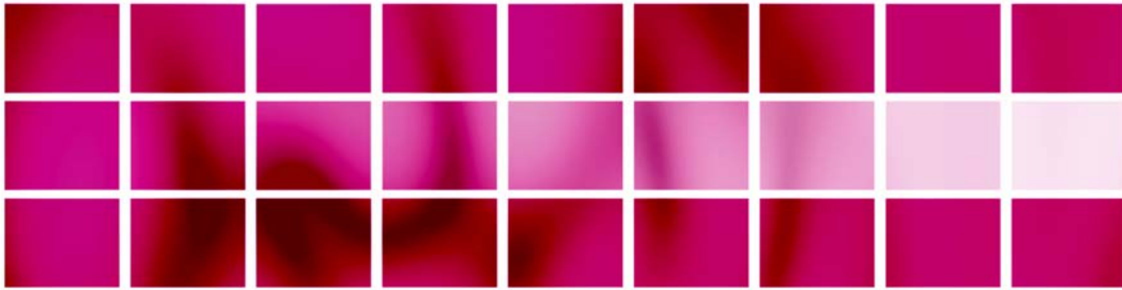

PRIVATISATION OF PUBLIC SERVICES AND THE IMPACT ON QUALITY, EMPLOYMENT AND PRODUCTIVITY (PIQUE)

Liberalisation, privatisation and regulation in the Polish healthcare sector/hospitals

Professor dr hab. Wieslawa Kozek, Institute of Sociology, Warsaw University

Country report on liberalisation and privatisation processes and forms of regulation

The project "Privatisation of Public Services and the Impact on Quality, Employment and Productivity" (CIT5-2006-028478) is funded by the European Commission's 6th Framework programme.

November 2006

Human Resources and Labor Relations Unit
Institute of Sociology, Warsaw University
Karowa Street 18, Warszawa, Poland
Tel: + 48 22 5520706, Fax: + 48 22 278599
For PIQUE: w.kozek@is.uw.edu.pl, www.is.uw.edu.pl

CONTENT

INTRODUCTION 1

1. MARKET STRUCTURE 3

1.1. Market structure before liberalisation 3

1.2. Processes of liberalisation and privatisation: Steps and processes 4

1.2.1. Hospitals in focus 6

1.2.2. Privatisation 7

1.3. Current market structure and remaining challenges 9

1.3.1. Hospitals in focus 10

1.4. Conclusion 11

2. REGULATIONS 12

2.1. Instruments: hospitals in focus 12

2.2. Problems 18

2.3. Conclusion 19

3. ACTORS/OWNERSHIP 20

4. ROLE OF GEOVERNMENT AND OTHER STAKEHOLDERS 22

4.1. Role of government 22

4.2. Other stakeholders 23

4.3. Conflicts 25

5. CONCLUSION 25

6. REFERENCES 27

LIST OF TABLES

Table 1: *Market structure before and after the process of liberalisation* 3
Table 2: *Private and public hospitals in Poland* 4
Table 3: *Public and private medical institutions between 2000 and 2004 in Poland* 7
Table 4: *The structure of expenses on health care according to sources of financing in 1999 and 2003* 9
Table 5: *Health care services providers* 10
Table 6: *Type of public hospitals* 10
Table 7: *Number of public hospitals by reference type for the year 2002* 11
Table 8: *Instruments of the regulation* 17
Table 9: *Main actors of the regulation* 17

INTRODUCTION

It is assumed in the Report that liberalisation in the healthcare services sector began in 1999. The demarcation is obviously very conventional since the expansion of commercial services has been taking place since the beginning of the 1990s. In 1999 budgeting of all healthcare services was abandoned in exchange for financing from health insurance contributions while budgeting was reserved for special services.

Before 1989 health services had in principle been provided by state institutions: clinics, hospitals, sanatoria (health resort treatment institutions), etc. This was a consequence of the fact that in the 1950s such institutions – even these which before the war belonged to religious and other voluntary associations – had been taken over by the state. Over time the state created new public entities and provided them with buildings, equipment and other devices as well as employees. All of that happened in the context of socialist propaganda about working class people's broad access to health care. However even before 1989 next to services offered by the public health care sector medical cooperatives and individual medical practices always existed. Their quantity was licensed by the state, however those who were better off could always officially buy the private services of doctors and nurses. It was and still is the prevailing opinion in Poland that health services obtained on a private basis are of a better quality.

Interpreters of the health care sector consider these services as one of the pillars of the welfare state until the collapse of the socialist system in 1989. The health care sector offered broad access to health services, but one has to bear in mind that these services were of a rather low quality and budgetary allocations for health were relatively low.

Poles spend 6% of GDP on health care, whereof some estimations based on questionnaire surveys quote that as much as 39% of this amount goes to charges paid to private health care providers and bribes handed over in public entities. Research dedicated to the evaluation of the accessibility of health services shows that 55% of patients seek out private practitioners while 20% use private diagnostic examinations. Moreover, from these studies it is known that even while staying in a public hospital patients purchase medicines (41%), pay for better care during their stay in hospital (41%), hand in so called 'tokens of gratitude' (37%), pay for better conditions of their stay (9%), pay for execution of surgery (28%) and for a shortening of the waiting time for medical operations (10%) as well as make payments for night duty service (10%) (Pączkowska, 2006). In effect market there are a lot of private resources on the medical services, which are not being spent in line with market regulations.

Medical circles estimate public expenses on health care protection as inadequate and believe they cannot ensure a good quality of medical treatment. When necessary medical groups mobilise and exert pressure on decision-makers, including the Lower House of Parliament (Sejm). Such pressure is getting more frequently based on collective actions supported by institutions of organised interests.

The dissatisfaction of patients and medical circles has remained steady for many years, regardless of the fact that reforms in the health care sector are undertaken constantly as well. However, politicians of all hues have been afraid to clearly express the opinion that not all of the most advanced treatment methods can be financed by public resources. Moreover, they are not able to win people over for more radical changes.

Public health care is perceived as the last remaining relic of the socialist society in the version present before 1989. Over the last fifteen years Poles have gone through many changes leading towards market society. During all this time, their sense of safety has been decreasing, yet the feeling of safety in case of illness has not been shaken as radically as other spheres were. So far areas that have undergone reforms towards a market system are pensions, partly education, the labour market as well as the industry and non-public services. The economy has been privatised, with only the biggest companies remaining in the hands of the State Treasury. However, these radical reforms have not affected health care.

In fact, the major change in health care lies in the gradual acceptance of the conviction that the range and quality of health care depend to a large extent on funds coming from aggregated insurance fees. To do so, however, first of all the decision has to be taken to create an additional voluntary health insurance system. Furthermore, this might also be the keystone to include the costs of such insurance as a tax allowance.

New regulations of the health services sector have been introduced quite continuously from the 1980s. Intense acceleration followed in 1999 along with the introduction of *sickness funds* similar to the German model. Liberalisation meant that the budgeting of health care services was replaced with an insurance model of financing. The *sickness funds* of each region had at their disposal the financial contributions of people insured in the area. They contracted services and controlled their performance. The system of contracting consisted of public calls for tender and final confidential negotiations in the second phase of contracting. Contracting was addressed on an equal basis to public and private entities.

In fact the greatest step towards a market system of providing health care services took place in primary care while, to a lesser extent, such a process happened in specialised treatment and hospital care. Hospitals especially felt the diminution of the financial stream, while primary care physicians (called family physicians at first) were the ones who benefited most from the financial advantages of this change.

