Chapter VI

Health care

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The basic indicators of the health of the Polish public showed significant improvement in the 1990s. The average life expectancy increased, while the presence of basic social and civilizational diseases declined. The general improvement in the provision of goods, the greater accessibility of food, the appeal of healthy lifestyles, as well as an improvement in ecological standards, have all resulted in favourable tendencies as regards the average state of the public's health.

This improvement took place against a background of serious problems concerning the functioning of the health care system. Indeed, Poland might serve as an example that the poor performance of health care services does not have a fundamental effect on the health of the public. This is because the health care system is involved in curative medicine and its services are addressed primarily to people who already have problems with their health. It determines the quality of life for people who are already affected by diseases, not the whole population.

Institutional and financial crisis has been troubling the health care system for quite some time. This is reflected in the tendency to create (recreate) imbalances and frequent organizational changes. The health care reform introduced in 1999 did not yield the anticipated results. Consequently, it has been largely reversed since, with the regional health funds having been abolished and payer functions centralized in the National Health Fund (NFZ) in 2003.

The privatization of health care services, primarily in the area of basic health care and outpatient specialist services, has increased the scope for participation in the system on individual terms, with fees for services. More affluent individuals are taking advantage of this opportunity, oftentimes supported by employers who have purchased health care service packages for them.

Meanwhile, public health care dominates as far as hospital care is concerned. This is the most troubled element of the system – with mounting debts, patients queuing for treatment and the staff, nurses in particular, frustrated with their measly salaries.

This chapter will present the main problems of public health care and the functioning of the national health care system. It will present the fundamental dilemmas and propose ideas to reform the system.

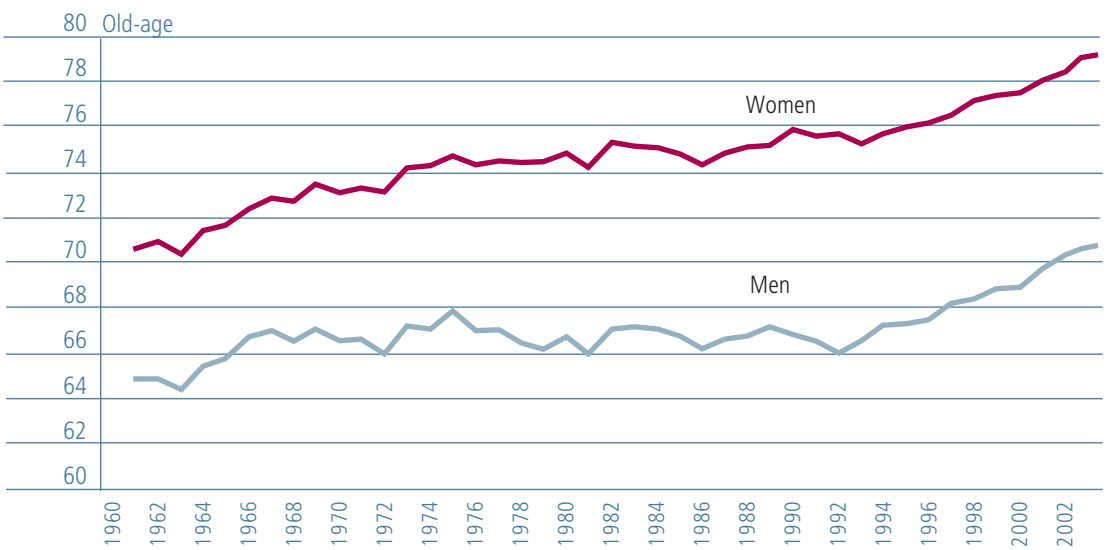
1. The state of public health

Over the past few years, the health condition of the public has improved noticeably, although Poland's relevant indicators are still inferior to the average indicators tabulated in European Union countries.

First of all, an improvement has occurred in life expectancy (LE). As Figure 1 below shows, tendencies in the average life expectancy for women and men in Poland were somewhat different. While in the case of women the life expectancy line has generally tended to rise, greater fluctuations can be observed with men. For some 20 years (1975-1995), the average life expectancy of men did not increase. These fluctuations gave grounds to the hypothesis of a higher mortality rate for men. The decline in the average life expectancy for men was convergent with the period of rapid industrialization, and later with periods of profound crisis, i.e., the turn of the 1970s and the turn of the 1980s. Incidentally, one may also observe minor fluctuations in the LE ratio for women in those periods.

The present average life expectancy for Poland's population is 74.3 years – 78.4 for women and 70.2 for men. In the 1990s, the indicator improved by almost three years: 2.1 for women and 3.5 for men.

