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Poland's Health Care Reform Disappointment and Hope

Jacek Holówka

At the beginning of 1999 Poland has undertaken a health care reform. Though its initiation was long overdue, its implementation has met with severe criticism. I will review the reasons for the undertaking of the reform, consider its shortcomings, point to its hopeful aspects and draw some general conclusions.

1. The Need for Change

The level of health care in Poland deteriorated visibly in the seventies and the eighties. The communist government had been dedicated to the idea of free medical services for all, but was unable to meet the costs of such care. Although basic material and technical provisions were at the level characteristic for the lower group of most advanced countries, the system as a whole became inert and inefficient. Government outlays were sufficient for the sustaining of the system only; they were too low to control and correct its operation. State money was used to cover all permanent costs, such as salaries for the employees, medical equipment, electricity, other utilities, and so on. Doctors were paid at a dramatically low level, with official averages falling below the level of the average for all professions. Nurses were paid even less. To compensate for the years of demanding studies and to cope with stressful work, most physicians sought multiple employment. They received full salaries from two or three institutions, and divided their time accordingly, coming late to every place where they worked, and leaving before the end of their office hours. As a result no one was paid in proportion to their efforts, qualifications or medical effects of the work performed. Doctors collected their salaries not because they offered high quality services but because they had legal contracts with their employers.

The system became insensitive to financial stimuli and administrative regulations. As all medical professions considered themselves underpaid, any additional sums directed to the system were absorbed without any perceptible change in its functioning. They were accepted as a long overdue compensation. Doctors' behavior could only be modified by direct payments made by the patients. Although such direct gratifications were, strictly speaking, illegal, nobody tried to control them. Medical administrators were happy to see that doctors could find

additional sources of income, because then they were relieved from the pressure to raise salaries. Patients were happy to pay only the supplement above the costs of services essentially covered by the state. Doctors were happy to double their income in a secret way, and not to have to pay taxes on their additional earnings.

All this meant, however, that the system was inefficient, wasteful and unfair. Everybody thought it could be made more rational and honest. After the political change of 1990, all political parties and public organizations expressed their determination to change the principles on which the system had operated. Several new organizations were created which undertook to draft a new system. They all seemed to agree where the failings of the old system lay.

1.1. The system was insensitive to incentives and, generally, to all fluctuations of external inputs. Any amount of money could be channeled into the system without producing the slightest improvement of its functioning. The system was propelled by bureaucratic measures that were strong enough to prevent it from disintegrating, but too weak to cause any changes in its operation. No changes of demographic or epidemiological factors seemed to affect it. In the periodic peaks of flue the same numbers of doctors and nurses had to cope with a greatly increased number of patients without additional pay. In the summer a large percentage of doctors took vacation, and no one seemed to notice any decrease of the supply of medical services.

1.2. The system was wasteful. Many doctors performed in two sectors. They were employed by state clinics for one part of their working day and practiced as private doctors in the other part. In state clinics they had access to equipment and medication, which they could use in their private practice. Moreover, their double engagement was a useful arrangement when a serious condition developed in their private practice. In case of emergency they could easily send their private patient to hospital. As the patients covered only a fraction of the total costs of private treatment, state institutions had to cover the rest. That also meant that doctors could overcharge, as nobody controlled the full cost of any service. On top of that, some patients abused the system if they knew they would not have to pay for the services. They could plague doctors with dubious symptoms again and again, and the doctors could not refuse to see them. Many chronically ill or senile patients specialized in demanding huge amounts of medication from several doctors whom they visited in turn.

1.3. The system was outdated and professionally unsatisfactory. It shunned from introducing advanced methods of diagnosis and treatment. As it had to operate on a tight budget for more than two decades, a pernicious dilemma set in. Its scarce resources could be used to treat a large number of simple cases or a more limited number of difficult cases. Generally the first alternative was preferred, leading to the situation when serious problems were detected unwillingly, diagnosed with delay and treated with palliative rather than advanced measures.

1.4. It operated without skilled managers. All expenses were made according to regulations issued by the Ministry of Health and Social Welfare. Ward directors had to make do with annual budgets irrespective of their local needs. Consequently some clinics were in bad disrepair for several years, many had to postpone their vital investments, most created long waiting lists for their patients and offered efficient treatment only to those patients who could be treated with inexpensive measures.

