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HEALTHCARE IN POLAND – THE MAIN OPERATIONAL ISSUES

Abstract. The objective of the paper is an assessment of the level and structure of financing the public health services in Poland; the main causes of deaths and relations between the health conditions within Poles and the level of financing public health care system. The aim of the article is indication main negative and positive issues of running the public health care system in Poland. The analysis is based on the last 5 years and refers to changes in Polish health care system which happened in 1999, when the public health services are started to be financed by a health insurance premium. The part of the premium reduces the income tax. The purpose of article is the test of answer the question: what kind of consequences in the level of financing and in health conditions have happened after changes which was carried into effect in 1999.

Key words: Public Health Care System, health services, financial situation of the National Health Fund, health insurance

1. INTRODUCTION

Health and human life are our most important and priceless possessions, all other risks that surround a human being become irrelevant once he loses his health.

The protection of health is an essential part of a widely understood public utility sector and the way the healthcare services are financed still remains a problem of successive governments, not only in Poland. The attempts undertaken to reform the healthcare system in Poland have shown the complexity and controversies of the problem.

From 1999 and the founding of Health Funds as regional organisations of public healthcare insurance, which were to provide the citizens with healthcare services, though their later transformation into Voivodship Departments of the National Health Fund solutions, which could be considered as satisfactory and effective, failed to be found. There is no doubt about the fact that "the health insurance premium" in function today which burdens the employers and has the same rate for all the insured citizens, is in fact a special-purpose tax which does

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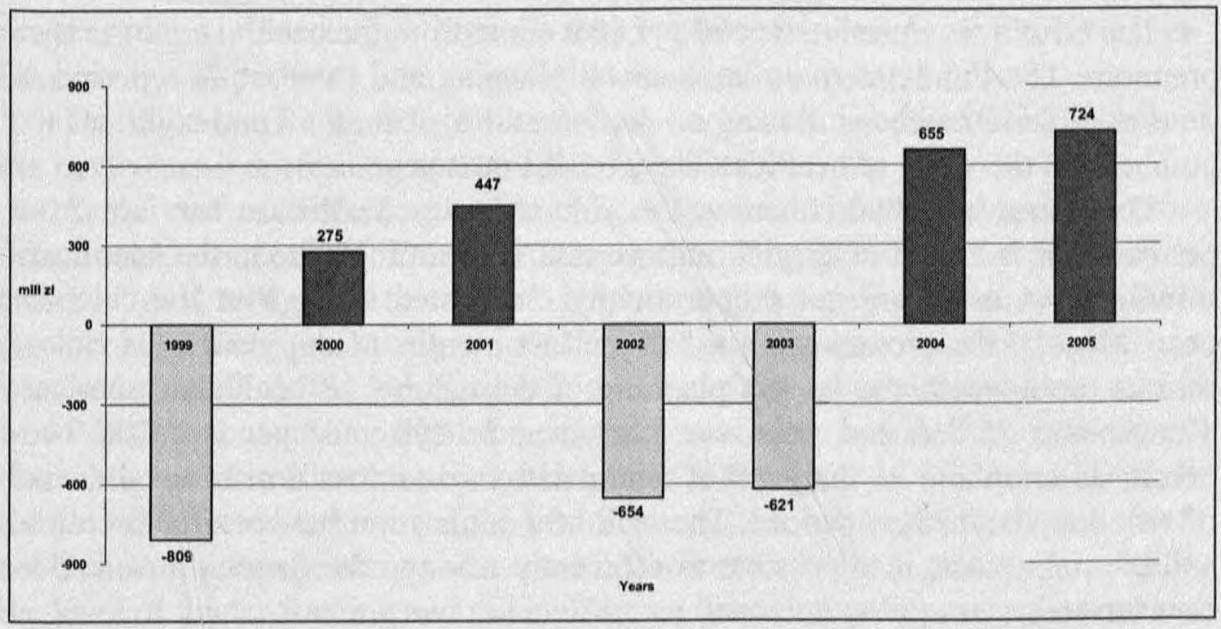
not relate to the actual risk connected with an illness and does not motivate the employers to improve the working conditions. It cannot be an effective tool to efficiently manage the healthcare insurance system.

The rudimental problems of heath protection in Poland include: the lack financial balance in healthcare system, the indebtedness of public healthcare institutions, the poor technical state of the infrastructure, low remunerations of the medical personnel and the migration of the medical personnel, the delays in the implementation of new medical technologies, limited access to medications, waiting lines to specialist doctors and corruption in the healthcare system.

2. RESULTS OF FINANCIAL ACTIVITY OF REGIONAL HEALTH INSURANCE ORGANISATIONS IN POLAND

If we analyse the financial situation of the Fund between 1999 and 2005 we should pay attention to an extremely high amplitude of the fluctuations of the financial results of National Health Fund. This phenomenon should be considered as negative, especially when we talk about non-profit institutions. The taxonomy analysis of Health Funds, which was prepared by the writer in her dissertation, allows us to draw some conclusions: from 1999 to 2002 the funds very often modified the position of taxonomy classification and they were not be able to keep the same position for a long time, which proves that there has been no stability in the health care system.