Figure 1. Average life expectancy for women and men in Poland



Source: based on GUS data, Demographic Yearbook 2002 and OECD 2004

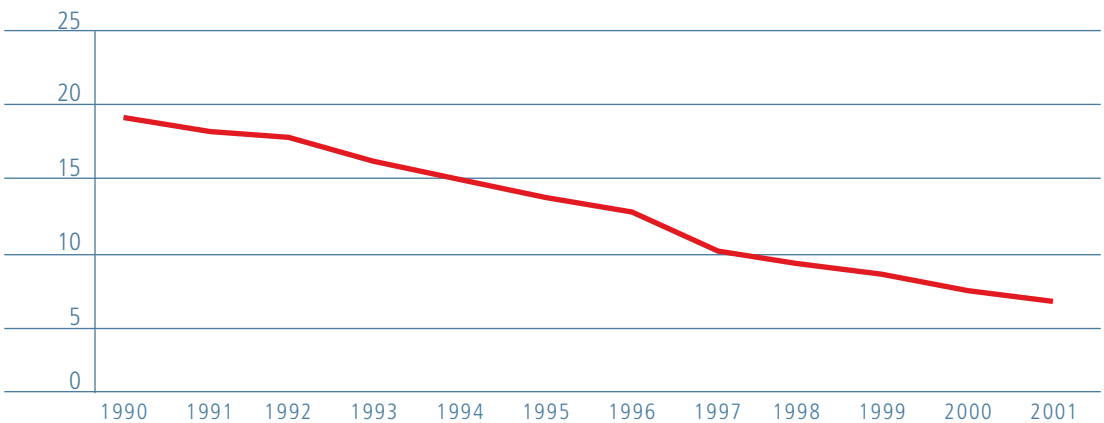
The life expectancy ratio in Poland is lower than the European Union average. According to OECD figures, the EU average is 4 years higher than the Polish rate for the population as a whole, with almost 3 years difference in the case of women and more than 5 in the case of men. In 2002 only five European countries recorded a lower figure than Poland. All of them have since become EU member states.

The life expectancy ratio does not give a full picture of the real health condition of the population. An actual increase in life expectancy can be accompanied by an increased burden of diseases, disability and indeed, a qualitative deterioration of the extended life. This is why, in line with WHO suggestions, we have applied the adjusted LE indicator called HALE (health adjustment life expectancy), which describes the number of expected years of life in full health. It combines information on life expectancy with that on a population's quality of health. The HALE indicator for Poland was equal to 65.8 years in 2002, meaning that it was 8.5 years lower than the LE indicator. This means that life in full health is notably shorter than overall life. With such a HALE value, Poland ranks low among EU countries. Only Lithuania, Latvia, Estonia and Hungary have poorer ratios. The difference between Poland and the country with the highest HALE value in the European Union (Italy – 73.2 years) is more than 7 years. It should be noted, however, that a favourable tendency can be observed in the HALE figure, which over the period of two years (2000-2002) improved by 1.5 years.

Another indicator of clear improvement in the health condition of Poles is the dynamic decline in infant mortality rates. In the 1990s infant mortality per 1,000 live births decreased from a high level of 20 to a figure well below 10. This constitutes an improvement of more than 60%. However, compared to older EU member states, this figure still leaves much room for improvement, as the EU average is approximately 5. One of the main risk factors for child mortality in Poland is low birth weight.

A fundamental health problem in Poland is that of the high morbidity and mortality rates associated with diseases of the circulatory system, coronary ischemic diseases and cerebral

Figure 2. Infant mortality rate – per 1,000 live births.



Source: based on GUS data, Demographic Yearbook 2002

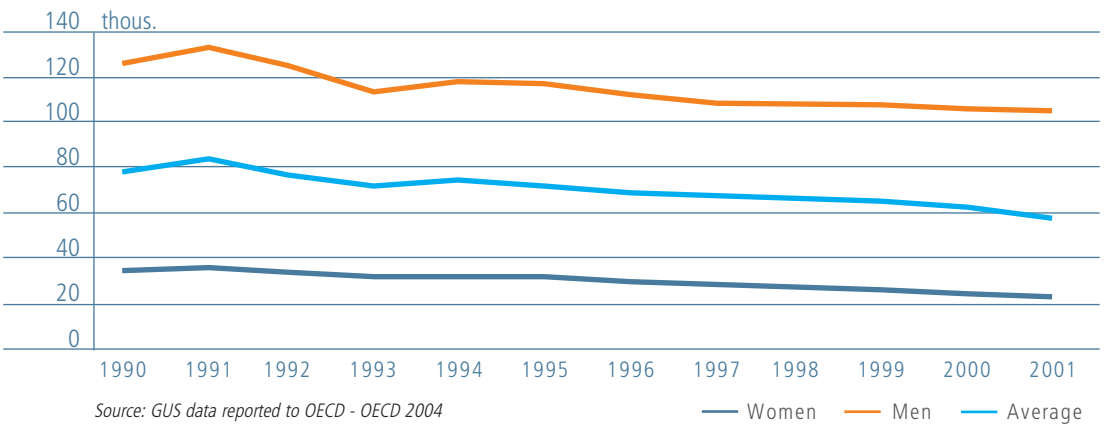
vessel diseases. The standardized ratio of circulatory disease mortality had been rising at the beginning of the 1990s (re: the transformation crisis), but since then, a clear downward trend is visible. Over the period of 1990-2001 mortality among women declined by more than 25% and among men by more than 28%. Despite this declining trend, the mortality rate associated with these diseases is notably higher in Poland than in other EU countries. Circulatory diseases still constitute the main cause of hospitalizations and in-patient care, with a steadily increasing trend observed in this regard.