The transformation of the *sickness funds* into the National Health Fund system in 2003 did not change the idea of liberalisation as such. Thus, liberalisation continued to reflect a withdrawal from budgeting towards insurance contributions as a source of financing and a system of contracting services addressing both the public and the private sector. Improvements were introduced to the system as problems with gaps were arising. This improvement is based on a pattern of gradual formalisation (pin-pointing) which causes the need for further formalisation and, in effect, creates a loop of bureaucratisation. This tendency is weakened by the substantial conditions of some formalisations, since units consisting of medical professionals in fact take decisions upon them.

It seems that nowadays the insurance model and the idea of contracting services via such system has become assimilated and accepted. Postulates of medical circles have led towards an increase of insurance contributions calculated on the basis of an individual's income. However, this explicitly contradicts the postulate of reducing the non-wage costs of labour endorsed by business circles.

1. MARKET STRUCTURE

1.1. Market structure before liberalisation

Since 1972 access to health care had been provided by the public health care institutions (Zespoly Opieki Zdrowotnej – ZOZ). A ZOZ usually consisted of a hospital, a primary care and specialized care unit as well as partly social care. Since 1983 the public health care institutions (ZOZ), which previously depended on the Ministry of Health became strongly administratively dependent on regional authorities and obtained decisive competencies in relation to subordinated hospitals and care units.

Estimations concerning the share of private health care services (except for hospital care) in comparison with public care concerning the period before 1999 are very difficult to judge if official data are taken as a source of information. It is known that health care was dominated by public entities while the share of medical cooperatives was relatively low and private services remained on a marginal level (see Table 1).

Table 1: Market structure before and after the process of liberalisation (out-patient health care institutions, excluding hospitals)

	Before the process of liberalisation 1991	After the process of liberalisation 2000
Public health care institutions	93.5%	73.3%
Cooperatives	6.12%	4.99%
Private institutions	0.38%	21.80%

Source: Statistical Yearbook of the Republic of Poland (1995, 2001), GUS, Warszawa.

In the hospital care sector only public hospitals were present (Table 2). They remained in government hands and were entirely financed by the state. The number of hospitals constantly grew. This increase can be explained by aspirations of administrative authorities making efforts to create local hospitals in their area. This was true especially from mid 1970s when 49 voivodships had been created in Poland. Voivodship authorities aspired to create large hospitals at voivodship level and smaller regional ones, so that average hospital could serve inhabitants of the area within a radius not bigger than 50 kilometres.

Table 2: Private and public hospitals in Poland

Type	1990	1995	2000	2004
	Before liberalisation		After liberalisation	
Public	100%	98.7%	96.0%	84.3%
Private	-	1.3%	4.0%	15.6%
N	677	714	746	937

Source: Statistical Yearbook of the Republic of Poland (2001, 2005), GUS, Warszawa.

1.2. Processes of liberalisation and privatisation: Steps and processes

The health care sector in Poland has been and remains until now under strong government influence. At present, after fifteen years of the market economy in Poland getting strengthened, the health care sector is still under government control since currently the government has firm control over the health insurance system. The gradual process of transferring the health care services sector into a market system started fifteen years ago as well, though its is more univocal to take 1999 and the introduction of sickness funds as a demarcation line. The *sickness funds* were allowed to contract services also with private health care institutions as far as they met the required conditions and offered cheaper service costs. Furthermore, in 1999 purchasing procedures regarding health care services were introduced and since those procedures were based on parameters it meant that "the manual steering" was consequently abandoned.

From 1990 to 1997, a both hidden and evident commercialisation of part of the health care services took place. First came the mass privatisation of pharmacies on the basis of the *Freedom of economic activity Act* (1989). Then payment for health services started to be carried into effect. Alongside hospitals, clinics and health centres set up foundations or voluntary associations which accepted charges for performing better quality or difficult to access services.

By virtue of a government ordinance to the *Budgetary Act* (1991), hospitals and other health care units began to collect charges from patients outside their catchment area. Moreover, health care institutions began to exert pressure on patients and their families to purchase so-called 'shares' predestined for the needs of the unit.

These changes led to a growth of out-of-pocket expenses of patients spent on medical services, irrelative of better treatment. Likewise, people's expenses and budget expenditure on medicines grew in relation with an inflow of more expensive foreign medicines onto the Polish market. The same effect began to appear with reference to medical equipment.

From the beginning of the systemic changes taking place in Poland there was a visible need for changes in the health care services, which grew more intense over time. Debates upon this issue started at the beginning of the 1990s both in medical circles as well as in political debates. After all, radical market ideas were not executed, mostly due to the prevailing opinion about the low social acceptance of such projects. Major projects – created mostly outside medical circles – oscillated between German concepts of insurance and concepts of British public health care after their reform. More radical ideas of privatisation or commercialisation were never submitted (Golinowska, 2000).

The past and present discussions stem from common discontent with the state health care system. Every actor of the contemporary system has had reason to be dissatisfied and to search for a solution of the problem. The Ministry of Health was conscious of the fact that the budgetary financing of integrated health care institutions (ZOZs) resulted in an ineffective usage of allocated funds, contributed to excessive investment ambitions on the part of the ZOZs, to purchases of idle medical equipment and to overemployment. Moreover, it was associated with the indebtedness of the ZOZs as well as many pathologies related to the reimbursement of medicines, corruption and a decline of accessibility to treatment, including a decrease in the quality of medical care. Patients were dissatisfied because in spite of increased expenditures they did not experience greater accessibility to health care services or an improvement of their quality. On the contrary, it seemed as if the health care system was sinking into chaos and medical circles were becoming corrupted and pauperised while the traditional ethos of doctors and nurses walked off into non-existence vanish. Patients complained about the quality of the work of medical staff and, especially, about doctors working in several places (e.g. hospital, private clinic and emergency ambulance service simultaneously). Doctors and nurses believed that the state administration was limiting health care expenses on purpose, making the treatment of patients impossible and causing a decline of earnings in the sector. Moreover, medical specialists did not want a reform of the health care system that would make them lose status, including financial advantages, for the benefit of family practitioners or primary care physicians. The public administration was confronted with a growing avalanche of medical units' debts and could not find a method to limit them. Organised pressure exerted by doctors and nurses via the trade unions as well as medical and nurses' chambers also created problems for politicians and the administration. This pressure meant that medical circles can effectively demand an increase in state budget expenses allocated to health care. Information about corruption, mismanagement and the abuse of patients' constitutional rights were presented in the press, radio and television. By the same token critical opinions concerning poor managerial skills were given to managers of public units (mostly doctors).

The total expenditure on health as a share of GDP in Poland for the years from 1990 to 1997 stood at the level of other EU candidate countries at the time and was considerably lower than that of the richest EU countries. Such a level of financing ran against external pressure exerted by big European and global pharmaceutical companies as well as medical equipment providers which by all possible means tried to establish

themselves on the Polish pharmaceuticals, medical equipment and medical components market. Dumping prices, abusing their originally monopolist status and corrupting government officials and the managers of medical institutions were and still are common methods used by these companies. Such efforts found favourable conditions in the social climate of the medical circles, where people expect to grow rich or aspire to achieve relative wealth.

Failing to respond to these negative aspects would have been very irrational. Thus, as a result of the above mentioned debates, the Sejm (Lower House of the Parliament) passed the *Universal Health Insurance Act* and adopted a two-year *vacatio legis* period before its implementation. It was assumed that universal health insurance contributions would amount to as much as 11% tax from earnings and this assumption markedly satisfied medical circles. However, the government could not fulfil this promise over the time.

