POLAND'S HEALTH SYSTEM ANALYSIS

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ABSTRACT

The paper investigates the changes in Poland's medical sphere. After regaining its independence in 1989, Poland initiated a series of reforms, with the medical sphere included. The Semashko system has been transformed into the social health insurance (SHI), which today covers about 98 percent of the population. From 2018, Poland plans to move to the Beveridge system, which unlike SHI, is funded through government revenues. However, there are still challenges to be solved. For now, Poland is still among the countries with the lowest health expenditures and long waiting lines in hospitals. Nevertheless, Poland may serve as a great example for Ukraine of how to implement the health reforms and improve the health status of its citizens.

Key words: healthcare reform, Poland, Harvard Flagship approach

JEL classifications: H51, I15, P46

1. Reforming the health system

1.1. Geographic, socioeconomic and economic characteristics

The 1989 revolution led Poland to the establishment of democracy. The country elected parliament and entered the market economy. Nowadays, Poland has the sixth largest high-income economy in the European Union, and in 2017 it was ranked as 24th worldwide in terms of GDP by the Ease of Doing Business Index. The service sector, industry and agriculture are the main contributors to Poland's economy. The GDP per capita, with adjustment of PPP (Purchasing Power Parity), was 26,003.01 US dollars in 2016.

In 2016 the country's population was 37.948 million (3, 2016) with an administrative area of 312,679 km2. Poland borders Lithuania, Belarus and Ukraine in the east, the Czech Republic and Slovakia in the south, Germany in the west and the Baltic Sea delimits Poland in the north.

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1.2. The pre-reform health system

During 1918-1939, Poland remained independent and its health care system was based on the Bismarck model, which covered about seven percent of the population. The Ministry of Public Health, Social Assistance and Work, founded in 1918, was responsible for the information campaigns among the population and fighting infectious diseases.

Under the Communist Regime, Poland's healthcare system was based on the Semashko model and funded through taxation. The system was highly centralized with a focus on mother and child care. However, it should be noted that private health practice was never completely abandoned.

There were several issues with the state of Polish healthcare system before 1989. For example, to begin with, there were no breakdowns for the various types of healthcare services. Up to 35 percent of the population had to make "gratitude" payments in order to obtain decent care and have access to drugs, medical equipment or long-term care. The patients also paid for various types of healthcare services out-of-pocket and had limited options in choosing a physician.

1.3. The health-care reforms

Poland became independent in 1989 and actively began reformations. Under the Constitution of 1997, all citizens have equal right to health services, no matter their financial status. In 1997 the Law on the Universal Health Insurance was introduced, and it came into force in 1999. At that time social health insurance (SHI) was implemented, alongside with the creation of 17 sickness funds. The system was highly decentralized, and only after four years of being active, those sickness funds were replaced by the NFZ in 2003. Nowadays, almost 98% of population is covered by SHI, which is compulsory for the majority of citizens.

1.4. The health-care reforms

Poland continues to develop its healthcare system. As the moment Poland is in the process of switching to a Beveridge system, the example of which serves the British National Health Service (NHS). The NHS is a coverage health system, which is funded through government revenues. The law of restraining the NFZ system will take into power on January 1, 2018 and furthermore the healthcare will be funded through government revenue. Such a change will definitely have an effect on drug pricing and reimbursement, but how it will affect the patients is still unclear.

1.4.1. Financing

Poland still remains the country with one of lowest health expenditures as a share of GDP among other countries. Such a rank may be partially attributed not only to low GDP, but also to the low share of healthcare expenditures. The corresponding trend is presented in Figure 1.

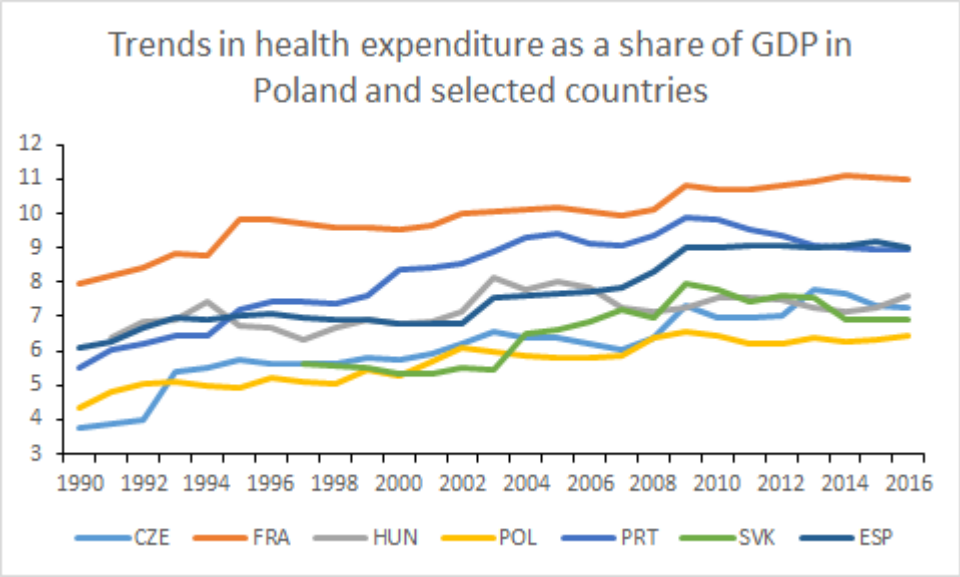

Figure 1. Health expenditure in Poland and selected countries over 1990-2016. Source: Authors' calculations based on OECD database (Organisation for Economic Co-operation and Development 2011)