The second leading cause of death in Poland, after circulatory diseases, is that of malignant tumours. Unlike circulatory diseases, the number of deaths caused by malignant tumours has not shown a declining tendency since 1990. In the first decade of the 21st century we have even observed an increase. The level of mortality caused by malignant tumours is higher in Poland than in the older EU countries, but this difference is not as large as in the case of circulatory diseases. Poland is one of the countries with the highest uterine cancer morbidity and mortality rates in Europe. In most EU countries, the situation in this regard has improved significantly in recent years thanks to early diagnostics. In Poland, however, preventive examinations and early diagnosis of carcinomas have been glaringly neglected.

The third leading cause of death is that of "external cause", namely, accidents, injuries, poisonings and suicides. The overall mortality rate due to these causes declined by some 25% in the 1990s. External causes constitute an incomparably greater threat to the lives of men than women. As Figure 3 demonstrates, the differences between the sexes in this regard are very pronounced. The mortality rate per 100,000 persons is almost four times lower for women than for men (26.7 for women, 95 for men). Road accidents are the most significant of all external causes of death, accounting for more than 25% of such cases.

Despite a clear downward tendency observed over the past few years, mortality rates due to so-called external causes are still much higher in Poland than in the older EU member states. In 1999, the standardized ratio for Poland was almost 15 deaths per 100,000 higher than the EU average.

Figure 3. Indicator of deaths due to external causes per 100,000 persons.

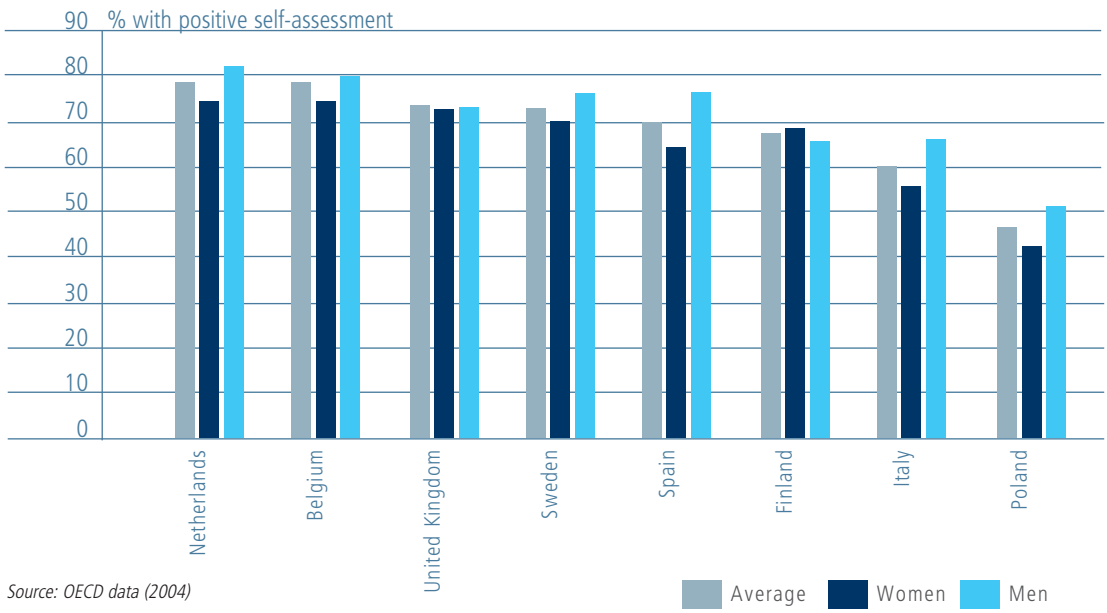


Source: GUS data reported to OECD - OECD 2004

Aside from the objective indicators of the health status of the population (such as life expectancy, mortality and morbidity rates), increasing significance is also attributed to subjective measures, such as self-assessments of the state of public health. Although the self-assessment of health in Poland is lower than in the pre-2004 EU countries, the overall tendency is positive. During 1996-2001, 6% of men and 5% of women assessed their health as being better (Figure 4). Just as in most countries, Polish men assess their own health more favourably than do Polish women.