1.5. Patients were humiliated by unkind behavior from professionals and exposed to arbitrary decisions. In order to minimize the demand for services, medical institutions condoned artificially created barriers put in place in order to discourage patients. Arrogant behavior and impatience with less articulate clients were rather common. The concept of patients rights was vigorously opposed by medical professions, and the concept of entitlement to medical assistance, although confirmed by the Constitution, was trivialized to the meaning that no one would be treated better than any other. The presumed power of the entitlement as a mechanism that initiates required procedures of the system, was totally lost. Medical help was limited and meted out reluctantly. Much depended on the good will and the morale of the individual physician. If she/he was compassionate and conscientious, their patients could expect efficient and competent treatment. If the doctor was less scrupulous or overworked, the patients were treated perfunctorily.

1.6. Professional supervision was paralyzed. Although various medical associations continued as legal entities, they were not authorized to interfere with daily activities of medical institutions. They neither had the power of accreditation nor the right to perform periodical reviews of medical facilities. Firmly locked in their passive role, they could only offer their opinion or evaluation when called upon by hospital or clinic administrators. Their function was mainly ornamental.

1.7. All medical professions were underpaid. Official salaries in all clinics were fixed by the government guided by the Marxist principle that one should be remunerated for the amount of labor expended and nothing more. Qualifications, skill, responsibility and stress were not additionally compensated for. Hence nurses and orderlies were paid slightly above the minimum wage, and though doctors were paid more, their income fell short of the earnings made by technicians or engineers. The main incentive to become a doctor came from the short-

age of apartments. As several new clinics were organized in villages and small towns, and each was usually furnished with several apartments, young people who otherwise had no prospect of getting their own home, chose medicine as their employment, in the hope of obtaining a house faster than most of their peers.

1.8. The system generated corruption and profited from it. Mismanagement and arbitrariness led to secret privatization of many wards. By admitting private patients into clinics, ward directors made more money than renowned private practitioners. Their colleagues and team members demanded to be included in the external payment schemes or refused to cooperate. In many cases patients were openly given a simple choice: they either make a direct payment to the clinic, or they will not be treated. The payment was not considered a bribe but a contribution to be used for the purchase of most elementary equipment: surgical gloves, chemicals, radiological tests, etc. Official complaints about corruption brought no improvements. The Ministry of Health sent out periodic letters to clinic directors expressing their dissatisfaction about the alleged practice of demanding direct payments from patients. The directors responded by organizing ward meetings and asking the doctors if they accepted sidekicks. As no one volunteered to say they did, a spate of letters was sent back to the Ministry denying all allegations.

The deeply dysfunctional system was perceived as a miscreant of the communist rule. It was optimistically believed that all its vagaries would disappear if communism were gone. The truth turned out to be more complicated.

2. Political Controversies about Health Care Policy

In theory there are three ways of organizing health care services. It is possible to employ (2.1.) a centrally organized monopoly, (2.2.) insurance agencies, (2.3.) free market. The system that existed in Poland before 1990 had been intended as a centrally organized monopoly. However, its inefficiency and pathological degradation resulted in a permanent incorporation of some black market mechanisms within hospitals and clinics. Small internal markets were thus created in most public institutions, and patients who wanted to receive good quality treatment had to deal with the two systems operating side by side. They had to prove that they were officially entitled to medical services, and then they had to make direct payments for the services they were given. So the medical health care system in Poland was a mix of (2.1.) monopoly and (2.3.) free market.

At the Round Table Negotiations, which introduced a change of political system in Poland, much attention was paid to health care. The non-communist side seemed to agree that it was necessary to introduce (2.2.) an insurance system. That opinion was shared by most specialists of health care management. No one was in favor of the state monopoly. The communists knew how expensive and unmanageable it was. The non-communists remembered that it was slow, corrupt and inefficient. Similarly, nobody seemed willing to defend (2.3.) free market in health care. It was clear that an average patient would not be able to cover the cost of a major operation or a long term treatment. Consequently the proponents of Solidarity argued that the principle of solidarity is indispensable in health care. And yet, in the following eight years very little was done to design and create a system of health care based on (2.3.) insurance. Several proposals were offered, but none was endorsed by Parliament or the Ministry. Discussion about principles and goals were dominated by problems of political expedience.

