Polish Journal of Occupational Medicine and Environmental Health, Vol. 5, No 1, 1–11, 1992

OCCUPATIONAL AND ENVIRONMENTAL HEALTH POLICY

THE PAST AND PRESENT OF THE POLISH NATIONAL HEALTH SERVICES. REFORM PROJECT

MAREK M. SMOLEŃ

Health Economics Division, The Nofer Institute of Occupational Medicine, Lodz, Poland

Key words: National Health Services, Health Policy, Health Economics, Organization, Financing, Efficiency, Poland

Abstract: This paper presents a short historical outline of the national health service (NHS) system in Poland. Consecutive stages of the NHS system reform are described (up to October 1991), including the period of early 80's and the Round Table Conference. The general principles of the project of the Polish NHS system reform, which is intended to be implemented with support from the World Bank, are presented. These principles are related particularly to the scope of the questions assigned to the task forces established to solve the basic problems of the present system. Those include:
1. Health Promotion Task Force,
2. Primary Health Care Task Force,
3. Occupational Health Task Force,
4. Health Information System Task Force,
5. Cost Accounting Task Force,
6. Resource Allocation Task Force,
7. Pharmaceutical Monitoring and Drug Control Task Force,
8. Management Development Task Force,
9. Regional Health Services (Consortia) Task Force.

1. THE REALITY WHICH IS TO BE REFORMED

The current situation of the Polish health system is the result of long–lasting development, in which the historical events of the mid–'40s played a crucial role. In an attempt to attract broad support for its political program, the parties of the radical left proclaimed the principle that the state should be fully responsible for the health of its population. The factual manifestation of this principle was the rule of free access to an unlimited range of health services. Free-of-charge access was perceived not only as the proper means of improving the health status of the

Address reprint requests to M. Smoleń, Health Economics Division, The Nofer Institute of Occupational Medicine. P.O.Box 199, 90-950 Lodz, Poland.

population, but also as an important aspect of the socialist model of health care. The political interpretation of the right to a free health service, or more precisely to medical services, as well as its inclusion into the Constitution of 1952, has played a considerable role in the development of the Polish health system.

The legal construction materializing the rule of free access has been articulated rather clumsily. Although the right to health care is considered to be a universal attribute of Polish citizens – and it is presented as such on the international scene – the rights to particular services are rendered according to specific titles of individuals or groups. Originally it was the Insurance Law of 1933, still in force, that underlined the right to particular health services. In the late '40s, some groups like soldiers and their families or war pensioners became specificaly entitled. The Law of 1948 on public establishments and the planned economy in the health service introduced a concept of those "equal to the insured": thus the number of people entitled to health care increased (2). All those who are employed in the nationalized sector of the economy do not pay any premiums whatsoever: these are covered, and the necessary means are furnished – in the form of taxes – by employers. Unlike workers in the socialist economy, self–employed people working outside the state sector, as well as private farmers are included in the insurance system on payment of some premiums.

It should be emphasized that, though the very term insurance is frequently used in the vocabulary of the Polish health system, actual insurance–type economic structures are very scarce. Money raised via premiums goes to a general budget and is then distributed according to political and administrative decisions. Even if there are some autonomous "insurance funds", they are not used to finance the health service which is totally financed from the general budget. Thus, both the management and financing of health service is beyond the authority and interest of the insurance system.

In the mid–'40s when the principle of state responsibility for health was proclaimed, the health needs of the people were enormous. The heritage of pre-war times and, especially, the five-year period of Nazi occupation resulted in the nation being in an extremely poor state of health. Because of this, the idea of free access to health service would have had a very beneficial social impact, so in terms of health policy it might have been appreciated (3). On the other hand, economically speaking, the idea was way beyond the true capacities of a devastated country. The rational foundation for the health policy adopted was the assumption, that a centrally–planned national economy would lead to the blooming prosperity of the country and to the wealth of its citizens. Some progress achieved in the '60s and '70s gave rise to a further strengthening of the idea of unlimited access to, and utilization of, the health service. Health education and health propaganda openly encouraged people to make intensive use of the health service (2).