The Fund ended its activity in 2004 with the earnings exceeding the costs by 655 mill. zł which enabled the reduction of the accumulated loss from the level of 1580 mill. zł to 408 mill. zł. The profit was also used to reduce the level of external liabilities after their date of payment, including service providers and pharmacists (from the level of 224 mill. in December 2003 to 37 mill. zł). The liabilities resulting from the loan given to Health Funds were also reduced by 100 mill. zł, it means a decline of about 12 per cent. The level of the NFZ's financial result in 2004 was caused by several factors, which acted at the same time. First of all, the improvement of Polish economy caused an increase in the level of wages and salaries and that caused a growth in the level of earnings due to the healthcare insurance premium of 400 mill. zł. The Fund obtained a result of 170 mill zł – higher than expected – in financial activity of 38 mill. zł. The level of the costs of healthcare services was also reduced – by 27 mill. zł (administrative costs by 17 mill. zł; the costs of keeping a record of the healthcare insurance premium collection by 7 mill. zł).



Graph 1. The financial results of Health Funds and the National Health Fund in millions of zł

* also includes the first quarter of the operation of Health Funds

S o u r c e: own calculations based on NFZ Reports concerning 2000-2005 and the profit and loss calculation of NFZ for years 2000–2005.

2005 was another year which the Fund finished with a positive net financial result of 724 mill. zł, 137 mill. zł of which came from the voivodship departments (only the Zachodniopomorski department had a negative financial result) and the remaining 527 mill. zł from the head office of the Fund. The level of the financial result in 2005 was determined by the higher than planned earnings due to the healthcare insurance premium of 467 mill. zł, the higher than expected result in financial activity of 21 mill. zł, the lower than planed costs of healthcare services which were lower by 93 mill. zł; the lower (by 18 mill. zł) administrative costs and the lower (by 9 mill. zł) costs of keeping a record of the healthcare insurance premium collection.

Summarizing the financial activity of the Health Funds we can say that introducing an insurance model in the health care system and separating resources for financing health care services from the national budget caused difficulties in the correct working of the health care system.

In 2003 the NFZ's financial activity was finished with a balance of minus 600 mill zł. In 2004 the Fund obtained a surplus of 655 mill. zł and the next year the NFZ also gained a surplus of 724 mill. zł.

Considering the fact that both the Health Funds and the National Health Fund are profit-oriented institutions, we should note that large financial surpluses and high losses are not signs of a well run financial economy and efficient management in institutions of this kind.

The NFZ's revenues in over 90 per cent come from the health care insurance premium. The Funds' activity is based on planning and forecasting a period of 3 years of these revenues. Basing on the forecasting data, the Fund contracts the number and the value of health services for the next year.

The premium which finances the contemporary healthcare services from public funds is a kind of special-purpose tax. The earnings due to the healthcare insurance premium are not proportionally distributed throughout the calendar year. Most of the premium is paid in the last months of the year. This causes serious problems in the correct planning of the number of healthcare services. The amount of financial resources that enter the system depends on the economic situation and on the level of remunerations and does not reflect the level of risk that should be financed. The lack of a connection between the premium and the risk makes it impossible to efficiently manage the financing of healthcare services.

3. INDEBTEDNESS OF HEALTHCARE INSTITUTIONS

Despite the fact that year after year the public healthcare system was increasingly supported by financial resources the indebtedness of the healthcare institutions rose.

Table 1

Payable obligations of SPZOZs (Independent Public Healthcare Institutions) in 2000–2005 (in mill. zł)

Years	2001	2002	2003	2004	2005	2006*
Liabilities	2 744.4	3 245.4	4 729.7	5 872.3	4 933.6	3 845.1
Dynamics previous year = 100	–	118.26	145.74	124.16	84.01	77.94
Liabilities per capita	71.76	84.91	123.84	153.83	129.29	100.85

*estimated data

Source: own calculations based on: Indebtedness of the Independent Public Healthcare Institutions (*Zadłużenie SPZOZ)*, Ministry of Health, Warsaw 2006, http://www.mz.gov.pl/wwwfiles/ ma _struktura/ docs/dynamika_zadluzenie_2_22022007.pdf from 12.03.2007.

The extremely high level of debt in the SPZOZ units had grown until 2005 (the level of the year average rate of increase was 7 per cent), when the growth rate was visibly reduced and the last quarters of the year brought a reduction of the debt. The level of debt is calculated on the basis of payable obligations i.e. liabilities for which the time of payment has already elapsed. The highest (year

to year) dynamic change was in 2003 when the level of liabilities increased by 46 per cent compared with the previous year.

The highest amount of liabilities per capita was obtained in 2004 (154 zł), in the next years it decreasing and in 2006 was 100 zł.