The positive tendencies in the Polish population's overall health status are accompanied by an intensification of new phenomena that notably worsen the quality of life. This includes the spread of mental illnesses and of disabilities associated with both the process of the population's ageing and the difficult situation on the labour market (disability motivated by disability benefit entitlement). This is a significant challenge for Poland's health care policies and health care system a whole, as indeed it is for the functioning of the entire social policy system

Figure 4. Self-assessment of health in selected EU countries and in Poland



Source: OECD data (2004)

2. The structural organization of the health care system in Poland

Over the past five years, the health care system has twice been subjected to radical changes: in 1999 and in 2003 (see Chapter 2). In 1999 health insurance was introduced in place of budget (general taxation) financing, complemented by a system of regional health funds and so-called internal market principles (see Chapter 2). For four years (1999-2002), the health care system operated according to those principles in the face of mass-scale criticism on the part of medical communities, patients and opposition politicians. In 2000 the latter declared that the system would be changed. And that is what they did after assuming power in the fall of 2001. Although the reformed system's problems were being gradually overcome and the new organizational system was slowly falling into place, in 2003 the health funds were abolished and payer functions centralized with the creation of a central fund – the National Health Fund (NFZ) and its 16 branches in Poland's respective voivodeships (provinces).

The NFZ was created as an extra-budgetary entity of public finances. Such extra-budgetary entities are criticized in Poland, as they are not subject to the same principles of financial management as the central budget is. Management in these funds frequently lacks transparency. The transferring of such funds to the ministries responsible fosters less than smooth management and poor efficiency. Such criticism could also fall on the NFZ, although the Law on Health Care Services Financed with Public Funds of August 27, 2004[1] did establish the Finance and Health Ministers as supervisors of the fund, and clearly defined the relevant competences and responsibility. However, in the latter case, relations with the NFZ remain quite tense.

The activities of the NFZ have caused numerous problems since its creation, including conflicts over responsibilities, the lack of appropriate management tools, and above all the shortage of funds. As a result, the NFZ has been subject to no less criticism than the earlier health funds. The heads of the institution have been appointed and dismissed at a dizzying rate.[2] The election programme of the largest opposition party currently envisages such far-reaching measures as the abolishment of the NFZ. If this proposal was to be treated seriously, there would be reason to fear yet another organizational revolution in health care. This is not a good idea; rather, the NFZ should be strengthened with instruments of effective management over the funds it has at its disposal and gradually decentralized to the regional branch level, but not abolished. Such an institution is necessary to perform allocation and coordination functions[3].

The diagram below presents the organizational picture of the health care system in Poland. The main managers in the system are the Health Ministry (the body responsible for health care policy, and the coordination of activities and medical supervision) and the National Health Fund, the so-called "payer body", which has regional branches.

The position of local governments in the health care system deserves some attention, as they perform the role of "founding bodies" for some 85% of health care centres in Poland. This function implies responsibility for the creation and liquidation of units and for the development of its assets (investments). In addition, local governments have been assigned responsibility for catering to the health care needs of their communities, a task which is too tall an order, considering their real potential (limited funds and lack of competent staff).[4] Municipalities are responsible for basic health care, districts for third reference tier hospital care, and the voivodeships for second tier hospital care. The Health Ministry is

[1] *Dz.U. 2004 Nr 210, par. 2135*

[2] *Over a period of two years the institution had 5 different heads.*

[3] *Patients funds felt the need for an institution that would perform coordination functions and on their own initiative created the National Union of Patients Funds (KZKCh), which was supposed to support them as concerns information and tools. This need was underrated at the time.*

[4] *These problems are pointed out in research studies by Golinowska et al 2002*