The post-communist parties were not interested in maintaining the old system, but they knew that the idea of free medical care was extremely popular with a large segment of the population. So in their official announcements they continued to defend (2.1.). Activists of Solidarity started from the liberal position as opponents of communism. But they decided to abandon it before long. When communism was no longer a viable political alternative, Solidarity activists shifted their allegiances and sided with Catholic groups. In the political party abbreviated AWS they hunted for the same votes that the post-communists wanted to win, and they found it expedient to adopt the same health care policy as the Post-communist did, emphasizing universal coverage, accessibility of services and low costs. The old system was thus rediscovered as a fair and popular solution, and its shortcomings did not seem so troublesome now. State monopoly (2.1.) was not openly defended, but in practice, all arguments used by the AWS, the Post-communists and the Rural Party (PSL) stood in its defense. The only political group which supported (2.2.) the insurance system was the Union of Liberty (Unia Wolności), but even this party saw their commitment as a liability that could potentially cause them much damage. Consequently, for many years successive teams of ministers and vice ministers coming from all major political parties in Poland did very little to change the existing health care system.

The discussion about health care reform focused on abstract issues that had little impact on everyday realities. It was emphasized that universal health care was one of the prerequisites of a welfare state and that Poland was obliged to observe the principles of welfare state because her Constitution extolled "Christian values". It was argued that decentralization was necessary and had to be supported by such instruments as internal market for medical services, minimization of outlays for health care administration, regional autonomy, professional

quality of medical services, accountability of costs, the principle: money follows the patient, and a stricter control of the fee-for-service practice. But that was as far as the discussion seemed to go. The proponents of change quibbled over the supposed merits of these features, without trying to combine them into one system.

Independently of all these discussions some entrepreneurs began to open private clinics. Since 1992 it has been possible to open medical institutions and run them as one more form of economic activity. Small hospitals were organized in this way by people who did not care about health care policy but saw that medical services could bring them profits. In this way a system of private clinics (2.3.) - mostly composed of dental clinics, plastic surgery outfits, gynecologist and pediatric units - has grown alongside the health care institutions.

3. Political Compromise versus Functional Efficiency

On January 1, 1999 the Ministry of Health and Social Welfare introduced the health care reform. It was declared rather than constructed by appropriate legal and financial provisions. Its main elements consisted in the elimination of the state ownership of medical premises, introduction of global budgets in medical institutions and creation of Regional Health Funds (Kasy Chorych).

The reform was introduced by the Updated Bill on Universal Health Care Insurance (Znowelizowana Ustawa o powszechnym ubezpieczeniu zdrowotnym), but it was not supported by a new form of insurance. The features of the new system were conveniently summarized by Cezary Włodarczyk, a leading specialist in health care administration.[1] He highlights the following points.

3.1. The system officially introduced free choice of the payment scheme and free choice of the provider of services. In fact, however, the choice of the payment scheme proved illusory for most patients, as they had to contract services from the Regional Health Funds. Only the military personnel and police had a real choice and could buy services either from their local Health Funds or from military institutions.

3.2. The basic source of financing is the Social Security Administration (Zakład Ubezpieczeń Zdrowotnych). All fees are calculated as a percentage of personal income, irrespective of health hazards. The top annual premium is established at the level of approximately four times the average annual income. Whoever earns more, makes no additional payment to the ZUS. Employers make no payments for their personnel to the Health Insurance Fund at all. Pensioners, the unemployed, prisoners, and some other categories of people without work, have their contributions paid from the state budget. Collection of premiums is highly centralized and inefficient.

1 Cf. *Cezary Włodarczyk*, „Droga do ubezpieczeń zdrowotnych. Wędrówka koncepcji reformatorskich w procesie polityki zdrowotnej", in: Zdrowie i zarządzanie, (2) 1999, p. 27.

3.3. All requisite additional funding must be obtained from the state budget or patients themselves. University clinics and selected medical research institutions operate on state funds. Special program, such as e.g. inoculation against contagious diseases for infants, are covered by the state, too. But the major part of medication costs is met individually by patients themselves.

