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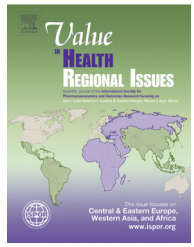

The Process of Privatization of Health Care Provision in Poland

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ABSTRACT

Objectives: In January 1999, a new institutional structure for Poland's health care system was laid out, instigated by the dramatic change in both the political and economic system. Following the dissolution of state socialism, private financing of health care services was encouraged to fill an important role in meeting rising consumer demand and to encourage a more efficient use of resources through competition and private initiative. However, from the outset of the intended transformations, systemic limitations to the privatization process hindered progression, resulting in varying rates of privatization amongst the distinct health care sectors. The aim of this paper is to describe the privatization process and to analyze its pace and differences in strategic approach in all major health care sectors. **Methods:** Policy analysis of legislation, government directives, and published national and international scientific literature on Polish health reforms between 1999 and 2012 was conducted. **Results:** The analysis demonstrates a clear disparity in privatization rates in different sectors. The pharmaceutical industry is fully privatized in 2012, and the ambulatory and dental sectors both systematically increased their private market shares to around 70% of all services provided. However, despite a steady increase in the number of private hospitals in Poland since 1999, their overall role in the health care system is comparatively limited. **Conclusions:** Unclear legal regulations have resulted in a gray area between public and private health care, where informal payments impede the intended function of the system. If left unchanged, official health care in Poland is likely to become an increasingly residual service for the worst-off population segments that are unable to afford the legal private sector or the informal payments which guarantee a higher quality service in the public sector.

Keywords: health care provision, health care reform, health policy, Poland, privatization.

Introduction

On January 1, 1999, a new institutional structure for Poland's health care system was founded, instigated by a dramatic change in both the political system and the economic system [1]. In the years preceding such change, a state-funded and centralized health care system had operated where the public sector had dominated in terms of both funding and service provision. The collapse of state socialism in 1989 because of increased opposition and a failing economy, however, had severe consequences on the state's ability to provide health care coverage [2]. This resulted in a growing imbalance between the needs expressed by the population and the system's ability to meet them, exacerbated by the ever-increasing cost of health care service provision. In an attempt to address this, Poland transformed the health care system and encouraged competition and private initiative [3,4]. From the outset of the intended transformations, however, systemic limitations to the privatization process have hindered progression. This has resulted in varying rates of privatization among the distinct health care sectors and an ambiguous relationship between public and private health care provision.

Initial Drivers for Health Care Reform

During state socialism, Poland, like many other Soviet bloc nations, adopted the Semashko model for health care [5]. State-funded through taxation and heavily centralized, this particular system was designed with the intention of guaranteeing egalitarian health care coverage for the entire population. After the dissolution of the Soviet Union, however, Poland along with many other Central European countries suffered severe economic difficulties that significantly affected health care provision [6]. Because of cuts in government expenditure and a shortage of providers, public health care facilities became overcrowded and had long waiting lists, scarce medical supplies, and out-of-date technologies [7]. Receptive to this, Poland began to allow limited private providers to manage demand for public health services [8]. The principal idea envisaged was to establish a new set of institutions and market-type mechanisms that would ensure a more efficient use of productive assets by creating stronger incentives arising from ownership, thereby increasing productivity and efficiency [3,9,10]. This signaled an initial step toward privatization, defined as follows: "the transfer of ownership and

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control of government or state assets, firms and operations to private investors" [11].

After this, the public sector gradually began to devolve further until budgeting of health care services was replaced with an insurance-based system of financing. Undoubtedly, this radically changed the population's right to health services, as access was instantly linked to registration with a mandatory health insurance and payment of contributions [5]. As insurance funds were initially regional and given autonomy, conditions were set for private sector service provision, which then intensified as official out-of-pocket payments for health services were started [12]. Alongside hospitals, clinics, and health centers, foundations or voluntary associations were established, which accepted payments for performing better quality or difficult-to-access services. This divided health care provision into both public and private, with a gray sphere of informal payments emerging between the two [2] that continued a long-standing history of informal payments in the socialist health system.

In the 2007 Stefan Batory Foundation's Corruption Barometer, 78 (9%) of 870 respondents declared that they had made informal payments in the last year, 52% of which were for informal payments in health care [13].