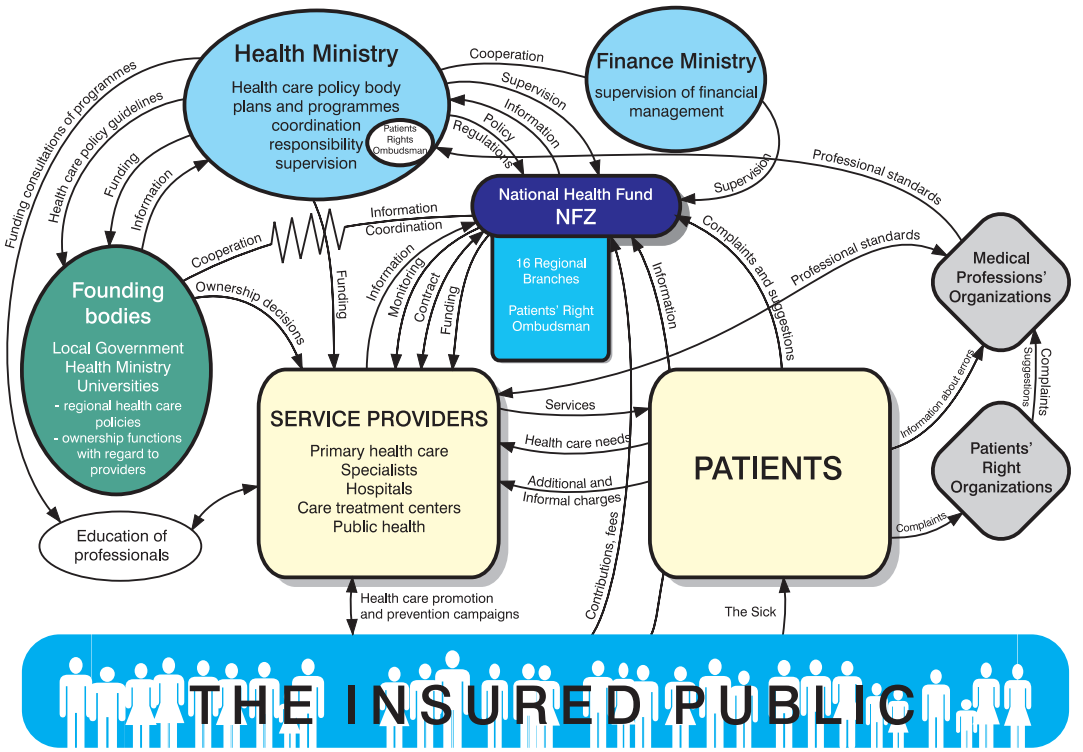
the founding body for national units and institutes (such as the Mother and Child Institute, the Oncology Institute, and the Food and Nourishment Institute).

Another notable organizational feature of the current system, is the independence of health care units, which were introduced before 1999. These units, called "sp zoz" (independent public health care units), obtained significant independence in decision-making concerning microeconomic management based on funds obtained from NFZ via contracts signed with the Fund for the provision of health care services. In a situation of the limited standardization of health care services, lack of medical treatment guidelines and a very low level of financing, the independence of health care units tends to lead to ad hoc decision-making and rising indebtedness, rather than rational management.

There are both public, as well as non-public health care units among providers. The already developed private sector is mainly present in basic health care and specialist outpatient services. Around 60% of outpatient units have private ownership status, and 56% of outpatient services provided take place in private units (data for 2002 – GUS 2003, p. 289). Meanwhile, hospital care is dominated by public units.

Private units are financed not only through purchases of health care services by individuals, for they also have contracts with the NFZ. Based on data collected as part of the work on the "Green Book" for health care financing, it has been estimated that the value of contracts signed with non-public sp zoz exceeded 20%, while in the Wielkopolskie voivodeship, where privatization of basic health care has progressed the furthest, it exceeded 30%.

Health care system from 2003.



3. Staff and the material resources of the health care system

There are contradictory opinions regarding the state of resources in health care. It is usually believed that staff resources are excessive. However, the number of doctors in Poland is relatively low (an average of 22 doctors per 10,000 inhabitants) and in terms of the number of dentists, Poland ranks last in the enlarged EU. Since 1996 the number of dentists in Poland has declined by almost 50%. Meanwhile, the number of pharmacists increased the most in that period: from 4 per 10,000 people in 1990 to 5.7 in 2000. (table 1).

The concentration of nursing staff is also low (table 1). This is not a problem unique to Poland, but rather one that has been encumbering developed countries for quite some time. The reason for this goes deeper than the insufficient reaction of the education system to the increase in demand for the services of this professional group, for we must also consider the nursing profession's comparatively difficult working conditions and low salaries, as well as limited opportunities for professional development it offers (Peltier, Schiborowski, Nill 2004). Numerous medical reports indicate that the deficit of medical staff could very soon become the most serious threat to the quality of medical care. In response to this threat, many countries are undertaking steps to encourage a greater number of candidates to train for the nursing profession, and are devising new concepts for managing medical staff that would make the profession more attractive, both in financial terms, and in career opportunities. The level of the employment of nurses in Poland (per 10,000 residents) is only 50% of the EU's average figure, with a continued downward trend (since 1996 by more than 10%). The decline in the employment of nurses has particularly affected the public sector – and indeed, more acutely than the authors of the 1999 reform envisaged when drafting their employment restructuring plan. At the same time, the decline in employment has been accompanied by a radical reduction of education opportunities in the various branches of the nursing profession. Between 1994 and 2000 the number of graduates of nursing schools declined seven-fold (from around 14,000 to around 2000 persons). Urged by a 2002 report by EU experts that warned Poland about the negative consequences of further decline in the education of nurses, in 2003 the authorities took measures to promote a quantitative and qualitative improvement in the education of nurses (Kózka 2004).

