TRANSFORMATION OF THE POLISH HEALTHCARE SYSTEM IN THE YEARS 1920–1999

TRANSFORMACJA SYSTEMU OCHRONY ZDROWIA W POLSCE W LATACH 1920–1999

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ABSTRACT

The research conducted on Polish healthcare system, the subject defined in literature as a group of individuals and institutions in charge of providing healthcare to people, indicates that it has evolved over the years taking a cue from the other countries' solutions. The healthcare system has gone through essential structural changes several times. The major changes aimed at developing free and universal healthcare.
The need for these changes originated from constitutional conditions aimed at subodination of healthcare structures to the authorities. Despite many attempts to reconstruct the system, the functioning of healthcare sector was not effective. There were different causes of healthcare poor condition and they all resulted from political and economical systems' conditions as well as the low living standard and the state's poor development.

KEYWORDS: healthcare system, free and universal healthcare, effective functioning of the healthcare system.

STRESZCZENIE

Badania nad systemem ochrony zdrowia w Polsce, w literaturze przedmiotu definiowanego jako zespół osób i instytucji mających za zadanie zapewnienie opieki zdrowotnej ludności, wskazują, iż ewoluował on na przestrzeni lat, czerpiąc wzorce rozwiązań z innych państw. System ochrony zdrowia kilkukrotnie przechodził istotne zmiany strukturalne. Podstawowe zmiany miały na celu rozwinięcie bezpłatnej i powszechnej opieki zdrowotnej.
Konieczność zmian wynikała z uwarunkowań ustrojowych, mających na celu podporządkowanie struktur lecznictwa organom państwa. Pomimo wielu prób przebudowy systemu, nie doprowadziły one do efektywnego funkcjonowania sektora ochrony zdrowia. Przyczyny złego stanu służby zdrowia były różne i wynikały z uwarunkowań ówczesnego systemu politycznego i ekonomicznego oraz niskiego poziomu życia i rozwoju państwa.

SŁOWA KLUCZOWE: system ochrony zdrowia, bezpłatna i powszechna opieka zdrowotna, efektywne funkcjonowanie systemu ochrony zdrowia.

Introduction

The Polish healthcare system underwent fundamental changes in the years 1920–1999. The criticism of the multi-sector healthcare system growing after the year 1946 was a sign of the political elite's aspirations to establish a central management system. The legal and organizational merger corresponded to the idea of social medicine in regards to objectives and structure, conforming with the requirements of central planning, management and financing. During the Polish People's Republic (PRL) period the system was modified multiple times. Improvements involved primarily organizational changes within the system. At the end of the 1990's the government became decentralized. Changes to the political system lead to a transference of management and ownership functions of most public healthcare facilities to local governments: communes, districts and provinces.

Evolution of the healthcare system in the years 1920–1999

The first legal act of the interwar period which regulated the healthcare system was the health insurance act [1], which became effective in the year 1920. According to the adopted legal solutions, the Polish healthcare system was modeled on the German system of health funds (the so called Bismarck model), although it more strongly focused on their territorial structure and self-governance. Health funds were local government institutions with their own legal personality. There was to be one in every district, and in cities above 50 000 inhabitants the bill allowed the establishment of separate municipal funds [2]. The primary objective of health funds was securing of benefits in case of illness, payment of monetary allowances and free of charge medical aid. Legal protection covered only hired workers, for whom health insurance was obligatory, while the amount of benefits paid out was dependent on the contributions paid by the employee, as well as the employer. The state did not bear any financial burden associated with the functioning of the insurance benefit system. Until 1931 there were 243 Health Funds of various types (communal, industrial, common, trade guild, associational). The organization of Health Funds was modified in 1931 [3]. The 243 district Health Funds existing up to that point were merged into 61 Territorial Funds.

