development of a positive attitude in the society towards the health system or the health reforms, although without those changes the state of the health care system in Poland would probably have been much worse. Low salaries in the public health care system remain a major issue, as are informal payments for health services and the emigration of health professionals to western European countries.

Currently, measures to raise revenue from out-of-pocket payments and from supplementary insurances, such as those provided by mutual societies or long-term care insurance, are being discussed. Another focus of attention is

the continuing effort to improve control over health expenditures, notably for pharmaceuticals, and to define specific benefit packages for certain population groups, such as the elderly, and for screening, rehabilitation services and social care. The matter of improving the health information system is again under discussion in order to make data- and evidence-based contracting of services feasible, with the aim of increasing the efficiency and equity of health services in Poland.

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9 Health care legislation

Laws

- Law on the State Sanitary Inspectorate, dated 14 March 1985 (consolidated act, Journal of Laws No. 90, item 575, 1998).
- Law on Health Care Institutions, dated 30 August 1991 (Journal of Laws No. 91, item 408 with later amendments).
- Law on Nurse and Midwife Profession, dated 5 July 1996 (Journal of Laws No. 91, item 410 with later amendments).
- Law on Physician Profession, dated 5 December 1996 (Journal of Laws No. 21, item 204, 2002 with later amendments).
- Law on Universal Health Insurance, dated 6 February 1997 (Journal of Laws No. 28, item 153).
- The Constitution of the Republic of Poland, Sejm Publishing Office, Warsaw, 1999
- Law on Medicinal Products, dated 27 July 2001 (Journal of Laws No. 126, item 1380).
- Pharmaceutical Law Law, dated 6 September 2001 (Journal of Laws No. 126, item 1381).
- Law, dated 6 September 2001, introducing the Pharmaceutical Law, the Law on Medical Devices, and the Law on the Registration of Medicinal Products, Medical Devices and Biocides (Journal of Laws, No. 126, item 1382).
- Law on Universal Health Insurance with the National Health Fund, dated 23 January 2003 (Journal of Laws No. 45, item 391 with later amendments).
- Law on Health Care Services Financed from Public Sources, dated 27 August 2004 (Journal of Laws No. 210, item 2135).
- Law on Public Help and Reorganization of Public Health Care Institutions, dated 15 April 2005 (Journal of Laws No.78, item 684).

Ministerial Decrees

- Decree of the Minister of Health, dated 21 September 1992, regarding the sanitary and technical requirements to be met by premises and equipment of health care institutions (Journal of Laws No. 74, item 366 with later amendments).
- Decree of the Minister of Health, dated 27 February 1998, regarding the standard performance and medical procedures related to the provision of anaesthesiological and intensive therapy health services in health care institutions (Journal of Laws No. 37, item 215).
- Decree of the Minister of Health, dated 21 December 1999, regarding the system of setting employment norms for nurses and midwives working in health care institutions (Journal of Laws No. 111, item 1314).
- Decree of the Minister of Health, dated 27 March 2000, with regard to the system of ministerial identification codes for health care institutions and the specified rules of their assignment (Journal of Laws No. 30, item 379 with later amendments).
- Decree of the Minister of Health, dated 30 August 2000, regarding the registration of health care institutions (Journal of Laws No. 74, item 864, 2000).
- Decree of the Minister of Health, dated 25 March 2003, regarding the announcement of competitive tendering by the National Health Fund for health services delivery and the invitation to participate in negotiations, submission of tenders, calling and dissolving the competition commission, dated 30 August 1991 (Journal of Laws No. 55, item 493, 2003).

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