Table 1. Staff resources per 10,000 residents

Country	Practicing doctors per 10,000 residents in 2002	Practicing dentists per 10,000 residents in 2002	Nurses per 10,000 residents in 2002
Austria	33	5	93
Belgium	39	8	56
Denmark	34	9	97
Finland	31	9	90
France	33	7	72
Germany	33	8	99
Greece	45 (2001)	1.2	40 (2000)
Ireland	24	5	153
Italy	44	5	54
Luxembourg	26	6.1	–
Netherlands	32	5	128
Norway	34	8	104
Portugal	32	5	38
Spain	33	5	71
Sweden	30 (2000)	9	88
United Kingdom	21	4.0 *(only the National Health Service)*	92
Czech Republic	**35**	**7**	**94**
Hungary	**32**	**5**	**85**
Slovakia	**36**	**7**	**71**
Poland	**22**	**3**	**49**

Source: authors' compilation based on OECD database (Health Data 2004)

The former socialist countries still have a sizeable hospital base, larger than that of the older EU countries. This is the legacy of a health care doctrine in which the hospital played the central role in the health service system. The consequence of this was the underdevelopment of basic health care units and an oversized hospital network. Since the late 1990s significant changes have taken place in this regard.

Table 2. Hospital beds and average length of stay

Country	Hospital beds per 1,000 residents (serious cases)		Average length of stay (ALOS), days	
	1990	2002	1990	2002
Austria	7.1	6.1	9.3	6.0
Belgium	4.9	4.7 (1995)		8.0 (1999)
Denmark	4.1	3.4	6.4	3.7
Finland	4.3	2.4	7.0	4.3
France	5.2	4.0	7.0	5.7
Germany		9.0	16.7	11.6
Greece	4.0	4.0 (2000)	7.5	6.3 (1999)
Ireland	3.3	3.0	6.7	6.5
Italy	6.2	4.6	9.5 (1991)	6.9
Korea	2.7	5.7	12.0	11.0
Luxembourg	6.8	5.8	11.0	7.6
Netherlands	4.3	3.5 (2000)	11.2	8.6
Norway	3.8	3.1	7.8	5.7
Portugal	3.4	3.2	8.4	7.3
Spain	3.3	2.8 (2000)	9.6	7.1 (2000)
Sweden	4.1	2.4 (2000)	6.5	4.8
Switzerland	6.5	3.9	13.4	9.2
Turkey	2.0	2.1	6.0	5.2
USA	3.7	2.9	7.3	5.7
United Kingdom	2.8	3.9	5.9	6.9
Czech Republic	8.5	6.6	12.0	8.3
Hungary	7.1	5.9	9.9	9.9
Slovakia		5.5		7.8
Poland	6.3	4.6	12.5	~8.0

Source: OECD database for the years 2003 and 2004, estimates for Poland

Basic health care services have expanded in Poland together with the introduction of general practitioners, and the number of hospital beds per 1.000 residents has declined. Indicators of the duration of hospital-stays, called the average length of stay (ALOS) also improved, yet they remain quite high, which fact indicates room for improvement (table 2).