About 70 percent of healthcare expenditures in Poland come from public sources. The main one is NFZ (about 65.7% covered in 2008) and the other ones are the state budget and the territorial self-governments. About 30 percent of healthcare expenditures come from private sources. So, the share of private healthcare financing is higher in Poland than in any other EU country, although it experiences a decreasing trend.

The NFZ insurance covers a vast range of health care services with the exceptions of drugs, medical products, resort treatments, dental services and some auxiliary medical devices.

1.4.2. Payment and incentive structure

The payment mechanisms differ depending on the service's type. The co-payment system is mostly used for the medicines and medical products as well as for rehabilitation and recreation centers. A positive reimbursement list exists (lump sum), where the patient pays 30% or 50% for the required drug.

As for indirect payments in Poland, they usually are "envelope payments", gratitude payments or bribes to avoid the waiting list, or so-called "voluntary" donations to the hospitals. But with the implementation of anti-corruption law, the guidebooks of legal behavior for physicians and patients have been prepared. The further reforms of privatization and salary increases would allow for a more formal payment scenario. Generally, primary care is funded through annual capitation payment per patient registered with a primary care physician. Specialist ambulatory services are used in a fee-for-service system and inpatient care is financed by the Polish JGP. The NFZ provides the pharmaceuticals in ambulatory care.

Several methods are used for payment of the medical personnel. They are contractual employment, civil law agreements (contract, mandate), self-employment and state financing of medical students and trainees. It should be noted that the salaries in the health sector have risen by 15 percentage points between 2000 and 2010.

1.4.3. Organization

Most hospitals in Poland are public, but the share of private entities is increasing. The non-public hospitals may be split into two groups: those with 100% total ownership and those with local self-governments being the stakeholders.

The hospitals differ in size, but most medium-sized entities are public, while the small-sized hospitals are usually private (see Table 1 from Sagan et al. 2011).

Table 1. Number of hospitals by size, mid-2011

Number of beds	Public hospitals	% Public	Private hospitals	% Private	Total	% Total
<50	27	4.4	331	61.7	338	30.2
50-150	133	21.6	92	18.3	225	20.1
151-250	138	22.4	43	8.5	181	16.2
251-500	195	31.7	40	7.9	235	21.0
>500	120	19.5	9	1.8	129	11.5
Hospitals with only day-care beds	2	0.3	9	1.8	11	1.0
Total	**615**	**100**	**504**	**100**	**1119**	**100**

Source: Sagan et al. (2011).

All hospitals with the NFZ contract receive financing from JPG no matter of their type, location and ownership status.

In October 2017 the law which may come into force will introduce the new model of contracting and accounting services, and will prohibit hospital privatization. The law's main focus is to stop publicly-funded hospitals from being profit-focused.

1.4.4. Regulation and persuasion

Sagan et al. (2011) describe in detal a regulation of healthcare system in Poland.

The NZT presents all information about its services on a web-site and the share of patients seeking health-related information increased over years. The public campaigns aimed at promotion of healthy lifestyle and public discussions about importance of health reforms have led to the awareness among citizens about the healthcare situation in the country. As for now, the Polish know where to find needed information and to whom to come in case of sickness.

1.5. Reform Effects and remaining challenges

The healthcare reforms in Poland have resulted in increased life expectancy, and the proportion of aged citizens has also risen. So, despite positive changes, there are further needs for improvement. For example, the average Polish person is more likely to die from circulatory disease and approximately one-third of disease causes are attributed to unhealthy behavior, such as smoking, alcohol consumption,

physical inactivity and obesity.

1.5.1. Ultimate system goals

- *Population health status*

The overall improvement of health status of Polish citizens indicates the substantial increase in average life expectancy with 80.2 years (women) and 71.6 years (men) in 2009. The immunization of the population is high, especially for tuberculosis and childhood diseases.

The bigger share of population claims to be in good health, but income inequality still exists. In 2015 71% of citizens with a high-income status that they are healthy, while only 53% of citizens report being healthy.

- *Financial protection*

Under the NFZ system, most residents are secured against catastrophic events and their share of out-of-pocket payments decreases over time. The insurance system is broad one and only several services require co-payments.