3.4. The costs of medical services are covered by the Regional Health Funds from the contributions collected by the ZUS. The Health Funds do not collect premiums directly but receive their funds from state institutions, the central and local governments, and the Social Security Administration. They disburse the money to medical institutions on the basis of capitation contracts.

3.5. The transfer of funds to the provider of services is based on contracts between Health Funds and clinics. A medical institution proposes to sell a certain amount of services of different types. The Health Fund makes its own calculation of the local health needs and commissions a fraction of the amount offered. Clinics receive money for their expenses after the services have been delivered. They are financed up to the level that has been contracted by the Health Fund.

3.6. Forms of ownership of premises and equipment are not regulated. Public institutions, such as foundations or NGOs, can own clinics. Private persons can possess them, as well as the central and local governments. There are some legal limits concerning the change of ownership, but in principle a wide plurality of forms of ownership is accepted.

3.7. Outpatient clinics and hospitals are strictly separated even if they work within the same physical premises. All medical institution have their global budgets. Directors can use their budgets as they see fit, but it is in their interest to offer as many services as they have agreed to provide and not one more.

It is interesting that the Ministry did not identify the goals to be achieved by this Updated Bill and never discussed the expected functional relationships among the main actors in the field of health care. In the current situation there are more actors on the scene than one would expect: the central and local governments, the Social Security Administration, the Health Funds, medical institutions and patients. Their respective interrelationships are poorly defined, and

essential responsibilities are vague and diffused. Most importantly, patients have not been empowered to receive services. Even if somebody pays high premiums to the Social Security Administration, he cannot argue in the local outpatient clinic that he is entitled to a particular service. The director of the clinic can always say that the particular service has not been included in the contract with the Health Fund or that all contracted services of the kind have already been delivered. Apparently this is already a serious problem with laboratory tests. Many general practitioners say they must economize on the allotted number of tests, because they can not use them all up too early. So they tell their patients to make tests in the fee-for-service mode. As a matter of fact none of the contracting parties has an incentive to increase the number of tests. Laboratories want to receive cash and the Health Funds want to minimize global expenses. All parties are happy to see that patients first pay the premiums and then pay for the services. Ingenious methods are used to extract double payments. For instance most clinics do not contract home visits and at the same time many GPs tell their patients they do not have enough time to perform full diagnostic examinations in their offices. Consequently the patient has to contract a home visit by a doctor and cover the full costs of such a visit.

The overall results of the reform are rather disappointing. The efficiency of health care has not been improved. Equal access has not been guaranteed. The extent of guaranteed services has not been broadened, and, as before, expedient, high quality service can only be obtained for cash payments. Although some of the shortcomings of the old system have disappeared (1.1., 1.2., 1.3, 1.7), the level of health care has not improved.

But the new arrangements have brought some improvements, too. Patients can choose their clinics and specific doctors within the clinics. The principle of solidarity has not been lost, and some effects of the internal market are already visible - some clinics were unable to sell as many low quality services as they had expected. These advantages are not enough, however, to say that the changes introduced amount to a complete reform, or that a system of health insurance has been introduced. Instead of a reform, we have a new mix of (2.1.) centrally controlled supply of services with (2.3.) private practice. Before 1999 every clinic was either public or private, and it had to operate as such. Now every clinic can run private and public operations within its own premises, which alleviates drastic differences in the level and civility of treatment, but creates new forms of corruption. Clinics reluctantly offer services paid for by the Health Fund. The position of private practice is stronger than before, but it is still partly hidden and disguised as an activity conducted within the centrally financed scheme. No elements of insurance have been introduced, either in planning or in financing.

The Health Funds do not collect premiums, they do not modify contributions according to the health risk involved, and they do not discuss with the patient and the provider of services the most efficient method of treatment. These are - in my opinion - the three main shortcomings of the current situation.