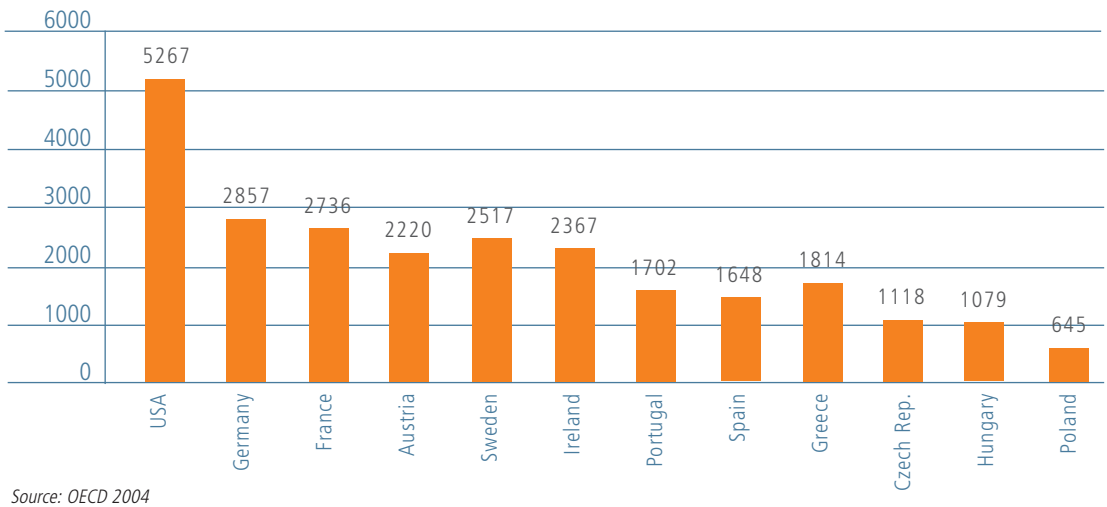
4. The financing of the health care system

It is estimated that total outlays on health care in Poland exceed 6% of GDP (in 2003 – 6.3% of GDP). This is a low level of financing, one of the lowest among OECD countries. Only Mexico and Slovakia have a ratio to GDP quite as low. The level of spending on health care is also measured by per capita indicators of absolute spending totals measured in purchasing power parity (PPP) in USD (Figure 6).

The main reason behind the low level of overall expenditure on health care in Poland is the low level of public spending in this area. Expenditure has not increased in real terms since 1996, with the single exception is 1998, when funds increased slightly due to the anticipated thoroughgoing reform of the system (introduced in 1999). The debts of health care units were therefore written off, investment purchases made "in advance", etc.

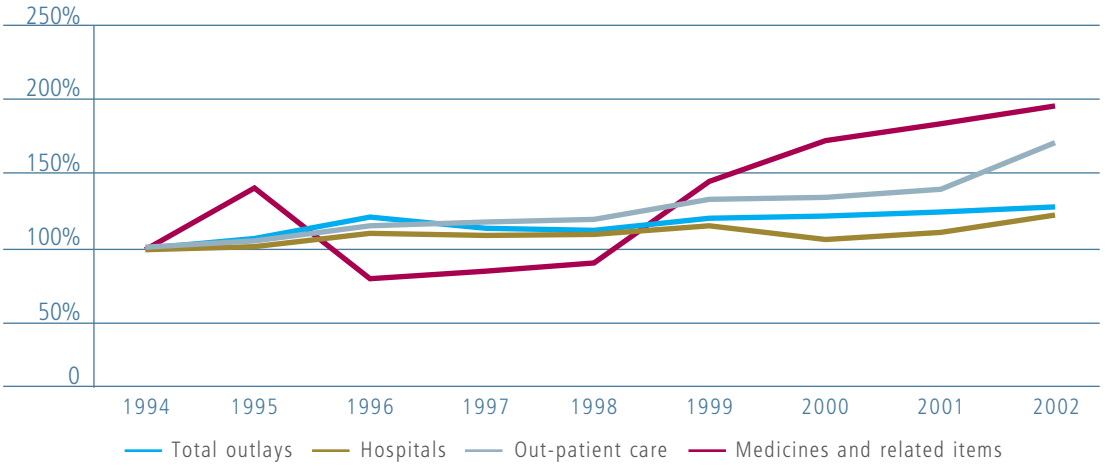
If we evaluate the real growth of public expenditure based on an index of prices in health care (which in the period analyzed was higher than the consumer price index), we will see that there was no increase in real terms. This means that the amount of funds in the public health care sector did not increase. Meanwhile, if we look at the structure of expenditures, there is a clear upward trend in spending on medicines that began in 1998. Spending on outpatient care was also rising faster than overall expenditures. However, real spending on hospital care did not increase, despite a significant increase in hospital stays from 1999.

Figure 6. Total outlays on health care in selected OECD countries in per capita PPP USD in 2002



Source: OECD 2004

Figure 7. Public outlays on health care in 1994 constant prices



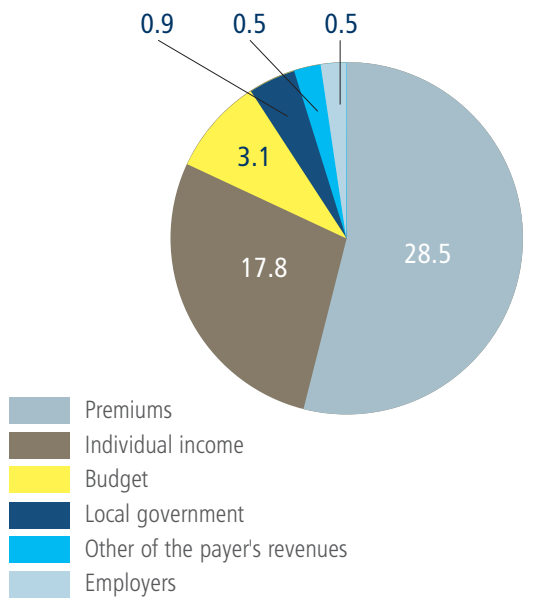
Source: author's calculations based on Finance Ministry data (acc. to COFOG classification)