As to the consequences of such a policy, Polish society evidently feels that a free health service is its natural, fundamental right. Neither social group nor individual is willing to be restricted formally or financially. Some experts believe that the lack of formal barriers and relative ease of access have resulted in something like a "claiming attitude" among patients. It means that people are convinced they have the right to contact a doctor – preferably a specialist – anywhere, any time and as frequently as they wish (3).

It also means that patients expect their needs to be fully met by professional action with no self–involvement in the healing process.

The political and psychological process, as depicted above, has led to an obvious lack of balance in the provision of the health service: the demand has greatly exceeded the supply. This fact has been generally neglected by the general public, dissatisfied with quality of health care services, as well as by many experts working on projects of health system reform in Poland. This highly detrimental bias can be attributed to specific conditions under which both health policy and health economics have been developed in Poland.

The health of the population was perceived as a value of socialist – realist morality, and the right to health as one of the essential principles of the socialist – realist health system, so any analysis of these values in terms of economics was rejected. It was assumed that health was "priceless", especially in the context of socialist – realist axiology where the human being was the greatest value and criterion of praxis (2). This priceless outcome could not be measured against the price of input, not only because of technical difficulties but because of substantial impropriety.

Consequently, no analysis of cost – effectiveness and – horror of horrors – cost – benefit could be undertaken. The planning process, whose formal importance had been stressed very strongly in health policy, was performed only in terms of resources. Numbers of doctors, hospital beds or units of equipment were firstly, and almost exclusively, considered by planners. Only some rough indicators of the process – the number of vaccinations or pre – employment examinations, for example, were taken into account. It should be added that both health policy and health economics as academic disciplines were also very weak, hence their chance to contribute to rationalizing the health system was also limited.

Another important result of the non – economic or even antieconomic approach to health planning and management emerged in the process of resource – allocation. A centrally planned economy could have been expected to have promoted one of the first priorities of socialist health care – equity. The reality has proved such an expectation to be completely wrong. As far as territorial allocation is concerned, neither demographic nor health factors can explain the structure of resources allocated. The best predictor is the amount of resources already claimed: therefore, the richer provinces become richer, the poorer, poorer. The "supply side" model of resource allocation has influenced the process of health planning for years and has been insensitive to all attempts to make it more rational, that is to say, more responsive to health needs (2).

2. A PROPOSAL FOR NEW SOLUTIONS

A search for a more efficient approach to the health system began in 1980 along with a wave of social and political unrest. Groups of experts, called up both by government and independent milieus, have produced many reports, documents and papers. A lot of various aspects of the malfunctioning health system were scrutinized, but only as late as the end of 1988 was a suggestion to change the very principle of the uneconomic approach to the problem put forward. It was included in a report prepared by a team led by J. A. Indulski and submitted to the Government in December 1988 (5).

It should be mentioned, however, that the High Commission Report published in 1986 took up these problems. It was recommended to restore the institution of health insurance. The institution would not only raise money – through premiums – but also watch the rationality of resource–utlization. To make this possible, a precise cost–accounting system in health institutions should be established. Resources would be allocated to the institutions according to the amount of services actually provided. In this way the insurance bodies would buy services from health institutions and the providers' income would depend on their efficiency.

The Indulski Group Project (1) referred to earlier documents, especially to HFA 2000, and outlined the following features of a reformed model of health service:

– actual socialization of the system achieved by accepting the autonomy of both the providers and receivers of health services;

– ability to safeguard health safety due to free access to a basic package of health services and implementation of the institution of the family doctor; and

– assurance of the citizen's right to a full range of health services by a new, voluntary, health insurance system.

The real novelty of this document was the idea of a basic package of health services. Services beyond the package – more sophisticated or more comfortable – would have to be paid for. The patients, however, would not be expected to pay from their pocket. Developed schemes of voluntary health insurance would enable people to deal with the problem of money constraint.