At the end of 2005 the payable obligations totaled 5.8 bn zł and had more than doubled since 2001. During 2002 payable obligations rose by 501 mill. zł (from 2 744.4 mill. zł, at the end of 2001, to 3 245.4 mill. zł), whereas in 2003 the increase of obligations was more than 2.9 times greater than in the previous year and totalled 1 484,3 mill. zł (an increase of payable obligations to a level of 4 729.7 mill. zł). Since 2004 the debt's increase rate has slowed down – payable obligations in 2004 rose by 1 142.6 mill. zł to a level of 5 872.3 mill. zł. In the period before the reform of the healthcare system, when the institutions were not financially independent and were financed directly from government funds, the level of under-funding and the ineffective financing policy caused a constant increase of the obligations. From 1 January 1999 the majority of these debts totalling 8.4 bn zł were taken over by the National Treasury and were paid of through Bank Handlowy and in the form of a tax compensation. This writing off of the debts did not bring long lasting results, since 1999 the independent public healthcare institutions have started to generate a new debt. From 1999 on the expedient reserves of the state's budget finance the obligations of the National Treasury which date back from before the independence of the healthcare institutions. For this purpose 499.2 mill. zł was assigned from 1999 to 2005. This phenomenon could be caused by: the act of delegating tasks connected with healthcare to the local government without adequate funds to perform them; a very low level of financing of services in the public healthcare system (the service procedures are often financially underestimated) and the services exceeding the limit are not financed by the payer. Such a level of debt was also caused by the act of 22 December "2000 changing the act of 16 December 1994 on the negotiating system of determining the increase of remunerations and on the changing of some acts and the act on healthcare institutions" (the so called „203 act"), according to which in 2001 the healthcare institutions were obliged to give their employees a raise of no less than 203 zł with social derivative charges and in 2002 a raise of no less than the increase of the average remuneration in the national economy.

In 2000–2004 payable obligations rose approximately at a rate of 0.8–1.3 bn a year. During 2005 the pace of the growth of debt slowed down and at the end of 2005 the debt was visibly reduced to less than 5.0 bn zł, which was connected with the implementation of the public aid and public healthcare institution restructuring act.

As far as the geographic aspect is concerned, looking at the problem of debt one can state that four voivodships dominate in terms of the amount of indebted-

ness and together represent more than a half of the total healthcare debt. The cumulated debt of healthcare institutions in 2005 in these 4 voivodships: dolnośląskie (21.9%), łódzkie (10.9%) mazowieckie (10.8%) and pomorskie (10.2%) – represents 53% of the total debt. The SPZOZs and other healthcare institutions connected with the Ministry of Internal Affairs and Administration and the Ministry of Defence in the remaining 12 voivodships are responsible for the remaining 47% of the total debt. In 2005 in the total sum of SPZOZ's debt the most important points are:

- public legal obligations – 41.9%,
- obligations towards pharmaceutical and medical material providers – 19.6%,
- obligations due to purchasing external services – 8.5%,
- obligations towards the employees – 7.9% (40% of which is connected with the "203 act")
- other obligations due to conducting the activity represent 12% of total payable obligations.

Due to the increasing financial difficulties of the independent public healthcare institutions, on 15 April 2005 the Chamber of Deputies of the Polish Parliament passed an "act on public aid and public healthcare institution restructuring ,which determines the tools for debt restructuring and aid to the public healthcare institutions", introduced mechanisms enabling the restructuring of obligations of public healthcare institutions and research and development units which on 1 January 2001 employed more than 50 people. The restructuring of the obligations required that the institutions performed a number of actions aiming to improve their financial-economic situation.

Public healthcare institutions in debt could participate in the process of financial restructuring which included public legal and civil legal obligations (already known between 1 January 1999 and 31 December 2004). In terms of personal claims made by the employees connected with the so called „203 act" – the new act enabled those obligations to be paid (with a government loan) and gave an option for signing individual settlements between the institution and the employees. As far as public legal obligations were concerned – the restructuring process was based on their extinguishment along with interest after the ending of the process (provided that the institution fulfilled all the conditions set by the restructuring organ). As for the civil legal obligations – the restructuring process was based on reaching a restructuring settlement between the institution and its creditors, that determined the way the obligation would be paid (dividing the payment into installments, a partial or total extinguishment of the obligation).

The institution could acquire the means for the financial restructuring through:

1. taking a government loan – with a 3% annual interest rate,

2. issuing bonds,

3. taking bank loans.

2.2 bn zł was assigned for this loan in the country's budget for 2005. The budget bill for 2006 assigned 1.1 bn zł for this loan, however, with the assumption that the total of payments made to this end in budget years 2005 and 2006 would not exceed the amount of 2.2 bn zł.