Poland has been a member of the European Union since 2004 and from 1993 was an associate country preparing for membership. However, the reform proposal passed in 1997 were not closely linked with these processes. It is clear that consecutive governments aimed at reaching budgetary equilibrium and efficiency of public expenses including health care expenditures. Regarding concepts of rationalising health care services, the inspirations and experiences of EU member states were looked upon. The results of reforms undertaken in neighbouring countries were important as well. This is particularly true for Czechoslovakia, which initially adopted a very market-oriented reform model, with evident negative consequences. This effectively frightened Polish politicians off such concept and as a result a model based on a more evolutional change was chosen.

1.2.1. Hospitals in focus

Since 1993 hospitals have been assigned to their funding body, i.e. to their legal owner. This public funding body could be:

a) the respective minister (hospitals of the Ministry of Health, the Ministry of Interior Affairs and Administration and the Ministry of National Defence),
b) and Medical Academies – academic hospitals,
c) self-government – voivodship – voivodship hospitals,
d) since 1998 – self-government at county level (starosta of district) – county hospitals.

In terms of the liberalisation of the market this was a certain progress since the management of hospitals benefited from decentralisation tendencies related to a strengthening of municipal administration. The state or municipal founding body had at their disposal money from the state budget allocated to the hospital. Furthermore, the founding body could provide additional financial support to a hospital, offer credit guarantees, appoint and dismiss managers as well as sell, declare bankrupt or liquidate the unit. In practice, the public founding body had limited direct influence on how the hospital was administered. This was a gap in the system, perhaps an intentional one.

Quite often hospital managers – either in bad or good faith – drove hospitals into debt by buying equipment, medicines, materials, services without the financial resources to cover such expenses and thereon taking advantage of postponed payment of bills. Such decisions were justified as essential for health needs.

1.2.2. Privatisation

The data presented in Table 2 show that the process of privatisation of Polish health care services accelerated at the beginning of the second half of the 1990s, even though changes had already started earlier. Certainly the new regulations as well as the liberal social and political climate, which led to entrepreneurial attitudes among employees (including health care staff as well), determined such a situation. For example, at the beginning of the 1990s, regulations in the health care sector remained almost the same as during the 1980s, while employees were already braver in undertaking work on their own. Religious associations and the Catholic Church took up efforts to reclaim hospitals nationalised after World War II but the retrieval process lasted long.

In the period between 1999 and 2005 some types of private medical institutions developed dynamically (see Table 3).

Table 3: Public and private medical institutions between 2000 and 2004 in Poland

Units	2000	2003	2004
Public hospitals	716	664	643
Non-public hospitals	38	103	147
Public health care institutions	4717	3575	3369
Non-public health care institutions	3471	8403	8732
Private medical practices	5080	7847	7675
Public pharmacies	579	73	22
Private pharmacies	7739	9512	9736

Source: Rocznik Statystyczny GUS 2002, 2004, 2005 (Statistical Yearbook).

The privatisation process in the sector has visibly been greatest in terms of pharmacies and primary care units offering services of primary care (so-called first contact physicians). The number of doctors offering private services, mostly specialised ones, has grown as well. However, hospitals do not show a propensity towards very quick privatisation. There are many reasons for these developments.

Pharmacies proved to be an easy and profitable business. Many new private factories have been established while the former monopolist on this market (that is CEFARM) remains as a chain of pharmacies. The high and still attractive profitability of pharmacies is based on surcharges to reimbursed drugs and the dynamics of the over-the-counter drugs and diet supplements market supported by heavy marketing activities. The growth of private non-public health care units was possible because many doctors (mostly

internal medicine doctors) were in a position to meet the requirements of the *sickness funds* and later on the National Health Fund in order to successfully submit a tender for contract for providing health care services. Bank credits, loans from families and private lenders as well as doctors' own resources allowed them to open private health care units. It is important to highlight the great number of doctors who decided they were in a position to run such a business individually or in a partnership. This kind of positive attitude might have been a consequence of the experiences they made in providing private medical services before 1989 as such services (offered via medical cooperatives and in private practices) were accepted by the public administration. The increase in services offered by private specialists outside National Health Fund contracts is also due to the formation of a growing middle class willing to use higher quality services without tiresome lines. Nevertheless, the low dynamics of this phenomenon results from the fact that the National Health Fund does not offer specialists prices of services comparable to commercial market rates (the difference is sometimes ten times).

Hospital services are not characterised by large dynamics but it has to be noted how great a financial and organisational effort is required in order to buy out a public hospital or create a new hospital from scratch. In general, municipal county hospitals are potentially beast suited to privatisation. Yet, these hospitals are not very susceptible to privatisation since the local self-governments on county (*powiat*) level are afraid of the local communities' reactions, such as organised protests, lost elections and protests of hospital employees. It is common for trade unions operating at hospitals to express their distrust to county officials (suspected of making attempts to sell hospitals cheaply to private investors). Very rare cases of privatisation of such hospitals took place when the hospital was probably about to declare bankruptcy and no alternative solution was found. Public hospitals (voivodship, ministerial, academic) offering specialised treatment are not regarded by their founding bodies and staff as entities which should be subject to privatisation at any time. Perhaps ideas to privatise public hospitals would take shape if National Health Fund financing was generous; in the present financing conditions, however, this is a very difficult 'business'. Current examples of such repurchased public hospitals include the *Pulmonology and Alergology Hospital* in Karpacz and the *Hospital of Lung Diseases and Oncology* in Szklarska Poreba.

As a result, private hospitals are mostly entities created from scratch. Most often these are established by:

a) religious associations, e.g. the hospitals established by the convent of the Brothers of St. John of God in Krakow and Lodz,
b) legal entities (companies, foundations, associations),
c) natural persons, mainly doctors.

Private hospitals are clearly specialised and most often dedicated to gynaecological and obstetrical care. Almost all of them make an effort to obtain a contract with the National Health Fund even though their collective representative body currently expresses the opinion that the Fund discriminates against private hospitals in favour of public ones. Nevertheless there are large network hospitals that do not participate in tendering for

public financing of services. These include, for example, the *Damian's Hospital* in Warsaw, the *Certus Poznań, Carolina Medical Center* in Warsaw. In medical circles, the view clearly dominates that private hospitals cannot perform more complex services (Walewski P, 2006).

The inflow of financial means to the medical services market is very important in order to estimate chances of privatisation. Health care services market expenditures in Poland indeed come from both public and private sources, even though the share of private expenses is quite high in comparison with European countries (Baran, Zyra 2006: 40). Expenses covered by private health insurance schemes, expenses of employers and households could be located in the private sector. In total, they amount to 30% of this market's value. The private sector can also effectively compete for public resources with the public sector since such formal rights are guaranteed. The basis for starting such competition is of course an evaluation of the benefits.

Table 4: The structure of expenses on health care according to sources of financing in 1999 and 2003

Expenditures	1999 at the beginning of liberalisation	2003 (currently)
Insurance funds	57.6 %	60.2%
Budget resources	13.6%	9.8%
Private insurance	0.4%	0.6%
Household expenses	26.6%	26.4%
Employers expenses	1.0%	2.3%
Non-profit institutions	0.8%	0.7%
Public in total	71.2%	70.0%
Private in total	28.8%	30.0%

Source: Baran, Zyra, (2006: 41).

1.3. *Current market structure and remaining challenges*

An analysis of the structure of expenses according to service providers shows that the medical services market is clearly divided into three segments: medicines, hospital services and out-patient health care:

Table 5: Health care services providers

Health care services expenditure according to providers of medical services	1999 (at the start of "liberalisation")	2003 (currently)
Hospitals	30.0%	28.1%
Out-patient health care	26.0%	26.9%
Medical articles	27.0%	33.1%
Public health care programs (e.g. preventive)	3.0%	2.9%
Long-term care	2.0%	1.3%
Others	12.0%	7.7%

Source: Baran, Zyra, 2006: 42.