A crucial role in the system was assigned to the family doctor. The authors unanimously favoured this model of primary health care (PHC) viewing it as an effective tool to integrate the services provided in different specialties and at different levels, as well as to debureaucratize the process of care. According to the proposal, the family doctor would have the right to participate in all medical decisions made by specialists concerning his patient, and his opinion could not be ignored by them, or by the rules of the reimbursement mechanisms.

The Indulski Group Project – in a form modified by the Ministry – was used as a framework for the Round Table negotiations, the most important event on the Polish political scene of the last decades.

The majority of the recommendations suggested by the Indulski Group were included in the Round Table Agreement (6). Some of them, however, were extensively modified and the project lost its coherence. The idea of the basic package was angrily rejected. This decision made the whole mechanism of voluntary health insurance redundant. It was accepted again that all citizens would have full and free access to all kinds of health and social services, according to one of the first principles of the socialist–realist model of the health system. In all particular cases the scope of necessary services would be defined by a medical professional, referring to "objective premises of current medical knowledge" (3).

The recommendation was included in the agreement to set up a new commission, on a combined Government/Opposition basis, to prepare a new detailed project of health service reform.

In November 1989 a project entitled "A Proposal for Reforms" (known as the "social project") was worked out by the Committee for Reforms in Health Care and Social Welfare Systems as a result of this decision (7). At the same time, however, a second report, known as the "authors' project", entitled "In the Interests of the Health of Society. A Proposal for Health Care System Reorganization" also dated

November 1989, was produced by an independent group of specialists (8). The existence of two sets of reform proposals, recommending partially divergent solutions, was a little confusing for the political authorities.

In evaluating both projects, and taking into account the fact that the reform of the health care system neither should nor can be discussed separately from the whole of the social insurance system, one should agree with the opinion of the team of authors who perceive the reform in a much broader sense than that of a "social" project. The latter has been largely encumbered by the decisions taken at the Round Table and by their too orthodox perception. The costs of the variant presented in the "social" project, aiming to set up a separate Health Insurance System, at a time of the persistent shortages in the national economy caused by an extensive collapse of industrial production and a high rate of inflation, would have been beyond the means of a poor State.

It was decided, therefore, that further work on reforming Polish health care system would be based on the document "The Political Framework of Health Care Reform in Poland", a result of the heretofore proposals contained in earlier projects. The document has been prepared as a result of the International Conference on Health Policy in Poland organized by the Ministry of Health and Social Welfare (Warsaw, February 1990) and cosponsored by the WHO Regional Office for Europe, the World Bank and the Project Hope (8).

Since that time an important stage of a new phase of the reform work has occurred. Experts have been relieved from a political bias and gathered mainly in the National Center for Health Systems Management as a team, later led directly by the First Deputy Minister of Health, responsible for the reform (8). At the same time extensive cooperation was started with the developed countries of West Europe and North America, and with some international financial organizations such as the World Bank and the International Monetary Fund to receive aid for the preparation and implementation of major structural transformation of the Polish economy.

The functioning of the present–day health care system is also deeply affected by those transformations. The necessity of the thorough rebuilding of the system, in addition to the appropriate structural changes, relates also to the problems which might be termed as "health investment". Such an approach to the reform of the system has enjoyed support, particularly from the World Bank. That is why several World Bank missions visited Poland during the period from February 1990 to July 1991.

During the period February–September 1990, the objective of the World Bank mission included a sectoral study; in October 1990 the problems of the health care system were finally identified, while in April 1991 the mission's objective included preparation of general outlines for a project of health care system reform in Poland.

The works of the next missions on defining both the scope and the chances for the implementation of the Project were carried out in collaboration with Polish experts. It is worth noting here that in April 1991, the Minister for Health and Social Welfare established several Task Forces with the objective of preparing the Project with technical and financial support from the World Bank. These include:

1. Health Promotion Task Force,
2. Primary Health Care Task Force,
3. Occupational Health Task Force,
4. Health Information System Task Force,

5. Cost Accounting Task Force,
6. Resource Allocation Task Force,
7. Pharmaceutical Monitoring and Drug Control Task Force,
8. Management Development Task Force,
9. Regional Health Services (Consortia) Task Force.