The insurance in case of illness and maternity, incapacity for work or death of the insured, due to a fall from height during work, occupational illness and due to any other reasons was introduced by the 28th of March 1933 law [4] on social insurance. The law specifies the functioning of the healthcare system in the area of providing medical aid through the social insurance. Health funds were abolished and replaced with the newly established Chamber of Social Insurance, which consisted of Social Insurance and the Social Insurance Institution, which included:

- Insurance in Case of Illness Institution,
- Insurance Against Accidents Institution,
- Worker Pension Insurance Institution,
- White-Collar Worker Insurance Institution.

The operation of the insurance system was changed by the resolution of the President of the Republic of Poland dated 24th of October 1934 [5] amending the 28th of March 1933 social insurance law. The act closed down the abovementioned institutions, in their place appointing the Social Security Institution (ZUS) and social insurance companies, called social security companies in the act's text. The Social Security Institution was appointed in order to carry out all operations in the area of insurance, which were supervised by the minister of social welfare. The objectives of insurance companies, which reported to the Social Security Institution, were: establishing insurance obligations, administering illness and maternity benefits, calculation and collection of insurance contributions, as well as insurance record keeping [6].

The tasks of the State in the area of overseeing citizens' health were specified by the 15th of June 1939 public healthcare act [7]. The act established the objectives of public healthcare which especially included the following matters: combating and preventing diseases, treatment and preventive facilities, health resorts, cemeteries, hygienic and medical care of the mother and child, especially in public and training schools, schools hygiene, physical education, care over summer camps and summer play centers, provision of water for the public and removal of waste, sanitary control of food articles and utility products, domestic and work hygiene, bathing resorts, public transportation hygiene, sanitary control of the production and circulation of medical and prophylactic products, pharmacies and drugstores, supervision over active professions within healthcare. The minister of social welfare was responsible for the execution of tasks established in the act and authorities of the general administration, local government, economic self-government, as well as social security companies and other public and social organizations [8].

The 1939 act was the culmination of hitherto work and almost nineteen year experience of Poland in the area of institutional and social organization of a healthcare system, highlighting the medical treatment and preventive obligations, care for the development of treatment facilities and health centers [9].

The Polish Committee of National Liberation (PKWN), which in its manifesto [10] from 1944 announced restoration of social security companies, had significant meaning in the organization of healthcare after the World War II. Restoration of the insurance companies in the scope of organizational form began by appointing the insurance companies' self-governments and boards.

The same year saw the creation of the Commissioner's Office of Epidemic Control, which began establishing the central administrative structure in the area of healthcare. The Ministry of Healthcare was established in 1945 as a result of separation of the Ministry of Labor, Social Welfare and Healthcare. The actions taken by the state in terms of healthcare organization were aimed at covering the broadest possible social masses.

A change in supervision over healthcare took place in association with the entry into force of the 3rd of January 1946 act on medicine supervision [11]. The Minister of Healthcare was tasked with establishing a general healthcare supervision plan, taking into account the needs of the population in tis area and the potential of facilities, institutions and organizations providing medical care.

The dominant organizational form of providing medical services during that period were free-practicing physicians and surgeons, while hospitals continued to function based on the rules specified in the 1933 act.

The functioning of healthcare based on the state and self-government model was introduced with the 22nd of July 1948 act on public healthcare facilities and planned economy in healthcare [12].

It was a model based on Soviet templates called the Siemaszko model [13]. According to that model, healthcare was [14]:

- state-governed – a part of the state's organizational structure and financed from its budget;
- public – provided care for the entire population by ensuring available and free of charge medical services to all citizens;
- unified and comprehensive – i.e. all healthcare institutions constituted one organizational and functional whole, which reported to the central state management, aimed at prophylactics and maintaining continuous care.

The law began a process of unifying the healthcare structures in line with central planning, management

and financing. In subsequent years the following acts were passed: the 20th of March 1950 act of territorial unified state authority bodies, the 20th of July 1950 act on the establishment of the Worker's Medicine Institution, and the 15th of December 1951 act on the state takeover of healthcare institutions, which would lead to the creation of a unified healthcare system. The minister had full supervision over healthcare, in particular: its financing, organization and operation of open and closed healthcare facilities and their workforce. Healthcare was financed from the state budget regardless of the inflow from contributions, which employers were charged with. The only groups not covered with free of charge medical services until the year 1972 were individual farmers and their families.