- *Patient satisfaction*

Table 2. Patient satisfaction with service

Indicator	Poland		Ukraine	
	2010	2016	2010	2016
Problems with local public health clinic or hospital during the past 12 months, which were mentioned by respondents:				
Long waiting times	28.65%	66.23%	35.98%	58.01%
Staff disrespectfulness	7.98%	13.73%	18.79%	21.19%
Payments for free services	6.00%	9.97%	28.29%	36.82%
Absence of doctors	5.01%	12.51%	13.34%	18.81%
Facilities not clean	2.60%	2.54%	6.16%	7.02%
No drugs available	2.41%	7.15%	31.11%	58.41%
Have used health services during the past 12 months	55.88%	70.87%	70.17%	50.10%
Satisfied (or very satisfied) with the quality and the efficiency of the service/interaction	34.59%	45.72%	32.39%	38.94%
Assessment of current health (good or very good)	57.80%	59.80%	31.94%	37.69%

Source: Authors' calculations based on Life in Transition Surveys II and III (Steves et al. 2011, European Bank for Reconstruction and Development 2016).

Based on LIT data (see Table 2) we can state that during 2010-2016, patient satisfaction in Poland generally decreased. The main issue in this period was long waiting times in local public health clinics or hospitals due to lack of financing and poor organizational level in hospitals. Mainly this is the reason for the increase in such issues as staff disrespectfulness and absence of doctor or drugs. In the same time period, Ukraine had many more problems with shortage of drugs and payments for free services; issues with waiting times are relatively the same. It is worth noting that Poland has a much higher self-assessment of health (60% and 38% respectively).

Table 3. Patient satisfaction with payments

Indicator	Poland		Ukraine	
	2010	**2016**	**2010**	**2016**
1st priority of government spending	44.18%	43.27%	41.76%	33.38%
2nd priority of government spending	23.95%	29.31%	25.72%	26.21%
Willingness to give extra money on health improvement	31.99%	30.07%	53.88%	48.64%
Think that receiving medical treatment in the public health system requires unofficial payments or gifts (always)	1.98%	2.27%	16.04%	3.65%
Made an unofficial payment or gift when using medical treatment in the public health system over the past 12 months	5.38%	6.49%	36.31%	33.25%
Reasons for making an informal payment for services while they should have been received for free:				
I was asked to pay	0.37%	-	9.94%	29.88%
I was not asked to pay (but I knew that an informal payment was expected)	2.91%	27.54%	13.60%	20.72%
I offered to pay, to get things done quicker or better	0.43%	28.99%	6.48%	23.90%
I was not asked to pay (but I wanted to express gratitude)	1.30%	37.68%	5.39%	24.30%

Source: Authors' calculations based on Life in Transition Surveys II and III (Steves et al. 2011, European Bank for Reconstruction and Development 2016).

In 2010, 44% of respondents in Poland indicated that health is the first government priority and 24% indicated it as the second priority. The 2016 indicators do not change much, which demonstrates that people do not see any significant improvements in the health care system. In general, based on expectations about unofficial payments and experience of such payments over the past 12 months, Poland has a better situation than Ukraine, as presented in Table 3.

2. Reforming Health System Governance

Generally, the parts of health care system are divided between the Ministry of Health, the NFZ and the local self-governments. The Ministry of Health states the national policy and provides the financing of the long-set healthcare goals. The NFZ deals with the division of finance between the population that is covered by insurance. And the territorial governments are responsible for local provision of healthcare services, hospitals and physicians' payments and organization.

3. Lessons for Ukraine

Ukraine is similar to Poland in that it suffers from the legacy of the Semashko system. The attitude towards free health services and lack of personal responsibility in maintaining the healthy lifestyle are just a few examples, among many others. The other ones may include corruption among physicians and the so-called "gratitudes", where a patient thanks a doctor by giving him an envelope with cash.

Poland has come a long way to leaving the Semashko system in the past. The salaries of health personnel have increased (between 2000 and 2010 the salary rise was about 15 percentage points). The budgetary system has undergone changes (the shift from one therapeutic area to another one in term of financing or reallocation of the funds) and the hospitals have been reorganized (decreasing the number of departments or changing the hospital profile).

The private sector dominates in most spheres of healthcare services, and the public sector mostly covers hospital treatment. This allows for better management of hospital efficiency and improved allocation of treatment methods. This is a great example for Ukraine, which demonstrates that private medicine not only exceeds the patients' needs but also provides effective long-term care.

Medical tourism is another prospective sphere in which Poland is actively evolving. Since the cost of treatment in Poland is lower than in most EU countries, there are a great number of foreigners who come to be cured or to relax in Poland's health facilities. Such kind of tourism is extremely abreast of the times and has great potential in Ukraine.

Patients' perceptions of healthcare and physicians have also endured a shift. Now the Polish are more likely to see a good doctor in a clinic with a high quality of services rather than simply visiting a random physician.

Therefore, Poland which has experienced a similar healthcare system background to Ukraine may serve a great example of neat and effective health reforms, which should be taken into consideration for further changes to Ukraine's health system.

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