The second mechanism supporting the restructuring actions was the possibility to obtain a subsidy by the healthcare institutions which at the time of placing a claim for the subsidy did not have any delays in the payments of their obligations which were known on 31 December 2004 and which were not subject to financial restructuring. The subsidy was aimed to suport:

- employment restructuring,
- changes made in the organisational structure of the institution,
- other actions aiming to improve the economic situation of the institution or improving the quality of the healthcare services performed.

As a result of the *act on public aid and public healthcare institution restructuring* there was a decline of 18.9% in the level of debt of public healthcare institutions in the end of December 2005 in comparison with the level of debt from the third quarter of the previous year. In the first quarter of 2006 payable obligations declined by 362 mill. zł, that is by 7.3% in comparison with the last quarter of 2005. In the end of June 2006 in comparison with the level of debt from the first quarter of the same year the debt declined by 227 mill. zł, that is by 5%.

Individual claims connected with the so called „203 act" were satisfied. According to the information from 31 July 2006 94% of employee claims were satisfied. Up to 28 August 2006 Bank Gospodarstwa Krajowego had signed 551 government loan contracts for the total amount of 1.6 bn zł. The subsidy awarded to healthcare institutions for the improvement of their infrastructure and for improving the quality of healthcare services provided was used up in 95.95%.[1]

When we evaluate the efficiency of undertaken restructuring operations we can observe that from 1994 to 1995 the liabilities of the healthcare institutions were covered from the budget subsidy of 1 bn zł. In 1997 the public legal liabilities were cancelled. In 1998 the National Treasury took over the debts of the healthcare institutions in the amount of 8,4 bn zł. The data from the Ministry of Finance and the Ministry of Health show that the decline of the indebtedness in

[1] Information taken from the realisation of the act from 15 April 2005 on public aid and public healthcare institution restructuring, Ministry of Health, September 2006, pages 11–21; Information for the Chamber of Deputies of the Polish Parliament on the situation of the healthcare system, Ministry of Health 23.05.2006, pages 69–78, http://www.mz.gov.pl/wwwfiles/ma_ struktura/docs/ooz_622_07062006.pdf, 12.03.2007 < 0}.

50 per cent was caused by cancelling it. The second half of the decline was the effect of changing it to the loans or credits. The data concerning the numbers of the healthcare institutions without liabilities account for a low effectiveness of restructuring activity. In 2001 there were 790 healthcare institutions without liabilities (which account for 44% of all), in 2005 there were 787 of them (45,3%) and in 2006 – 856 healthcare institutions. In my opinion, undertaking further attempts is only a temporary measure, which improves the financial conditions of the healthcare institutions. However it does not incline the managers to run the proper financial activity.

4. THE TECHNICAL CONDITION OF MEDICAL INFRASTRUCTURE

The issue of under-funding is closely linked with the problem of the contemporary condition of hospital infrastructure, the necessary repairs, modernisations, regeneration of property and the purchase of new general and medical equipment.

The average age of hospital buildings occupied by the healthcare institutions (those which were founded by local government) is 42 years – 43% of all the buildings were built before 1970, half of which dates back to before the WWII, buildings constructed after 1990 represent less than 20%. From all the buildings 11.5% are under the care of a conservation officer, in the case of 8,5% of the buildings a modernisation, that would make them fulfil the contemporary legal regulations (Ministry's of Health requirements), is not possible.

The information presented by the healthcare institutions shows that from 2000 to 2005 1.86 bn zł was spent on repairs and modernisations of the buildings, and in the years 2006–010 only the necessary repairs and modernisations (not taking into consideration the new investments) require at least 5.5 bn zł. The average age of buildings occupied by clinic hospitals and institutes is 48 years. Over 65% of the buildings were built before 1970 and only 12% can be considered new – built after 1990. From these buildings 12.5% are under the care of a conservation officer and in the case of 6.3% of the buildings a modernisation, that would make them fulfil the contemporary legal regulations (Ministry's of Health requirements), is not possible.

From 2000 to 2005 1.0 bn zł was spent on repairs and modernisations of the buildings, and in the years 2006–2010 only the necessary repairs and modernisations (not taking into consideration the new investments) require at least 1.0 bn zł.

The technical infrastructure of the health protection system apart from the buildings also includes technical devices and medical equipment. In all the aspects of our civilization we can observe a rapid technical and technological development, in healthcare one can notice an equally swift progress in creating

new methods of therapy and diagnostics and new medical technologies. This makes it necessary to constantly provide funds for investments such as the purchase of new medical equipment. In medicine we face a phenomenon of "moral" obsolescence of equipment which takes place much faster than the real "ageing" process. A good technical state of the medical infrastructure is the indispensable condition for an efficient and effective healthcare system.