It has been assumed that the principal objectives of the reform are:

(a) to improve general health condition by upgrading health-promoting activities;

(b) to improve quality and effectiveness of the primary health care;

(c) to strengthen the management capability of health sector institutions through appropriate information system and health management training; and

(d) to improve the efficiency and effectiveness, and contain the cost of health services in three regions through coordinated decentralization.

Therefore, in order to reach the aforementioned objectives, the project for the reform of the health care system concentrates on the following interdependent areas:

(a) Health promotion,
(b) Primary health care,
(c) Infrastructure of health care system management, and
(d) Regional systems of health care services – consortia.

It should be noted here that, within those areas, not only nation-wide but also regional problems will be dealt with. This refers in particular to consortia, functional structures which are completely new, not only in Poland.

2.1. Coordination of activities in the area of health promotion

The project should enable the establishing and strengthening of inter–sector, regional and local coordination for health promotion. This would be enhanced by establishing an independent National Health Promotion Centre. The Centre would develop and propagate national health promotion strategy, as well as provide information on health promotion and disease prevention to the public and private sectors.

One of the most essential priorities within those activities would include preparation of educational and expert advice programs for reducing health risks by limiting tobacco smoking, alcohol drinking, promoting a healthy style of life and eliminating occupational risks. The Centre should remain in close contact with the three consortia, especially now, when the Project is in its early stage, to support project works on health promotion programs to be handed over to the regional level. Basides, the Centre should conduct short– and long–term training of specialists and non–specialists from Polish institutions and universities.

2.1.1. Development of health–promotion education

To strengthen health-promotion teams among health-care professionals as well as in local areas, the Project shall support educatonal programs at the National Institute of Hygiene in Warsaw and at the Universities of Cracow and Lodz. The units entrusted with the task of health educational shall design health education programs for academic medical teachers and for the people of other medical as well as non-medical professions, such as journalists or secondary school teachers. Short term and graduate courses, grants and fellowships shall include programs for the development of the departments participating in the training.

2.2. Occupational health

This subcomponent will support the Ministry of Health and Social Welfare in its endeavours to meet the requirements of ILO Convention No 161 on the protection of health of employees at their places of employment.

Studies in conjunction with foreign experts shall be undertaken to implement rational methods of planning, management, and organization of occupational safety programs. Primary risks in the basic industries shall be determined. Standards of workers' health protection and safety shall be brought into practice and fundamental rules for the prevention of occupational diseases and occupation-related injuries shall be laid down. Administrative structures shall be designed to develop standards, provide inspection at employment sites and take other measures to improve occupational safety. Schedules for the necessary training of the required personnel, including occupational safety advisors, occupational hygienists, physicians and laboratory technicians shall be prepared. The activities shall be carried out in close co-operation with the Ministry of Labour and Social Policy.

2.3. Primary health care

This subcomponent shall initiate structural changes in the functioning of primary health care. This will be effected by education of primary health care physicians, who should play the main role in disease prevention and medical treatment of all inhabitants of our country.

A primary health care physician shall be the crucial factor in the process of formation and integration of the teams required not only to perform health care services, but also to ensure health promotion activities for the population of a specified area.

2.4. Development of primary health care policy

Three regional training units (RTUs) for training of physicians in the problems of primary health care shall carry out their activities in conjunctions with the departments of the existing medical academies and other establishments or institutes active in the area of post-graduate training.

Until those institutions develop their own training programs for 1992, RTUs will design and start an intensive training course for primary health care physicians. It is envisaged that the first unit shall start training of 100 physicians who will then become lecturers to teach other physicians. Each RTU's operation shall be based on a 3-year formal program including theory, practical clinical training at selected hospitals, and supervision of activities of selected primary health care units. After starting those activities, it will be possible to train 100-200 students per year in a 3-year training program.

2.4.1. Teaching and training within the primary health care units

This subcomponent shall be concerned with the role of the collaboration and practical combination and interlocking of the functions of practice and community nurses, midwives, rehabilitation workers and social workers forming a part of the primary health team.