The transfer of multi-sector medical facilities to state authorities took place in two stages. In the first instance, private, local-government and congregational healthcare was abolished, followed by insurance-based healthcare [15].

The newly appointed institution named the Employee Healthcare Institution (PL – Zakład Lecznictwa Pracowniczego, further ZLP), which directly reported to the minister of healthcare, played a significant role in the process of administrative unification of healthcare facilities. The task of ZLP was swift takeover of the estate belonging to Social Insurance Companies, local-governments, the Polish Red Cross, Children's Friends Association, among others [16].

The merger did not cover medical facilities under the Ministry of Public Safety, Polish Military and Polish State Railways. These institutions had separate rules regarding financing, medical equipment and pharmaceutical supply [17].

The nationalization of the healthcare system in Poland led to the matters of health protection dependent on socialist ideology, which ultimately did not serve to improve its functioning.

In the 1950's and 1970's there was further work performed on the improvement and development of the Polish healthcare system's organizational structures. Scientific facilities and schools educating medical and medicine-related staff were established. There was an increased significance of industrial medicine, which contributed to the creation of company clinics. Large emphasis was put on prophylactic actions, care of women and children, while periodic medical examinations became a priority in healthcare. The general and specialized care system, open and closed medicine, medical care and social welfare became integrated into a basic healthcare system [18]. The changes which happened in the healthcare system did not lead to its proper functioning. The established system was seemingly free of charge, the public was provided with free or very low cost medicine, while the burden of decisions regarding medical actions taken was transferred from the citizens to officials and healthcare employees. As a result of this healthcare system citizens lost the awareness of moral and material responsibility for their own health and life [19]. The irregularities of the system operation became much more apparent. The economic crisis growing at the time, which also affected the healthcare system, additionally contributed to its deteriorating condition.

Among the reasons justifying the necessity to reform the Polish healthcare system, the most important were [20]:

- excessive centralization and bureaucratization of decisions,
- insufficient funding compared to the needs of healthcare and omission of economic tools, including simple cost calculation, as mechanisms of medical action rationalization and exploitation of reserves present within the system,
- unsatisfactory utility of motivational instruments, which could positively influence the effectiveness of work of personnel employed within the system,
- insufficient knowledge of the management staff in the area of public healthcare, especially in relation to the so called managerial issues, i.e. system organization, management and economics,
- impracticality of organizational structures of the system compared to local conditions and requirements,
- formal treatment of the public's participation in the system's functioning and control over its operation,
- underestimation of the rights and responsibilities of the public and patients in the area of contributing to decisions in matters related to their health.

Change in the functioning of the healthcare system became a necessity. Central management failed to bring the expected results in terms of the system's efficiency, which resulted in the commencement of work on changes which were aimed at introducing market-based mechanisms. Work on changing the rules of healthcare functioning began with the 30th of August 1991 act on healthcare facilities [21]. According to the new law, a healthcare facility was an organizationally separate group of individuals and assets, established and maintained for the purpose of providing healthcare services, health promotion, conducting scientific research and research and development work, didactic tasks in relation with the provision of healthcare services and health promotion.

A facility, providing healthcare services, undertakes actions in order to maintain, save, restore and improve

health. The passed bill made it possible to introduce radical changes in the area of financing and organizational authority of all institutions which formed the healthcare system. The functioning of public healthcare could be supported by market mechanisms. The public resource circulation market was to bring benefits in the form of competition between medical service providers, which would in turn result in rationalization of expenditures and improvement of the quality of services provided.

The healthcare facilities act in its mode, which was based on community care, did not bring the intended result, which was improvement of the health of the general population. Additionally it became apparent, that the model became too costly and poorly integrated. The healthcare system became inefficient, which is why the government and Sejm of the Republic of Poland adopted the "Strategy for Poland", which included a reform program of the citizens' social security, including the establishment of public healthcare insurance together with specifying the range of healthcare benefits guaranteed by the state from public funds [22].