1.3.1. Hospitals in focus

Table 6: Type of public hospitals

Type of hospital (not including psychiatric)	2003	2004
Non-public	103	147
Public	664	643
Including self–government units	609	589
Ministry of Health hospitals	55	54

Source: Centre of Data Systems of Health Care: www.mz.gov.pl.

Public hospitals are beginning to perceive the competition of non-public hospitals. Compared to 2003, in 2004 the number of private hospitals grew more than two-fold, and in 2004 the number of beds in private hospitals amounted to 4.8% of all beds.

Therefore "the market" of hospital services is still dominated by public hospitals (i.e. county, voivodship, ministerial and academic). In effect – though currently informally – hospitals have defined three referral levels. County hospitals are hospitals of the first reference level with four basic departments: internal medicine, surgery, paediatrics, obstetrics and gynaecology. Specialised voivodship hospitals are second referral level hospitals, which, in addition, offer specialised departments of cardiology, dermatology, oncology, urology and neurology. On the third referral level there are ministerial and academic hospitals offering highly specialised medical care provided by medical specialists.

Table 7: Number of public hospitals by reference type for the year 2002

Type	2002
Hospitals – first level of reference, county	429
Specialized hospitals – second level of reference-voivodship	231
Academic hospitals – third level of reference	57
Other hospitals (mostly ministerial) – third level of reference	22
Total number	739

Source: State Institute of Hygiene, www.pih.gov.pl.

According to the all-Polish Association of Non-public Hospitals, the number of non-public hospitals operating in Poland in 2006 is 160 (including 120 clinics). Clinics are smaller, with 50 to 100 beds. The remaining 40 hospitals are former public hospitals transformed into private hospitals through buy-outs (LUX MED, 2006).

1.4. Conclusion

An entirely free health care services market does not exist in Poland. Neither is it planned as such. The Constitution guarantees citizens the right to health care based on rules of equal access and social solidarity. The political elite is afraid of further commercialising services these days, due to possible social tensions. Private financing of health care services has reached a relatively high level. This refers least to hospital services. A further rapid growth of private financing would not be accepted socially, though some medical circles opt for it.

The Constitution warrants private providers of health care services equal treatment with public entities. If there were considerably more private entities, including hospitals, they would have to be treated equally in the procedure of contract negotiations since they would be able to exert greater collective pressure.

Private investors are revealing plans of creating new hospitals. According to these plans, over the next two years five huge hospitals (with 150 or more beds) would come into being in Warsaw. Managers of public hospitals are afraid that such new and modern hospitals might take over the most qualified medical staff, including doctors, hospital technicians and nurses, due to better working conditions offered.

Most entities in the health sector are public. This especially refers to hospitals. As a result, after fifteen years of introducing changes, the governmental agency (National Health Fund) in practice conducts negotiations over contracting health care services financed by insurance fees with public (i.e. mostly self-governmental) hospitals.

2. REGULATIONS

2.1. Instruments: hospitals in focus

Providers' access to the health care services market was and is strictly controlled on the basis of parliamentary bills. Before liberalisation, the Ministry of Health managed the register of Health Care Institutions and took decisions regarding the hospital network based on the proposals submitted. Public providers had to meet several criteria concerning premises and equipment as well as staff entitled to practice medical professions. Licences to establish a medical cooperative or run a private medical practice were limited to a given area.

In principle, health care services until 1999 had been financed by state budget, namely voivodship self-government budget and the Ministry of Health. These services covered almost all population groups (since 1972 also farmers leading private farms) on the rule of gratuitousness. Public health institutions received resources for their functioning according to annual plans prepared by the public administration. These plans were drawn up in a process of inter-institutional negotiations and lobbyist activities that were hidden from public opinion. The political power of the regional administration or the power of the industry in a given territory or even a single public enterprise played an important role in such negotiations. As a consequence new health care units were developed in industrialised regions, where staff of the preferred sections were employed in public enterprises (e.g. mining, metallurgy, heavy industry, machinery, chemical). In agricultural areas and small cities, the health care infrastructure was less developed and thus there was a lack of doctors and nurses.

Before 1999, hospitals, as other health care institutions, were financed by the budget. Decisions about the level of financing were taken by the public administration, i.e. were part of the competencies of the government and legislative authorities. Before After 1999, the Ministry of Health divided these resources for each voivodship whereas those where allocated for specific health care units that is mostly individual health care management units (ZOZ). Such subjective subsidies were allocated for activities of the entity.

In order to be allowed to provide health care services, hospitals had to comply with the conditions and medical standards of treatment defined by separate regulations. The most important include:

a) Law on medical chambers (associations), dated 1989,

b) Law on the self-government of nurses and midwives, dated 1991,

c) Law on rules of payment for medicines and sanitary ware, dated 1991,

d) Law on Health Care Institutions, dated 1991 with multiple amendments,

e) The Budgetary Act of 1993 (with particular importance),

f) Law on Nurse and Midwife Professions, 1996 with amendments,

g) Law on the Profession of Physicians, 1996 with amendments,

h) Law on the voivodship self-government, 1998,
i) Law on the county self-government, 1998,
j) Minister of Health Ordinance regarding requirements to be met by the premises and equipment of health care institutions, dated 1992.

Hospitals did not limit their financial expenses to budget funds allocated for a given period. In effect, they could buy equipment, external services and medicines on invoices with a postponed payment date. Thereon hospitals constantly ran into debts with the state budget continuously confronted with the problem of growing hospital debts. Hospital debts are a permanent problem. In the period between 1991 and 2006, the state treasury discharged public hospitals debts five times amounting to a total of 11 billion PLN (for the estimation of the scale: state budget expenditures for 2001 were about 151 billion PLN). Any effective means to prevent such indebtedness did not exist at the time.

In 1997, the Sejm adopted the *Law on Universal Health Insurance*, which implied that general health care services will be financed through insurance contributions and not the state budget. In reality, a mixed budgetary-insurance system has been adopted, since the budget financed various health policy programmes on a separate basis. Examples of budgetary financing include various health prevention programmes as well as the *Programme of Care for Mother and Child* providing services for pregnant women and children regardless of their insurance status.

Within this concept, the Ministry of Health had to monitor regulations, initiate necessary changes and elaborate drafts of new regulations. Some of these regulations can be prepared as ministerial ordinances but the most important ones are designed as parliamentary laws.

In 1999, the post-Solidarity coalition government started to implement a system of *sickness funds*. Sixteen regional *sickness funds* (one for each voivodship) and one *sickness fund* for the uniformed services was established. In March 2003, *sickness funds* covered 40.5 million people. Health care for uninsured had to be provided through budget financing. The role of the *sickness funds* was to contract medical services and supervise their execution. Services contracted by the *sickness funds* could also include those of private health care institutions. The *sickness funds* could not act for profit and neither could they provide health care services directly or possess medical institutions. Patients were free to chose place of treatment and *sickness fund.*

The *sickness funds* contracted health care services predominantly from within self-governmental health care institutions. However, already in the period from 1999 to 2002, in primary care (family doctors, first contact physicians) such contracts were more often signed with private institutions. The *sickness funds* prepared a schedule for contracting health care services. This schedule was slightly amended during a given accounting year. Services were contracted in following categories: primary health care, outpatient specialist care, hospital care, psychiatric care and treatment of addictions, medical rehabilitation, long-term care, dental care, health resort treatment, emergency services and sanitary transportation, prevention, supply of orthopaedic equipment,

auxiliary means and technical medical devices and reimbursement of expenses on medicines.