2.5. Health management infrastructure

This part of the Project is aimed at supporting the health care system management at the regional level and institutions responsible for the provision of health services. The activities shall concentrate on improving the efficacy of decision-making procedures by establishing information systems and developing professional health care management in Poland through education and training.

2.6. Hospital admission/discharge information

A system of epidemiological supervision based on demographic data shall be established to enable routine control of the effectiveness of the employed procedures and of the costs of hospital services rendered to a defined population.

A portion of the data shall be standardized for all hospitals in Poland and used as a basis for analyses, both at the central and regional levels. Training in data logging, electronic data processing, transmission to a higher level and data analysis as well as interpreting the results shall be undertaken. Managers of the primary-level education shall participate in decision making based on data prepared thus.

Automation of the system, in the first phase, shall be undertaken in three regions (consortia), to be extended over the whole territory of Poland at a later date.

It is envisaged that the capacities of the information systems will be increased step by step according to the degree of developments of tools and available resources, including outpatient department and polyclinic services, some more specific descriptions of clinical services, including laboratory services or those rendered by radiology centres, and pharmaceutical supervision of medical treatment procedures and costs.

2.7. Cost accounting

The primary objective of that part of the Project shall be to establish national standards of accounting practices to be used in the whole health care system by implementing computer-aided hospital accounting systems. These shall include detailed records of spending, based on market prices. In the three pilot regions, the system shall be automated. Local managers shall be trained in the application of the system for monitoring spending, identifying the ways costs are incurred, and for improving system operation and effectiveness of the services. Clinicians shall be trained in the methods of defining and using cost-effective medical procedures to enable selection of the relationship between the financial data and the information obtained from the clinical information and clinical supervision systems.

The Project will also develop the capacity to aggregate financial data in a meaningful way at local, regional and central levels into a system to use those data to analyse costs and define public expenditure trends, thereby providing the desired data to support politicians, managers and providers of medical services.

2.8. Resource allocation

This subcomponent deals with preparation of a more effective system of resource allocation at the regional level based on a combination of demographic data, mortality rates, social and economic factors, interregional flows and the market force factors which affect the health service market.

Objective criteria for financial resource allocation on the regional level shall be determined. Resource allocation processes shall be developed by the Ministry of Health and Social Welfare using the data collected by the clinical information, cost-accounting and hospital admission/discharge systems. The above refers also to the prospective determination of the amounts of regional budgets. Cooperation should be started with the Ministry of Finance to prepare yearly budgets for individual provinces and deciding on the priorities of regional investment projects.

It has been assumed that the Project shall provide expert aid to central- or national-level managers and politicians within the Ministry of Health and Social Welfare and to those of the local level to indicate ways of using the resource allocation system for preparing yearly budgets.

2.9. Quality control and pharmaceutical monitoring

This subcomponent of the Project deals with the problems of the present-day escalation of public expenditures on drugs which adversely affect the realization of the budgetary expenditures of the health care sector. It is, therefore, intended to supervise, on a up-to-date basis, drug utilization through enhancing the technical possibilities of the system of cost-effectiveness and quality estimation. The Project provides for the computer-aided distribution and utilization of drugs with the help of new, useful methods of prescription and non-prescription drug provision. Those measures, aiming at introducing structural changes already in the starting phase, should be based on European standards. A National Pharmaceutical Monitoring Centre shall be established, and the Polish Drug Institute as well as the Pharmacy Department of the Ministry of Health and Social Welfare shall be rearranged and suitably strengthened. The activities shall include also setting up a data base on the national standards of drug utilization both for "prescription drugs" and for those requiring extra payment for by the Government. An improvement of system utility is expected to be achieved by implementing Daily Drug Dosage and Anatomic Therapeutical Chemical (ACT) systems, the role of the latter system being to code and register drugs available in Poland. The activities shall involve:

– identification of physicians who prescribe drugs;
– identification of pharmacists who deliver drugs; and
– identification of the patients who receive drugs, using standard (generally used) identification numbers.