In 1994 the minister of healthcare and social welfare presented a policy document titled "Strategy for health", which included a reform program of Basic Healthcare (PL - Podstawowa Opieka Zdrowotna – POZ) [23]. The organization of POZ was based on a family physician as the coordinator of the medical process, supported by a pediatrician, as the objective of family medicine was provision of patient care throughout their entire life. The activity of a family physician was supported with mid-level personnel, i.e. an obstetrics nurse and medical personnel trained in diagnostics and rehabilitation.

The „Strategy for health" also included the following proposals of changes:

- decentralization of basic healthcare,
- replacement of the financing of healthcare from the state budget with a mixed system of insurance and state budget financing,
- organization of benefits transferred to local governments,
- transformation of healthcare facilities into self-government entities,
- restructuring of hospitals and categorization.

Work on reforming the healthcare system were completed in 1997, which in February that year made it possible for the Sejm to pass the public health insurance act. The act became effective on the 1st of January 1999 [24], changing the budgetary (command and quota) system to a public system of health insurance. The state abandoned the role of monopolist in the area of healthcare, however retaining the obligation of its financing and control. 17 health funds were established (one for each voivodship and one for uniformed services), which managed the accumulated financial resources and at the same time served as payers for health services. As a result of the transformation, the transfer of funds to healthcare facilities was abandoned and replaced with the purchasing of medical services.

Health funds, ensuring performance of services to the ensured, did it by purchasing appropriate products, which could be a medical service, medical procedure, package of services and medical procedures [25]. They specified the number of services purchased based on data associated with the performance of services in prior periods. The main objective of health funds was more efficient use of the resources at their disposal, creating a supply of medical services. Contracts on medical services were limited by the budget at the disposal of health funds in a given calendar year, not the actual demand. Such operation was made possible as a result of introducing the term of cost carriers based on the resolution issued by the minister of health and medical care regarding detailed calculation of costs in public healthcare facilities.

Contracting of medical services took place in the form of an agreement, in which the quantity and price were a result of negotiations. On one hand service provision agreements ensured the financing of healthcare entities, while on the other hand they specified the description and pricing of services and settlement procedures. The possibility of concluding contracts was also given to non-public healthcare facilities, which were to provide competition for public healthcare facilities on the medical service market. Competition in the provision of services was to bring about increased availability, as well as improved quality. The consequence of such a solution was, on one hand, limitation of financial resources transferred to public healthcare facilities, which later turned out to cause an upset or loss of financial liquidity, as health funds specified the pricing of medical services, procedures and hospitalization at their own discretion, since there were no unified contracting rules. On the other hand this resulted in rapid development of non-public healthcare facilities, especially in the area of basic healthcare.

With the effective date of the public health insurance act, the second local government reform was introduced, which led to a takeover of healthcare facilities from voivodes in relation to the execution of so called own objectives by local governments. Apart from holding ownership functions over healthcare facilities, local governments were tasked with establishing healthcare policies within broadly understood healthcare, covering organization of a local health protection system.

Final remarks

In the years 1920–1999 the Polish healthcare system underwent radical changes. The interwar period was characterized by health funds achieving a stable economic situation, at the same time securing illness benefits, payment of monetary allowances and free of charge medical aid. All the while a very significant flaw of the system was the coverage of only hired workers. Centralization of healthcare also failed to achieve its objectives. Top-down management of the healthcare system led to housing difficulties, lack of instruments and equipment, as well as a decreased quality of provided medical services. Discontinuation of reform resulted in the system finding itself in a state of serious crisis, not only of a regulatory, but also financial nature. Subsequent changes with the purpose of decentralizing the system failed to bring the expected results in the area of healthcare functioning. In the author's opinion, the failure of reform was not a result of a fallacious concept, but difficulties in its execution and much too rapid abandonment of the concept in favor of a different direction. The success of changes to a large degree depended on the system's level of financing and development of multi-sector medical care structures.

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