Table 2

Local government hospitals

ZOZ buildings from	Number of locations	Frequency (%)	Cumulative frequency (%)
18 th century	3	0.1	0.1
1 st half of 19th century	28	0.7	0.8
2 nd half of 19th century	102	2.4	3.2
1900–1909	183	4.3	7.5
1910–1919	101	2.4	9.9
1920–1929	137	3.2	13.1
1930–1939	250	5.8	18.9
1940–1949	77	1.8	20.7
1950–1959	257	6.0	26.7
1960–1969	704	16.4	43.1
1970–1979	672	15.7	58.8
1980–1989	860	20.1	78.9
1990–1999	584	13.6	92.5
2000–2006	207	4.8	97.3
no data	119	2.7	100.0
Total	**4284**	**100.0**	**100.0**

Source: own calculations based on: *Information for the Chamber of Deputies of the Polish Parliament – on the situation of the healthcare system*, Council of Ministers, 23 May 2006.

The analyses of the quantity and the condition of medical equipment in public healthcare institutions show that the repartition of medical equipment is not uniform on the national level and that some of the equipment is obsolete.

RTG diagnostics equipment is in the worst condition: in Poland on average the fixed RTG apparatuses are 16 and the portable RTG apparatuses are 13 years old. A similar problem can be observed in the case of steam sterilizers – their average age is 12 years. Magnetic resonance equipment is the newest (their average age is 5 years) which is mostly due to the fact that this diagnostic technology has only recently become widespread.

Table 3

Medical equipment in Poland (condition from 30.11.2004)

Name of the equipment	Number of devices	Averege age (in years)
Linear accelerators	120	7
Analysers, clinical chemistry, automatic multi-parameter diagnostic biochemical multi-purpose devices	6543	10
RTG Apparatuses (apart from portable ones)	4606	16
RTG Apparatuses (portable ones)	1294	13
Brachytherapy, systems of 'remote afterloading'	56	9
Echocardiography devices (cardiological ultrasound scanners)	1571	10
Gamma cameras	106	11
ESWL devices	113	8
Mammographs	508	8
Haemodialysis equipment	2839	7
Magnetic resonance	78	5
Steam sterilizers	9771	12
CAT scanners	264	7
Angiography sets	153	8

S o u r c: as same as Table 2.

An analysis of the information provided by the Ministry of Health (from April 2006) shows that the hospitals' founding institutions estimate the requirements in terms of equipment modernization in the 5 coming years at approximately 217.5 mill. zł, whereas in terms of purchasing new equipment at 3.2 bn zł (*Information for the chamber*... 2006, pp. 80–90).

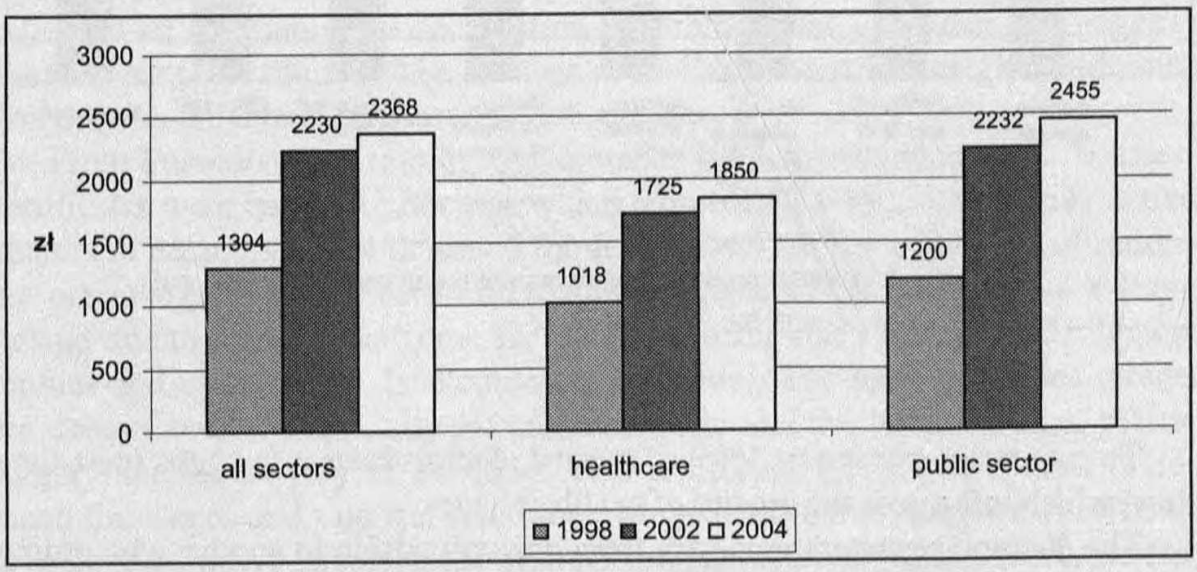
We can pose a question where the difficulties in the technical conditions of medical infrastructure in Poland come from. In my opinion it is a result of the not defined responsibility either of the founder body and the NFZ. The National Health Fund finances only the health services but modernization of the technical conditions of medical infrastructure is the matter of the founder body and also the health care institution – hospitals.

5. MEDICAL STAFF REMUNERATIONS

The remuneration level of the healthcare employees in Poland and the significant number of migrations of these professions from Poland are two major issues concerning the medical staff.