4. The Extent of Failure and a Potential for Further Change

The changes introduced have met with severe criticism from all quarters. Numerous letters of complaint have been sent to clinic directors, to the Ministry of Health and Social Welfare and to the Spokesman for the Citizen's Rights (Rzecznik Praw Obywatelskich). Patients often say that they cannot get services in the clinics they have chosen free of charge but are forced to pay. They argue that the practice is widespread so there is no point in going to find a better organized clinic. Most doctors and nurses are still dissatisfied with their salaries. As a rule their official incomes did not rise. In 1998 anesthesiologists staged a countrywide protest and paralyzed several hospitals for many weeks. They were aware of their weak position on the internal health care market (no one buys their services separately), and in anticipation of the upcoming changes they required a major raise of pay. Some clinic directors have yielded and increased their salaries even four times. Now they do not have sufficient funds to keep up these wages. Other directors apparently refused to give raises and had to limit the number of operations in their wards. Disgruntled patients sue them now for malpractice and the courts seem rather confused and unable to solve the matter. Nurses have stages several street demonstrations because they do not receive salary increments in proportion to inflation. The Ministry of Health was in fact obliged to raise their pay by 2% above the level of inflation and did so until 1999. After the decentralization of the final disbursements introduced by the reform, the Ministry claims it is no longer a party in any collective bargaining. It has transferred its prerogatives of the employer to the clinic directors, so the directors are responsible for the raises. The directors say they have global budgets and the Ministry cannot decide how they will be spent. The nurses are paid between 500 and 700 zloties per month, which is less than half of the average salary in Poland, and they are determined to obtain what they have been guaranteed. Doctors employed in hospitals are unhappy, too, because they have learned that clinic directors tend to bypass one more law. In the past doctors could take overtime duties and receive upgraded pay for the night service. Now clinic directors have eliminated overtime duties and claim that doctors are hired to work by shifts like, for instance, engine drivers or factory workers.[2]

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2 Cf. *Paweł Walewski*, „Nocny lekarz", in: Polityka, (27) July 1999, p. 28.

Many irregularities arise from protective contracting. Clinics have learned that they are reimbursed only for the services that have been contracted and delivered. To be on the safe side, many of them contract to give more services than they are able to provide, or they offer one sort of service and register another one, much more expensive. The Regional Health Insurance Fund in Warsaw discovered for instance that one clinic kept a dermatological patient in the intensive therapy ward and charged the Health Insurance Fund the full use of the resuscitation equipment. Many similar but less spectacular cases have been detected.

Transfer of patients from one unit to another has now become virtually impossible. If a patient is ushered directly from an outpatient clinic to a hospital, he/she is treated as one case. If the patient is first checked out and then readmitted again, she/he makes two cases and is worth more money. In this situation a failure of some specialist equipment can cause serious and dangerous complications. For instance, a young man in Warsaw suffered a skull injury and needed an examination with a computer tomograph. In the hospital where he was placed the machine had just broken down. No other hospital in Warsaw wanted to let the patient in without a provisory note from the director of the first institution that he would repay the full costs incurred in their premises.[3] The director did not want to pay, however, as such payments diminish the global budget of his clinic.

Alarmed by the rising number of complaints the National Chamber of Auditors (Naczelna Izba Kontroli) undertook to review selected contracts concluded between the formerly private institution and the local Health Insurance Funds. The review showed that mismanagement was as bad as before, and in some cases much worse.[4] There are the main findings.

4.1. Out of the sum that was initially intended by the Ministry as the budget for individual private doctors, 50% was not disbursed at all. At the same time half of the proposals from private doctors were rejected. In addition, some of the accepted projects were granted three or four times more money than the doctors had requested.

4.2. 27 million zlotys was paid to one private operator in Łódź, who worked in a rented room and employed one person. Less obvious cases of lavish financing are more frequent.

3 *Aleksandra Stelmach*, „Pieniądze i życie", in: Gazeta Wyborcza, (121) July 1, 1999, p. 1.

4 Cf. *Elżbieta Cichocka*, „Sami zdrowi", in: Gazeta Wyborcza, (146) June 25, 1999, p. 1.

4.3. The Ministry of Health did not formulate any criteria for the improvement of medical premises, and yet paid out arbitrarily 148 million zlotys to those who applied for grants.

4.4. 30 million zlotys were paid to print Personal Health Booklets (książeczki rejestracji usług medycznych) for every adult person in Poland. The booklets had been commissioned by the Ministry. When the booklets were ready, the Doctors' Chamber refused to make use of them.