Meanwhile, expenditures on health care from individual incomes, both of households as well as companies, increased. Based on data from a modular household survey, GUS estimates that households are already financing 35% of the health care system in Poland. This is a substantial figure, ranking Poland high among EU countries in this regard.

Figure 8 depicts the structure of outlays on health care. One quite surprising feature of this structure is the low share of local governments (JST), which, as we have noted, perform the function of founding bodies of health care units and which bear the responsibility for the financing of developmental investments. However, the resources of local governments, particularly at the district (powiat) level, are insufficient to perform such a responsible function, all the more so as health care is not a priority objective in the spending decisions of local governments.

A significant feature of the difficult financial situation is the system's imbalance. Costs are notably higher than revenues, in result of which health care units are constantly accumulating debt. The indebtedness of the health care system has

Figure 8. Structure of outlays on health care in 2003, in billions PLN



Source: based on Health Ministry data for 2004 - the Green Book for health care financing

already exceeded 10% of its total revenues. The costs of debt servicing increased significantly in 2004.

Health care units are providing more health care services than the value of their contracts with NFZ stipulates. This is because the Constitution still guarantees unconditional access to health care services in the case of the threat to health and life, while at the same time these services are being limited and those performed above the plan, i.e., the contract with the NFZ, are not being paid for. At the same time, there is a sizeable discrepancy between the rates (prices) for services in the contract and the actual costs of providing services. Moreover, in the context in which health care units are largely independent and where supervisory bodies have been abolished with the closing of patients' funds, the cost-control system is insufficient.

The results of the imbalance are also reflected in the deterioration of infrastructure and technical and medical equipment, and in the case of underpaying medical staff. This fact compels medical employees to obtain income from additional jobs (on average, doctors have two jobs). This of course happens at the expense of the quality of medical services and involves significant effort, effort resulting in the lack of time to upgrade professional skills and in the pursuit of entrepreneurial activity for the benefit of "their own health care unit". A doctor working several jobs often treats his or her primary employer in an exploitative manner and does not identify with the employer's interests. In addition, the underpaying of medical staff breeds corruption.

Conclusions

The health of the Polish population is systematically improving, although health indicators still significantly lag behind those of the older EU countries. This positive development observed in Poland over the past years is the result of increased consumption on the part of the population (as well as of an improvement in the structure of consumption), a change in lifestyle, and improving ecological standards.

However, the functioning of the health care system, aimed at treating the sick, has left much to be desired. The system was twice subjected to major organizational reforms, with the level of public financing, however, remaining unchanged. These changes engendered significant difficulties in the current functioning of the system, ones that have led to the frustration of medical staff (including protests and strikes) and to increased public anxiety about the provision of health care.

A significant feature of the new situation is the considerable extent of the privatization of the sector of health care providers, despite underdeveloped institutional solutions for cofinancing by patients. Households are already participating in the financing of the health care sector to a significant extent (more than 1/3). Their funds are mainly used to purchase medicines, make "informal payments" to medical staff, and, to a lesser extent, to pay for private health care services, mainly dental.

In view of the mounting difficulties, the health care system is facing the need for another major overhaul. The failures experienced thus far do not encourage additional changes. Particularly since any such changes will have to fit in the space between rationing (defining the public – i.e., guaranteed – scope of services) and rationalization, meaning control of costs (or, to put it more bluntly, 'stifling of costs'), especially as regards pharmaceuticals. Such reforms are not likely to be popular, and hence politicians will not leap to undertake them. At the same time, the current, extremely low level of financing investment and salaries in the health care sector appears unsustainable.

At the end of the decade, Poland will be entering a phase of the significant increase in the share of senior citizens in the population. The post-war demographic high (those born between 1946 and 1956) will be turning 60 in the years 2006-2016. This means a major increase in health care needs, implying a significant hike in health care requirements. Another plan for raising health care contributions will be necessary, meaning an even greater need for reforms and improving the efficiency of the system, both as regards medical results, as well as cost efficiency. The failure to carry out such changes, particularly with regard to the increase in health care needs, would result in excessive financing requirements.

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