For many years the remunerations of the healthcare employees in Poland have been lower than the national average remuneration. The average monthly

brut remuneration of healthcare employees in 2005 was 1 954.12 zł (according to GUS data), whereas in all sectors of the national economy it was 2 360.62 zł and in the public sector it was 2 500.89 zł (*Statistical Yearbook* 2006, Table: Average monthly brut remuneration).

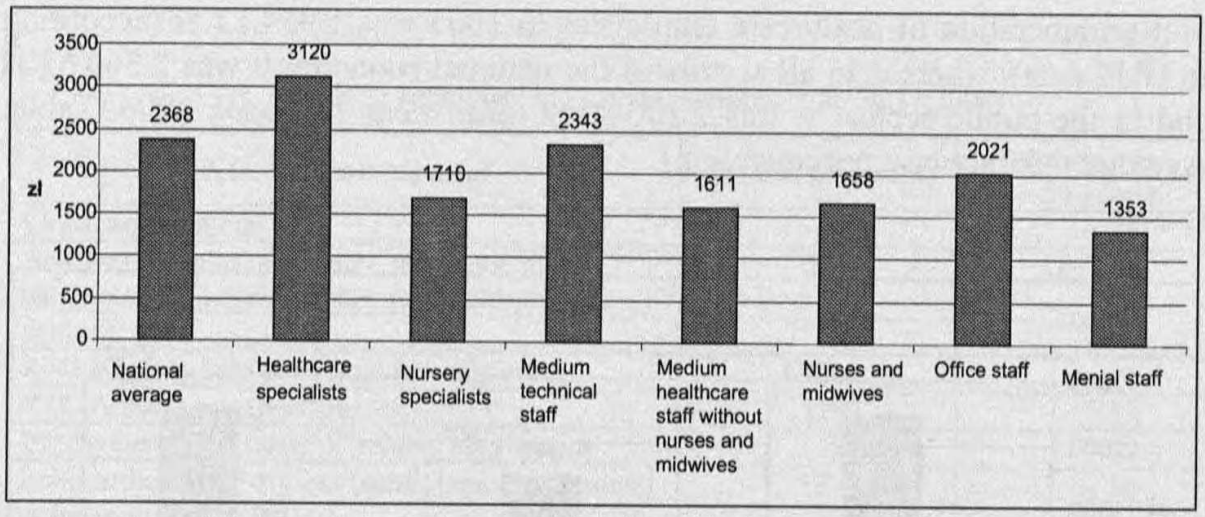


Graph 2. Average monthly brut remuneration

Source: *Information for the Chamber of Deputies of the Polish Parliament – on the situation of the healthcare system*, Council of Ministers, 23 May 2006.

Attention should be drawn to the fact that the brut remuneration of healthcare employees consists not only of the fundamental salary but also includes remuneration for duties and extra hours, which means that relatively the fundamental salary is really lower than in other sectors. In individual professional medical groups a large variety of the remuneration levels can be observed.

The average brut remuneration of specialists in the healthcare system, according to a GUS report from 2004, was 3 120 zł. This represented approximately 132% of the average brut remuneration in the economy (2 368 zł). The doctors are the only professional healthcare group whose remuneration is higher than the national average. Due to the fact that the doctors' remunerations include the extra pay for duties, their working time is significantly extended and the real per hour pay is lower than in other professional groups, teachers with higher education for example. As a professional group doctors are obliged to constantly improve their professional skills. The costs of this education are in majority financed from personal income.



Graph 3. Average monthly brut remuneration in certain professional

Source: As some as Graph 2.

To ensure an appropriate level of income, doctors have a few jobs (part-time ones) which influences the quality of health services.

The doctors' remunerations vary from one voivodship to another. According to GUS data, doctors in the lubuskie voivodship get the highest average remuneration (4 516 zł), whereas doctors in the podlaskie voivodship get the lowest (2 385 zł). As far as the nurse professional group is concerned, the average remuneration, according to GUS data in October 2004, was 1 662 zł and was approximately 30% lower than the average brut remuneration in the national economy. The nurses' remuneration in different voivodships does not vary as much as in the case of the doctors (the maximum difference is 300 zł).

The healthcare employees' remunerations, coming from contracts of employment, represent nearly 51.7% of the earnings of the independent public healthcare institutions which come from the contracts with the National Health Fund (NFZ). Moreover, medical workers (mainly doctors) perform services based on legal contracts. The costs of the SPZOZs connected with these contracts represent approximately 8.6% of the total earnings from the NFZ contracts.

The healthcare employees express their discontent with the level of pay and organise protests demanding a raise of their remunerations..

Protest demonstrations of these profession representatives could be very effective and in my opinion it is likely to happen in the near future and salaries will rise in the health care sector.