4.5. In one case the Ministry rented its buildings to an external organization for a low price and then rented it back for itself paying a rent 25 times higher.

Some of these irregularities have nothing to do with the reform but are simple cases of bureaucratic mismanagement or corruption. Others may have arisen from the sense of impunity predominating in the government institutions which are more interested in meeting the expectations of the political parties that support them than in fulfilling their statutory roles. But there can be no doubt that the reform had been poorly planned, designed with little attention to detail or introduced without consultation with independent specialists. It was an improvisation ventured by people who lacked in professional imagination.

At the same time it is equally clear that the old system could not go on. Its defects were glaring and unbearable. In comparison with it, even this poorly designed reform has some positive features. Some strict forms of accountability have been introduced. Overall costs of health care will be lowered and an excessive demand for services coming from depressive and hypochondriac patients will be eliminated. One can also hope that further changes will be introduced. The role of the Health Insurance Funds should be reconsidered and perhaps modeled on the example of insurance agencies. Patients should be empowered to demand services to which they are entitled. But first and foremost, the disbursement of health care funds can not be decided by two groups of bureaucrats of convergent interests – the clinic directors and Health Fund officials. Both parties are interested in limiting the amount of effectively offered services and increasing the fee-for-service practice.

5. Philosophical Conclusions

In general it is useful to distinguish between three kinds of political obligations: (5.1.) the obligation to form a constitution and adopt it, (5.2.) the obligation to protect the political system so created from degeneration, and (5.3.) the obligation to form short term agreements to reach specific ends that are supported by the legal platform created by the constitution. This pattern of thought is typical

for constitutionalists, liberals and contractarians. To a large extent it is also borne out by the current developments in the health care system in Poland.

The mistakes that have been made so far are of three kinds, and three kinds of corrective actions can remove them. (5.1.) The ultimate goals of the reform have not been identified. One can expect that the Ministry of Health will rectify this omission and make it clear by what standards it would like to see its effort evaluated. Then, a more serious discussion of the desirable ends of the reform can begin. (5.2.) Irrespective of the Ministry's intentions, it is an obligation on the part of every actor engaged in the provision of health care services to make the system rational, efficient and productive, to protect it from degeneration and waste. (5.3.) The reform seems to fail in many respects, but any group of people with common interests or opinions is entitled to make new proposals and help improve the system. Their efforts can change it and make it more efficient.

Health Care Reforms in the Czech Republic and Hungary: A Reappraisal of the Right to Health Care

André den Exter

1. Introduction

'Health care reforms can be often compared with teenage sex. Everybody is talking about it while no one knows who is doing it. And when it happens, it is often under lousy circumstances.' [1]

Since the beginning of the political turmoil in Central and Eastern Europe (CEE) in the early 1990s, this comparison has still remained valid. From a legal perspective, health care system reforms in these two countries do not appear to have been straightforward. Both the Czech Republic and Hungary have experimented with wonder drugs modified without sufficient understanding of their associated dangers. These necessary legal changes were not always preceded by a problem analysis to gauge their (potential) consequences but, instead, legal changes have been characterised by an ad hoc approach. Ill-considered measures have frequently frustrated necessary reforms.

This paper describes the path of reform in the Czech Republic and Hungary starting from the legal base of the health care system changes, i.e. the right to health care. Both pre-accession countries face substantial difficulties in effectuating this right through a social health insurance system. One of the mean reasons for this is the absence of a legal-theoretical debate on health care reforms. By describing recent tendencies on the right to health care, the author will underpin the (potential) consequences of this for countries which are in a state of flux, since the legal implications of measures taken have been underestimated by the legislatures in both countries. It would appear that the international and European dimension of such a right has to have a major impact on the right's realisation in law. Thus, the constitutional basis of the right to health care cannot only be considered from a domestic perspective. So as to position both health care systems in the mind of the reader, the revised legal frameworks of both countries will first be described.

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1 *M. Vienonen*, in: A.P. den Exter / H.E.G.M. Hermans, eds: The right to health care in several European countries, Kluwer Law International: The Hague, 1999.