The *sickness funds* made purchases of detailed listed health care services for a clearly defined amount of money. It was emphasised that the new regulations meant that s*ickness funds* do not providing financing of hospitals but only buy certain services. Thus s*ickness funds* do not finance repairs, purchase of equipment or staff rewards but buy medical treatment, surgery or patients' stays in hospital. This was a major change, which met with strong resistance and criticism among medical staff. Hospital managers pointed out that such a financing system leads to re-entry into debt and that hospitals receive limited resources to treat patients according to the medical state of the art. Health care providers had to fulfil many conditions defined in different regulations in order to qualify to enter contract negotiations. Many laws concerning health care were amended in order to adapt them to the changed situation.

Some s*ickness funds* were better off, because they could dispose of the insurance contributions collected from higher earnings and larger working population in certain voivodships. Wealthier s*ickness funds* such as the Mazovian and Silesian fund or the s*ickness fund* dedicated to the uniformed services were able to contract more health care services and greater number of modern services.

The criticism of s*ickness funds* by the political Left led to the liquidation of the s*ickness funds* when the Left came into power. This happened in 2003 before s*ickness funds* became firmly established in institutional terms. At that time, the National Health Fund (later referred to as NHF (NFZ)) was founded.

The NHF (NFZ) is a central body with sixteen voivodship branches building on the foundation of the s*ickness funds.* The Fund is the incorporated state organisational entity with strictly appointed competencies in the area of health care. In effect this is public entity operates as a monopoly responsible for the financing and management of health care services. The NHF (NFZ) is subject to supervision by the ministers responsible for health and public finances. The NHF (NFZ) operates through the Fund Council, the President of the Fund as well as regional councils and presidents. These positions are appointed according to merit as well as the political affiliation of candidates.

In comparison with the system of *sickness funds*, the principle competencies of the NHF (NFZ) has not changed. The NHF (NFZ) exercises control over resources dedicated to health care services from such sources as insurance contributions, state budget allocations, subventions to communes, donations and legacies, credits and loans, etc. The NHF (NFZ) conducts negotiations with health care providers on an annual basis in order to book services of the scope and categories forecast for a specific area. Similarly, the Fund monitors the execution of services, including the quality of the services offered. The NHF (NFZ) is responsible for drawing up a National Plan of Health Services Delivery accepted by the Minister of Health. The Plan qualifies the level of financial expenditures and maximum prices for various types of service.

The *sickness funds* prepared analyses of health care services accomplished in the area and thus were able to work out the required ratio of services per 10 thousand inhabitants. The natural migration of patients outside their sickness fund area was taken into consideration. Identification codes were granted to health care institutions and to specific types of treatment, so that in future monitoring of demand trends for health care services would be possible. Historical trends were used to draw up the contracting plan for a given year.

This plan formed the basis for decisions made about the purchase of services including hospital services. Nevertheless, hospitals had a relatively strong bargaining power in negotiations with the *sickness funds* since such services in a given area could not be ontracted with other providers than existing hospitals. Hospitals have been able to maintain this status as competition from private hospitals is still limited.

The system of public tendering for health care services, including hospital care, has consequently been improved. All public hospitals take part in such calls for tender. It is important to note in this context that from a formal point of view public hospitals accept patients that are not simultaneously covered by an NHF (NFZ) contract and outside this system, i.e. privately. This is supposed to prevent abuse and fraud, e.g. of public hospitals collecting payment for a service from the patient and from NHF (NFZ) at the same time.

Private hospitals do not need to sign contracts for services with the National Health Fund. Therefore some do not do that but concentrate on providing health care services to companies and more wealthy private patients. In these cases private hospitals offer health care services based on binding law but are not obliged by regulations related to the contracting of services set by the NHF (NFZ).

The system of regulations set by the National Health Fund is based on competitive tendering. At the beginning, the National Health Fund draws up a National Plan of Health Services Delivery and Voivodship Plans of Health Services Delivery including hospital services for a given area (in a country and voivodship). The Plan considers the demand for services in relation with population features and experiences of previous years. Such a Plan is no doubt burdened with estimation errors. The fact that an insured patient is eligible to undergo treatment in any hospital within the country makes the Plan even more complicated. Invitations to competitive tender include the value of the subject of the proceeding. The NHF (NFZ) compiles a catalogue of hospital services, which, for 2005, included 1362 items.

Every service has its own code, value in points, conditions to be met in the performance of the service and additional remarks. The remarks might consider such details of the service as: possible obligation to conduct a service according to described medical standards, place of execution and whether the service can be performed with other operations. The described value in points is fixed on an annual basis and has a great importance. The most expensive service in the basic catalogue is cardiosurgical service, with an estimated value of 3100 points. Services contracted separately are priced higher – the most expensive one is estimated at 4200 points.

The catalogue of services specifically bears upon a number of performance conditions. It qualifies whether an intervention must be carried out within one day or not, specifies whether it must be carried out in the hospital of the first, second or third level of reference. Its also includes information concerning NHF (NFZ) approval for the performance of an intervention and specifies the reference unit to conduct more complex operations and the possible necessity for additional, more detailed documentation.

The call for tenders is open to providers satisfying certain requirements defined in an ordinance of the Minister of Health of 1992. Hospitals must possess intensive care units or intensive medical care units. Moreover, hospitals must set up committees responsible for hospital contagions and therapeutic committees and there should be a hospital formulary drawn up. Furthermore, according to an ordinance of the Minister of Health of 1998, hospital premises and equipment must comply with professional and sanitary requirements. Hospitals must also ensure that standards of medical conduct and medical procedures concerning anaesthesiology and intensive care are met.

On the basis of the competitive tenders submitted by providers the NHF (NFZ) chooses the quantity and scope of services. Offers chosen are those proposing lowest cost but only if all conditions are met. The management of hospitals is invited to negotiations, especially if the hospital holds a *de facto* monopolist position in a given area and the NHF (NFZ) must make use of its services.

Only registered health care units can take part in the tendering competition. The type of registration depends on the founding body of the units; therefore a unit can be registered either in the Register of the Ministry of Health or through a registration provided by the voivod in the region. Admission to private medical practice remains in the competencies of the Chamber of Medical Doctors, the Nurses' Chamber and the Laboratory Diagnosticians' Chamber.

On the free market of medical services regulations bear upon access conditions while prices are fixed individually by doctors, private health care units, clinics and hospitals and are usually higher than those offered for a given service by the NHF(NFZ). Private entities must keep medical records for every patient. Doctors running a private practice have kept the right to the simplified system of income tax settlement while other professionals have gradually lost this right. This is interpreted as an essential privilege of this professional group. However, medical legal subjects (companies) must apply the universal tax system (system of VAT, CIT and PIT taxes).

Table 8: Instruments of the regulation

Type of regulation	Before liberalisation	Under 'liberalisation'	Currently in insurance-budgetary system	Currently in free market of health care services
Financing means	Subjective financial plan	Contracting of services: negotiations; Plan of health needs.	Contracting of services: negotiations; Plan of health needs.	Open market sell-buy decision
Law regulations of access to the labour market	Regulated professions, obligatory membership in chambers, professional self-governments	Regulated professions, obligatory membership in chambers, professional self-governments	Regulated professions, obligatory membership in chambers, professional self-governments	Regulated professions, obligatory membership in chambers, professional self-governments
Law regulations of access to the services market	Meeting conditions of performing the service: registered health care units	Meeting conditions of performing the service: registered health care units	Meeting conditions of performing the service: registered health care units	Meeting conditions of performing the service: registered health care units
Regulations by means: concerning health care services performed		Catalogue of medical services	Catalogue of medical services	
Regulations by means concerning prices	Not fixed	Cost pricing of charges, gradual modification toward prices negotiated	Prices negotiated on the basis of NHF (NFZ) proposals; pricing of services in points; estimated value of one point,	Free market prices only
Law regulations concerning control	Administrative control; in regard to professional responsibility control held by professional chambers	Control held by sickness funds, obligation to conduct detailed documentation of the service.	Control held by NHF (NFZ), obligation to conduct detailed documentation of the service; in regard to professional responsibility control held by professional chambers	Obligation to conduct detailed patient' documentation; in regard to professional responsibility control held by professional chambers. Keeping financial documentation for tax revenue offices.