In the larger Social Diagnosis panel of 3000 Polish households, 1.8% of households declared informal payments in 2007, 1.3% in 2009, and 1.7% in 2011 [14]. In 2011, the average informal payment for health services was estimated at 1244 Polish Zloty (300 euros) per year and household. Furthermore, 18.1% of households declared that they refrained from purchasing necessary medicines, 17.3% could not afford dental treatment, and 13.9% could not afford medical treatment [14].

Legal Basis for Privatization

Between 1989 and 2001, approximately 20 new laws relating to health care provision were adopted in Poland, which facilitated the development of the private sector. In particular, the law of July 13, 1990, which related to the privatization of state enterprises [15], and after its abolition the law of August 30, 1996, which related to the commercialization and privatization of state enterprises [16], were exceptionally influential in instigating the privatization process. Although these acts did not directly refer to health care services, they drew a general framework for the process of privatization in Poland after the fall of communism.

The most important and far-reaching legislative acts to affect health care were those that shaped the contracting environment. The Health Care Organisation Act passed in 1991 introduced contracting in place of administrative relationships, allowing private surgeries and organizations to sign contracts for the provision of services to people entitled to care financed from public resources [17]. In doing so, categories of entities authorized to provide health services (including those that are established by nonpublic entities or individuals) were defined, as well as the technical requirements that such entities must fulfill.

This was followed by perhaps the most influential act—The General Health Insurance Act 1999, which introduced a social health insurance system in Poland of 16 regional sickness funds and 1 sickness fund for employees of military services [18]. This caused a vast increase in the number of private organizations holding public contracts because the regional sickness funds were allowed to contract services with private health care institutions as long as they met the required conditions and offered cheaper service costs [8]. This was the first time private providers were able to act within the public system of financing health services.

In addition to these, a package of laws regulating the competences of local self-government units have since been passed, which have gradually transferred the ownership duties of health care facilities from the central administration units to the local self-governments, enabling them at the same time (under some conditions) to transform those facilities into private entities. These laws include

- the law of March 8, 1990, on local self-government [19];
- the law of November 24, 1995, on a change in the range of responsibilities of some cities on the municipal areas of public services [20];
- the law of June 5, 1998, on regional self-government [21]; and
- the law of June 5, 1998, on district self-government [22].

None of these legal acts, however, has directly and systematically regulated the issue of privatization of health care facilities. This has resulted in a process that is complicated, legally unclear, and vulnerable to abuses, particularly in the case of hospitals that are the most controversial in terms of their privatization. During the last decade, successive governments have tried on three occasions to establish such a law but none of these efforts has been successful, each time being blocked during the legislative process, or even earlier, at the stage of preparation. In its first attempt, the Ministry of Health tried to implement obligatory transformation of all health care organizations into commercial law companies, entitled "Law on Commercialisation and Privatisation of Independent Public Health Care Facilities (2001)." Nevertheless, because of unfavorable political conditions (forthcoming elections, a breakdown of the governing coalition, and a strong political disintegration), the project was withdrawn and replaced with a less radical approach.

Progress of Privatization in Poland

An analysis of the scale of privatization in the Polish health care system shows significant disparity between the different health care sectors. Changes in the pharmaceutical sector and in ambulatory, dental, and hospital care differ in terms of pace, strategic approach, and public resistance. To understand these fundamental differences, each sector will be discussed separately.

Pharmaceutical sector.

The commercialization of health services began with the privatization of the pharmaceutical industry. This was based on the Freedom of Economic Activity Act (1988), which came into fruition at the very beginning of the postcommunist transformation period [23]. Around the same time, the number of private pharmacies accounted for approximately 43.9% of the total number. Following a program implemented in 1994 devoted to the privatization of pharmacies, however, almost all pharmaceutical outlets belonging to the Treasury have subsequently been privatized [24]. This dynamic transformation in pharmacy ownership between 1990 and 2006 is illustrated in Fig. 1.

Since the introduction of co-payments for dental care, patients have started to purchase services offered by private practices and clinics more willingly, even when required to cover the total cost of the treatment. In doing so, they are able to receive a faster and perceived better quality treatment. Because of this high acceptability, the private dental sector developed quickly in the early 1990s. After the Law on Social Health Insurance came into force in 1999, private dental practices started to offer treatment contracted within the Social Health Insurance system. As a result, the number of facilities offering services that are available only for out-of-pocket payments has started to decrease gradually since 1999 [25]. Currently, more than 80% of the active dentists work in the private sector and approximately 85% of the services are provided by nonpublic providers [26].