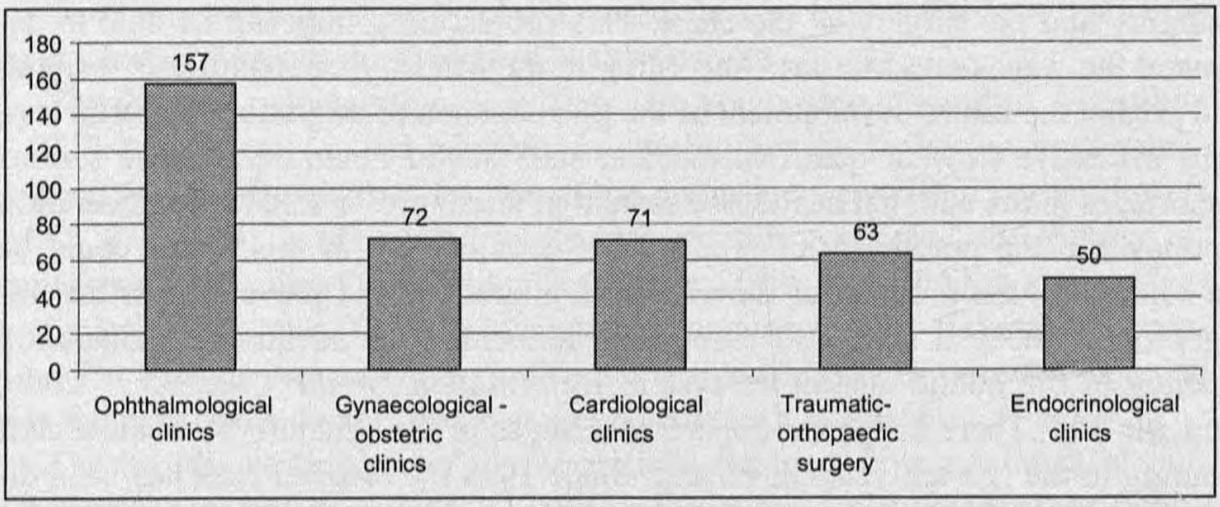
6. MIGRATION OF MEDICAL STAFF

The migration of the medical staff after Poland's accession to the EU is an issue that ought to be paid attention to. At present the number of people who started working abroad after Poland's accession to the EU remains unknown. The estimation of the scale of the migration was based on the number of certificates issued to enable the recognition of professional qualifications in other member states of the EU. The number of the issued certificates gives information only on the interest in starting a job abroad.

From Poland's accession to 31 December 2005 approximately 4.2 thousand certificates were issued for doctors, which represents 3.6 % professionally active doctors in Poland, and 2.4 thousand for dentists (4.6%). For a few specialisations the percentage of issued certificates is much higher. Medical employees leave Poland due to the fact that some EU countries offer much better income opportunities and professional development possibilities. The most numerous groups are doctors with the specialty of: anesthesiology and the intensive care, plastic surgery and the surgery of the chest. This profession group will be able to demand the wages and salaries. According to the Ministry of Health it is difficult to predict the future development of the phenomenon of migration. Nevertheless, the excessive flow of qualified medical staff out of Poland can cause serious shortages in the national healthcare system in the future. A suitable remuneration policy and the possibility of professional development in this sector could be a solution to the problem of the excessive migration. The prevention of the migration of medical staff also requires implementing an adequate remuneration policy in the public healthcare system (*Information for the Chamber*... 2006, pp. 90–105).There happened important changes in the structure of medical staff during in the last ten years in Poland. Since 1998 the medical staff has been diminishing. In 2005 there were only 76 thousand doctors, while in 1998 there were over 90 thousand. In 2005 there were 20 doctors for each 10 thousand citizens in Poland. In 2005 the number of doctors declined by 15% in comparison with 1995. In 2004 in the European countries there were 31 doctors for each 10 thousand citizens. The best situation was in Belgium, 40 doctors for each 10 thousand citizens. Poland was last but one in the European ranking in 2004. Romania was the last (20 doctors for each 10 thousand citizens). If Poland wants to improve this indicator and increase the number of the medical staff, it will be necessary to employ much more medical staff. In my opinion we will be able to observe the unbalance between demand and supply of employment in the health care system. This phenomenon will be caused by migration and retirement of the medical staff. This disadvantage can reduce by the increase in wages or employment of foreign medical staff.

7. WAITING TIME TO A DOCTOR

One of the problems most severely felt by the patients, perceived as a lack of good organisation of the healthcare system, are the long waiting lines to specialist doctors. In the first phase of the reform the queues were an inseparable element of the new system, especially in the initial stage of the work of Health Funds. Nowadays the waiting lines are present only in some medical specialisations, nonetheless they become a great social and organisational problem which significantly contributes to the negative public opinion on the system. Queues not only to specialist doctors, but also to full-time health care are a characteristic element of every healthcare system in the world, no matter how well it is financed. This will not be solved only by increased financing of the system (reducing or eliminating the financial limitations), simultaneous organisational, legislative and financing actions are necessary.