Table 9: Main actors of the regulation

Before liberalisation	Under 'liberalisation'	Currently
State and self-government administration	State and self-government administration *Sickness funds* competing with each other	State and self-government administration *National Health Fund* – public fund holder not competing with any entities of similar kind
Professional chambers	Professional chambers	Professional chambers
State legislature	State legislature	State legislature

2.2. Problems

Changes of the health care system introduced in the second half of the 1990s were possible because certain advantages were promised to medical circles. Those benefits were supposed to reflect the new financing model and to rely on a constant inflow of insurance tax resources instead of voluntary and discretionary budget financing. It soon turned out, however, that instead of the promised 11%, the tax would have to be smaller; therefore, at first, the rate was set at 7.5% and later, under pressure from medical circles, the level was fixed at 8%. However, this did not satisfy the needs of patients or the aspirations of medical circles. As a result, the climate of labour relations in the health care sector is very tense. By using protest actions including strikes, organised interest groups manage to influence decisions in their favour. Such collective actions have proven efficient twice.

Public fund holders (*sickness funds*) did not possess the agreed basket of health care services available to insured persons. The process of reaching an agreement over such services took place in a climate of tensions between the *sickness funds* and providers (health care units) as well as trade unions and the chambers of the medical professions. These tensions continue because the catalogue of guaranteed services has not yet been compiled. Medical circles would obviously like such a catalogue to be very wide, while public fund holders would prefer to limit it.

From the beginning, contracting plans of health care service were not – because they could not be – adequate to patients' needs. It is obvious that during the first stage of the *sickness funds* performance problems related to the inaccessibility of medical services arose. There are persistent problems with access to medical specialists on the second level of treatment. The same is true for access to hospital services.

Finally, long waiting lists for services, including hospital services, have been established as a requirement enforced by the NHF (NFZ). The problem of limited accessibility of services has not been solved, although more precise contracting plans are being worked out. Patients are still advised to choose doctors and hospitals without queues. Patients, however, seek health care services close to where they live by domiciles and such recommendations are met with resentment, because suitable information is hard to find. Patients try to avoid queues by means of bribes, using personal acquaintances or social station. Therefore it was necessary to introduce official public queuing lists.

The unsatisfactory financial coverage of services in hospitals and specialist care institutions is evident. Thus, for instance, specialised care units already inform patients during summertime that their limit for services covered by their insurance has been exhausted and that further services are thus only available at a charge. Part of the hospitals are faced with the same situation. They have to wait for contracting "the play-off" set by the NHF (NFZ) while not executing planned interventions but only 'emergency' treatments. It is evident that the NHF (NFZ) contracting system requires improvement.

The reimbursement of medicines also poses a problem. For the *sickness funds* and the NHF (NFZ), the cost of reimbursed medicines became a problem as these expenses grew constantly. By establishing a list of reimbursed medicines this tendency was gradually slowed down. This, however, has given rise to a new phenomenon: many poorer patients do not buy prescribed medication while hospitals have begun to treat patients with the cheapest drugs available.

During the first period, regulations did not include the homeless. Health care units, namely ZOZs, did not want to attend to them. Amendments made to the *Law on Universal Health Insurance* imposed an obligation to finance treatment of such people from the budget. Great tensions have arisen in the context of financing the treatment of unemployed. Certain parts of the unemployed do actually work in the black economy and thus profit illegitimately from treatment within the framework of the NHF (NFZ). This is a vicious circle as many unemployed work in the black economy because employers want to avoid the high non-wage labour costs. In this way, the NHF (NFZ) does not receive the insurance contributions it is due.

2.3. Conclusion

I. While the regulation system in the health care services sector has evidently changed considerably since the mid-1990s, the state remains the principal regulator. Even though the other actors taking part in these regulation processes do not play such an important role, it is important to highlight the participation of local and professional self-governments.

II. It seems that until a certain point in time, liberalisation was not related to privatisation. From 1999, this relationship has clearly appeared, since for many private investors (including doctors), public financial insurance transfers have become a stable source of acquiring the resources necessary for an expansion of private health care institutions. And while the process of privatisation is not very dynamic in the sector, it progresses steadily. A more dynamic privatisation of hospitals is unlikely to take place quickly. The actors of the sector are not fundamentally interested in privatisation. Trade unions present on hospital floors are particularly opposed to such changes.

A new phenomenon is the criticism of the NHF (NFZ) voiced by private providers, who believe that public and private providers are treated unequally. In their opinion, greater attention of the voivodship branches of the NHF (NFZ) is devoted to the survival of public health care units (ZOZ) in their region.

III. Liberalisation processes have led towards a distinct assignment of functions. The aim was to separate ownership functions, strictly regulatory functions, fund holder functions and the function of services performer.

In terms of progress, the process of liberalisation moving from a *sickness funds* system to a National Health Funds system can be described as detrimental. Between individual *sickness funds* there was minimal, but at least some rivalry for patients.

Patients could change *sickness funds* affiliation and join a wealthier one or one that managed insurance contributions in a better way. In principle, no such thing can happen at the NHF (NFZ), which is based on a rule of solidarity and equality of all insured. NHF (NFZ) branches do not need to compete with each other for patients.

IV. The loop of regulation creates a fundamental problem. The fund holder, i.e. the NHF (NFZ), aspires to ever more precise descriptions of providers' assignments as well as conditions of contract assignment and contracting procedure. The system becomes increasingly more difficult for providers and patients in terms of cognitive and technical aspects.

V. Certainly the new system of regulation can keep public expenses devoted to health care on services within fixed limits. Nevertheless it is not a factor of health care sector dynamics or greater depth of market.

3. ACTORS/OWNERSHIP

In the system of health care there are many actors with quite often overlapping functions. They include:

a) Actors of the legislature: the Sejm, the Senate and the President, who enjoy certain competencies. Together these actors have an influence on laws forming the legal basis of the health care system. Moreover, they qualify current administrative decisions by deciding upon the volume of health care expenditures within the state budget, then regulating tax rules (especially regarding tax exemptions and deductions dedicated to health care) and finally assigning the level of health insurance contributions.

b) Central and voivodship level state administration. Before 1999, the state administration also exercised the functions of consecutive management of health care, though a concentration on the strategic function was foreseen by introducing mechanisms for decentralising decision-making. Voivodship level administration supervises health care institutions as a founding body. This especially refers to hospitals.

c) The municipal (voivodship, district and communal) administration was assigned to devise a general strategy of health care in the region as well as outpatient health care planning. Specifically, the commune authorities were responsible for primary health care, county authorities were in charge of basic specialised care (internal medicine, paediatrics, gynaecology, obstetrics) while voivodship authorities took responsibility for the remaining highly specialised services. Moreover, the self-government was responsible for the local supervision of "the National Programme of Health" with regard to health prevention. In addition, local authorities, as the founding public health care institutions, also exercised decisive influence on the appointment of the management of these units. Municipal authorities were and still are the owners of public health care institutions, especially of hospitals. They had to take care of buildings and equipment and solicit the highest possible financing from the budget. A significant role is also by played lobbying undertaken by voivodship marshals,

starosta (county officials) and communal authorities over the Ministry of Health and state administration in general. The subject of these lobbying activities was the scope of financing.

d) Self-governments of the medical professions and occupations. These were the medical doctors' chambers, the chambers of pharmacists as well as the chambers of nurses and midwives. Membership in these associations was and is obligatory. They had the right to maintain registers and judge on issues of professional responsibility, and thus are entitled to revoke a person's right to work in one of these professions. Their strategic functions rest in the authorisation to give opinions on all legal acts and other decisions influencing health protection, the organizational shape of the system and methods of financing. Self-governments also negotiated conditions of work and pay. Acting in the name of state these associations controlled important an resource of the market, i.e. access to the occupation.
e) Medical Academies exercising large discretion of the freedom of research and education. Those ran their own clinics and decided about the number of graduates on the labour market by using clinical hospitals as a place of education for students and a place for medical researches.
f) Public health care institutions, conducting services within their own area to patients strictly assigned to a particular ZOZ (thus without the possibility of choosing a doctor or hospital).