Those systems are also intended to provide data for the nation-wide system of collecting standard code practices to facilitate decision-making by politicians and managers of health service units through indicating relationship and feedback between local, regional, and national levels. Local-level managers and clinicians shall be trained in employing the system to control expenditure on drugs. The Pharmacy Department of the Ministry of Health and Social Welfare, as well as local drugstores and pharmacists employed in the public sector shall be authorized to conduct coputer supervision. Besides, private or privatized drugstores shall require data on the supervision of utilization of the drugs financed from public resources.

2.10. Management development

This part of the Project shall be concerned with the development of institutions and information resources to train managerial staff. The Universities of Warsaw, Lodz and Wroclaw shall be designated to establish, within their structures, centres for under- and post-graduate training in health service management.

It is envisaged that this part of the Project shall concentrate also on increasing the capacities of the National Centre for Health Systems Management (NCHSM), Warsaw, and of the university-based managerial staff training units, as well as on research in health care, simultaneously enabling them to act as providers of consulting services to health care units.

The training shall be developed on the basis of postgraduate fellowships abroad or scholarships in health economics health care management, health care personnel resources management, medical sociology business and administration, informatic technology, and use of new technologies.

There shall be also training based on short-term studies abroad and professional conferences. Technical assistance of foreign experts is expected in the preparation of programs for scientific degrees and continuing education.

2.11. Health care financing

This component shall relate to the definition of alternative forms of health service financing. Feasibility studies have been undertaken about introducing the contribution health insurance system, recovering the costs of activity of the private sector and supporting the preparation of a package of legal regulations on health insurance.

2.12. Regional health care (Consortia)

This subcomponent is intended chiefly to support the Ministry of Health and Social Welfare initiative for reforming the system to improve efficiency of health care services by decentralizing responsibility and transferring it to a local level.

The Project shall be carried out in three regions: Ciechanow, Szczecin, and Poznan, which have been selected as a result of a nation-wide consent. The regions constituted themselves as "Consortia" by creating a suitable legal basis through negotiations which will be soon completed. After completing the estimation of the physical resources of the selected regions, started in May 1991, the individual Health Departments shall present plans for the consolidation of the equipment, assuming 3.5 "acute" beds and 1.5 "long-stay" beds per 1000 inhabitants. The assignment of the tasks shall be carried out within the Consortia, based on:

(a) system of admission/discharge hospital information; (b) cost accounting; (c) materials management; and (d) planning and evaluation.

The pre-appraisal phase of the Project was completed in October 1991. The Project negotiations were held in the beginning of March 1992 and now the implementation phase has been started.

REFERENCES

1. Directions of health system reform, Team: Dawydzik L, Gdulewicz T, Indulski J, Smoleń M, Włodarczyk C, Wysocki J. Warsaw, December 1988 – January 1989 (in Polish).
2. Indulski J, Smoleń M, Włodarczyk C. Some economic aspects of the Polish NHS reform project. Proceedings of I European Conference on Health Economics, Barcelona, 19–21. 09, 1989, C 44, 1–11, 1989.
3. Indulski J, Włodarczyk C. Projects of health system reform in Poland. Some trends in health policy perspective. Paper presented at the Seminar: Changing Health Care System, Situation and Perspective. Kiel, 23-24 May, 1989.
4. Points 2.1.–2.12 was based on "Poland Health Services Development Project", Aide-Memoire of the World Bank Preappraisal Mission, July 1–17, 1991.
5. Project of health care and social welfare reform. Theses. The Party – the Government Joint High Commission. Warsaw, January, 1988 (in Polish).
6. Round Table Conference, Committee for health services. Final official record with annexes, Warsaw, March 14, 1989 (in Polish).
7. The Committee for Reforms in Health Care and Social Welfare System; Proposal of Reforms, Warsaw, Novembr 1989 (unofficial translation).
8. Working Group (Golimowska S, Tymowska K, Włodarczyk C) In the Interest of Health of the Society. A Proposal of Health Care System Reorganization, November 1989 (reviewed translation), also Włodarczyk C, Mierzewski P. Health services reform in Poland: Issues in recent developments. Health Policy, Volume 18, No. 1, p. 13, 1991.

Received for publication: October 18, 1991
Accepted for publication: March 18, 1992