Nowadays the roles of actors have slightly changed and there are new actors. These are as follows:

a) Actors of the legislature: the Sejm, the Senate and President, who still enjoy certain regulatory and supervisory competencies. They can change laws concerning health care and still qualify current administrative decisions by deciding upon the volume of health care expenditures within the state budget, then regulating tax rules (especially regarding tax exemptions and deductions dedicated to health care). A third very important issue, they can determine the level of health insurance fees.
b) Central and voivodship level state administration. Nowadays it deals mostly with policy-making and regulation functions. The Ministry of Health is responsible for the national health policy, most important investments, education as well as the research policy regarding medicine. It also monitors the standards of medical treatment and performs several supervisory functions in relation to the Chief Pharmaceutical Inspector, the President of the Office the Medical Products, Medical Devices and Biocides Registration, the Chief Sanitary Inspector and direct managerial function of the State Medical Emergency Service, health resort treatment and regulation of medical professions. Voivodship level administrations supervise health care units as a founding body. This especially refers to planning hospital networks.
c) The municipal (voivodship, district and communal) administration is responsible for devising a general strategy of health care in the region as well as outpatient health care planning. Commune authorities still remain responsible for primary health care, while county authorities are in charge of basic specialised care (internal medicine, paediatrics, gynaecology, obstetrics) and voivodship authorities deal with the

remaining highly specialised services. Furthermore, local authorities, as founding bodies, still run health care units as well as exert decisive influence on the appointment of management of these units. They have had to take care of medical infrastructure on their own, but nowadays there are regulations preventing uncontrolled purchases or contracting by ZOZ or hospital managers. Municipal administrations are not entitled to conduct direct negotiations with the NHF (NFZ).

d) The National Health Fund is a governmental agency with departments in sixteen voivodships and the successor of the short-lived *sickness funds*. This is a public fund holder acting in conditions of lack of competition with other fund holders. NHF (NFZ) operations are supervised by the Fund Council comprised of members appointed by the Prime Minister for a 5-year term. The President of the NHF (NFZ) is chosen and dismissed by the Council. In effect therefore this is a political position. Therefore it has been assumed that vice-president must be a doctor.

e) Public Health Care Units (including hospitals) and their management is interested in winning contracts with the NHF (NFZ) that would allow them to perform necessary services within a given area in order to avoid critiques of the community for low quality and inaccessibility of services.

f) Non-Public Health Care Units interested in contracting remunerative services with the NHF (NFZ) that would allow them to perform services for patients in a given area.

g) Self-governments of the medical professions and occupations. These were the medical doctors' chambers, the chambers of pharmacists as well as the chambers of nurses and midwives. These associations have kept all of their rights but are not so visible in public especially because the collective interests of the medical professions are strongly represented by trade unions (this is especially true after 2000). The National Chamber of Laboratory Diagnosticians is a new institution.

h) Medical Academies exercise large discretion of the freedom of research and education. They run their own clinics and decide even more intensely than before about the number of graduates on the labour market by offering paid medical studies (next to studies reimbursed from state budget on candidates successful in high competitive examinations). After a short period of relative independence, the academic clinics became more strongly dependent on the presidents of medical academies.

4. ROLE OF GEOVERNMENT AND OTHER STAKEHOLDERS

4.1. Role of government

In the period before liberalisation, the functions of the state related to health care can be univocally qualified as omnipotent. A small private segment of services existed, although its size and rules of actions were strictly controlled by the state. The state

simultaneously carried out many health care services functions: it owned almost all institutions (including all hospitals), issued legislation, planned the activity, worked out the strategy, organised, financed, monitored and controlled. The only concession regarded professional self-governments, which were entrusted to control access to regulated medical professions. Those associations also served as supporting bodies in decision-making processes concerning the responsibility for medical errors and negligence.

After 1990, the state divided these functions a bit by admitting local authorities to many functions. At first this referred to the communes and voivodships, and after 1998 also to the counties. The territorial self-governments took over ownership functions and part of the functions related to financing, supervision and control. This was a strategy of decentralisation but it did not bring as many affirmative results as were foreseen. Money from the state budget allocated for health care services "flowed out" and contributed to the budgetary deficit.

The next change in the government's role resulted from the idea of abandoning the system of budgetary health care financing in favour of a system of general insurance. The government set the initiation of public fund holders responsible for the management of insurance funds. This way management of financing services was transferred to *sickness funds*. However, the appointment of management boards of the *sickness funds* remained among government competencies. In this period, the government, through the Ministry of Health, kept the functions of developing a health protection strategy, general supervision and several control functions. Neither did it surrender the right to make decisions about the purchase of very expensive medicines or particularly expensive treatments for specific patients.

After the liquidation of the *sickness funds* (which tended to escape government control), the National Health Fund (largely subordinate to the Ministry of Health and state administration) was established. This subordination resulted from the government's competence to appoint presidents and determine duties of executing strategies agreed upon by government. This has enabled the government to focus on elaborating strategies, on regulatory functions as well as on general supervision and control. The government is also obliged to take up collective negotiations with relation to the social partners. The Tripartite Committee responsible for Social and Economic Affairs constitutes the forum for such negotiations.

4.2. Other stakeholders

Other stakeholders present in the sector are split on several categories. Those are first of all trade unions, employers' organisations voluntary associations representing individual and collective patients rights, governmental regulatory institutions, global and European pharmaceutical firms.

A) Among the most important trade unions in health care the following can be mentioned:

All-Polish Trade Union of Doctors; Trade Union of Nurses and Midwives FZZ; NSZZ Solidarity, Secretariat Of Health Protection with the sections: National Section of Workers Of The Health Service, National Section of Workers of Sanitary and Epidemiological Stations, National Section of Workers Social Care Houses, National Section Of The Ambulance Service and Rescue Service, National Section of Polish Health Resorts; Federation Of Trade Unions of Workers Of Health Care and Social Care OPZZ, Trade Union of Doctors of the Ministry of Internal Affairs and Administration OPZZ, Trade Union of Anaesthetists OPZZ, Trade Union of Polish Health Resorts OPZZ, Federation Of Trade Unions of Technical Assistance to Medical Service and Medical Rescue OPZZ, Federation Of Trade Unions of the Industry and Pharmaceutical Trade OPZZ.

A significant change in this segment of group interest representation came with the creation of the very militant All-Polish Trade Union of Doctors and the Trade Union of Nurses and Midwives FZZ, enriched by a general strike and street protests in 2000.

B) Organizations of employers in the health care sector began to be present only in the era of sickness funds (that is after 1999). These associations were created at that time: Association of Managers of Health Care, All-Polish Association of Private Health Care Service Employers (KPP), All-Polish Association of Non-Public Hospitals (2002) and Association of Employers of Zielonogorskie Agreement.

Among them, the Association of Employers of Zielonogorskie Agreement is the most powerful one. In general, it brings together doctors managing non-public health care units, providing services within NHF (NFZ) contracts. In 2005 the association organised protest actions in the form of a strike and thus forced the NHF (NFZ) to make concessions.

The All-Polish Association of Non-Public Hospitals brings together the owners and managers of private hospitals (686 persons). It is a lobbyist institution; thus no negotiations with the NHF (NFZ) or Ministry of Health have ever been conducted. The Association organises conferences, and sat at “the round table on health care”. It did not call for the organised protest. It believes that the NHF (NFZ) prefers public hospitals. This can be seen as a tendentious rejection of offers submitted by these hospitals or through contracting of services at the same level as in preceding years.

C) Voluntary associations representing individual and collective patient rights: the older Polish Federation of Consumers and, established in 1998, the Association of Patients Primum Non Nocere. The first association is very systematic in undertaking actions aimed at a general awareness of consumer rights, including the health care sector. It offers its opinion on draft laws and conducts lobbying activities. The second association is more radical as it organizes annual demonstrations of harmed patients and offers legal assistance to patients.

D) Governmental: The Office for the Protection of Competition and Consumers has never been active before in the health care sector. In 2006 the Office for the first time analysed contracts signed by private units, clinics and hospitals with private patients and discovered several irregularities while pointing out illegal notations to patients.

E) Global and European pharmaceutical firms: they came to Poland already in the early 1990s. Almost all of them made Direct Foreign Investments in Poland. Most of them are involved in powerful marketing and lobbying activities since the prize is a pharmaceutical market worth about 50 million patients (Poland's citizens).

4.3. Conflicts

Social conflicts: The most important social conflicts in the health care sector refer to earnings and working conditions. These are the three main conflicts:

a) Conflict between the Ministry of Health and the Trade Union of Nurses and Midwives, dating back to 1999. As a consequence of a strike, nurses obtained the right to a salary increase guaranteed by the Sejm. Unfortunately there was no financial coverage in the budget for this increase. Some hospitals only just recently paid the outstanding increases but without interest. The wages of nurses are relatively low and even though this conflict was not followed through until the end, relations of trust were severely impaired.

b) Conflict between the Ministry of Health and All-Polish Trade Union of Doctors. This conflict regards overtime payments for doctors to be paid according to the same rule as for other professional groups, i.e. in compliance with the Labour Code.

c) Conflict between Association of Employers of Zielonogorskie Agreement and NHF (NFZ). This conflict reflected the conditions of contracts proposed by the NHF (NFZ) to doctors managing non-public health care units. The Association conducted a strike and as a result the NHF (NFZ) raised its offer.

Other conflicts: There is still one conflict that has not transformed into a social one and has not resulted in collective action. That is the conflict between patients and health care service employees, mostly doctors. These conflicts are mostly about the transparency of queues in hospital waiting lists, equal access to services of all insured people, doctors' refusal of diagnostic examinations of patients or the performance of additional services (e.g. transport, rehabilitation). Patients perceive that doctors tend to prefer some patients, to save on diagnostics and to show reluctance towards consultations with specialists.

5. CONCLUSION

The health care sector in Poland has been in transition for many years. Only part of it is acting under free market conditions, although nowadays almost 30% of financial spending (thus outside the obligatory insurance system) comes from the private pocket of patients and employers. The provision of health care services has become strongly regulated. This tendency towards formalisation seems to be an aftermath of the medical culture of the preceding system (before 1989). Therefore, even doctors offering their services on the free market are subject to very detailed regulations set by the state.

Principal changes achieved in the second half of the 1990s reflect a departure from a system of budgeting services according to the paradigm state economy and a shift to a system of insurance financing. This system is increasingly organised and deliberated, with more frequent negotiations and consultations with the medical circles (although consultations are managed on an ad hoc basis). The system is not a highly coordinated one; one negotiates from conflict to conflict, from problem to problem.

The progress made within this system comprises a limitation of spending to the amount of insurance contributions. The discharge of different parties functions (actors and stakeholders) is also a success. This way they can perform their own roles, absolute power is attached to nobody and every entity must consider counteraction (protest) to happen. This has created a sound basis to be elaborated in future solutions for reconciling the interests of all stakeholders within the system. Patients are after all represented on the equivalent level. The state still assumes the entire right to represent patients while not fulfilling this duty in a satisfactory manner.

The path to a privatisation of providers is wide open. It is however difficult to foresee the dynamics of this process.

6. REFERENCES

Baran A., Zyra M. (2006), Narodowy Rachunek Zdrowia. Wydatki na ochronę zdrowia 1999, 2002, 2003, [National Health Account. Expenditures for health care 1999, 2002, 2003], GUS. Warszawa

Cichocka E. (1999), "Polska reforma, wloski strajk" [Polish reform, Italian strike], Gazeta Wyborcza, 20.01.1999

Golinowska St. (2000), Polityka spoleczna. Koncepcje-Instytucj-Koszty [Social Policy; Concepts – Institutions – Costs], Poltext, Warszawa

Golinowska St. (1996), Polityka spoleczna w latach 1994 – 1996. Procesy regulacyjne i ich potencjalne skutki (Social policy 1994 – 1996. Regulation processes and its potential effects), Raport z 11, IPSS, Warszawa

Health Systems in Transition. Poland (1999), The European Observatory on Health Care, on website: http://www.euro.who.int/document/e67136.pdf

"LUX MED wybuduje w Warszawie nowy szpital", (2008) 2006 [LUX MED will build new hospital in Warsaw], Gazeta Prawna 27.06

Kuszewski K., Gericke Ch. (2005), Health Systems in Transition. Poland, Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health System and Policies. Vol. 7 No. 5, http://www.euro.who.int/Document/E88670.pdf

Ministry of Health (2004), Report: Health Care Financing in Poland – Green Book, Warsaw

Pączkowska M. (2006) Dostepność świadczeń zdrowotnych w opinii Polaków. Raport z badań [Accesibility of health care services in opinions of Poles. Research Report], Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa

"Podstawowe dane z zakresu ochrony zdrowia w 2004 r" [Basic statistical data concerning heath care in 2004] (2005), Informacje i opracowania statystyczne GUS, Warszaw

Raport Narodowego Funduszu Zdrowia za 2004 [National Health Fund Report 2004] (2006) NFZ, Warszawa, on the website: www.nfz.gov.pl

Raport spoleczny – Polska 2005 [Social report – Poland 2005] (2005), Friedrich Ebert Stiftung, Przedstawicielstwo w Polsce, Warszawa

Stachura R. (2004) "Market of private health insurance in Poland", *Polityka Zdrowotna,* vol II, December

Standing G. (1996), "Social Protection in Central and Eastern Europe: a tale of Sipping Anchors and Thorn Safety Nets", in: G. Esping-Andersen (ed.), Welfare State in Transition, Thousand Oaks, London

Walewski P. (2006), "Operacja prywatyzacja" (Operation privatisation), Polityka Nor 40

Wlodarczyk, W.C. (1996), Polityka zdrowotna w spoleczenstwie demokratycznym (Heath policy in democratic society), Uniwersyteckie Wydawnictwo Medyczne Vesalius, Lodz – Krakow – Warszawa

Wlodarczyk, W.C. (1998), Reforma opieki zdrowotnej w Polsce. Studium polityki zdrowotnej (Health care reform in Poland. The case of heath care policy), Uniwersyteckie Wydawnictwo Medyczne Vesalius, Lodz – Krakow – Warszawa

Wlodarczyk, C. (1999), "Reforma opieki zdrowotnej", (Health care reform), in: Kolarksa-Bobinska L. (ed), Druga fala polskich reform, Warszawa