Graph 4. Number of people waiting for health services of a specialist doctor in 2005 (in thousands of people)

Source: As some as Graph 2.

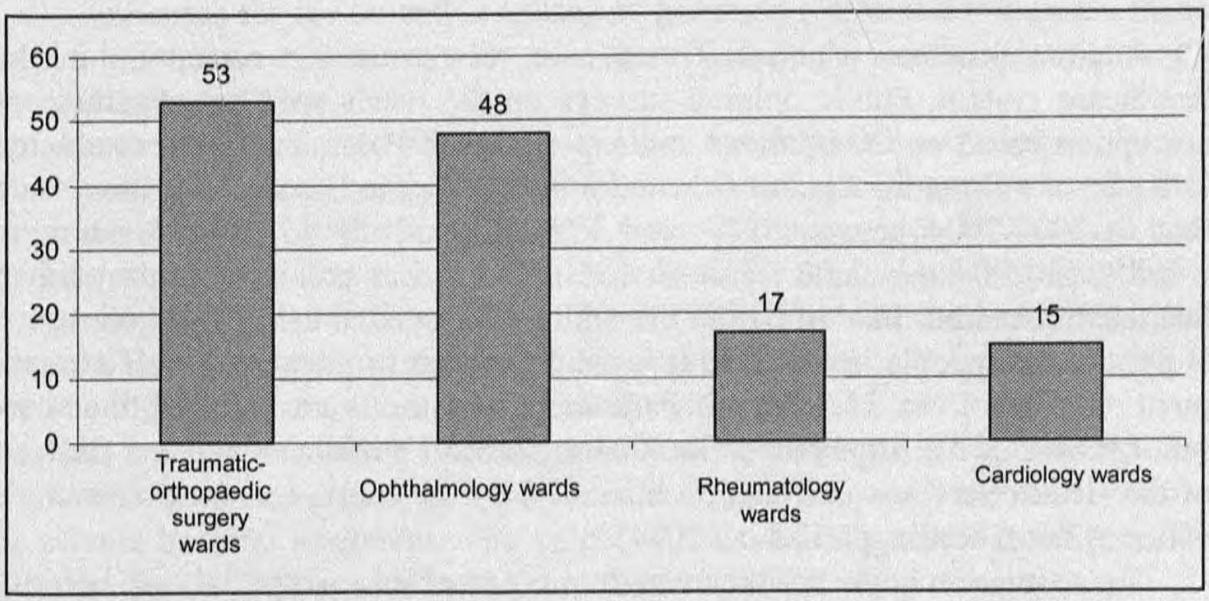
In 2005 and 2006 the first overall analyses of the accessibility of healthcare services were made. These analyses show that in the clinic specialist care most patients wait for services of the following clinics: ophthalmological (over 157 thousand people), cardiological (over 71 thousand people), traumatic-orthopaedic surgery (63 thousand people), gynaecological – obstetric (about 72 thousand people), endocrinological (for over 50 thousand people).

The longest average waiting period in 2005 took place at haematological (82 days), endocrinological (71 days), osteoporoses (71 days), children allergy (70 days) clinics. In other clinics the average waiting period did not exceed two months. Furthermore, the waiting period for prosthetic services in dental clinics

and clinics and studios of the dental prosthetics is a major problem. The average waiting period for these services is more than half a year.

In the hospital specialist care the most people waited for services carried out by wards of: traumatic-orthopaedic surgery (about 53 thousand people), ophthalmology (about 48 thousand people), rheumatology (about 17 thousand people), cardiology (15 thousand people).

The longest average waiting period took place in the case of services performed by wards of: surgery of the hand (576 days), children's urology (150 days), rheumatology (95 days), internal diseases (90 days), ophthalmology (85), child cardiac surgery (81 days), traumatic-orthopaedic surgery (79 days).



Graph 5. Number of people waiting for hospital treatment in selected specialised clinics in 2005 (in thousands of people)

S o u r c e: As some as Graph 2.

Creating lists of patients waiting for a service is a solution which was also adopted in other countries. Information given by the OECD suggests that different kinds of difficulties in healthcare service accessibility can be observed in Australia, Canada, Denmark, Spain, the Netherlands, Norway, Sweden or Great Britain. The waiting period for certain planned services is long. Ensuring a very quick access to all kinds of services would be extremely expensive and unjustified socially.

One should remember that the present data concerning the waiting period cannot be used to determine the real waiting time for healthcare services, as the contemporary list registration system gives the possibility to enlist one patient to a few specialists. If the patient gets the service from one of the service providers,

whose lists he was on, or if he abandons the service or treatment, then this information usually is not communicated to the other service providers. This results in the fact that on the lists there are many patients who in reality are not waiting for the healthcare service anymore. A complex identification of people on the waiting lists will enable getting improved information on the healthcare service waiting periods and will make it possible to provide better planning of financial resources for specific types of services (*Information for the Chamber*... 2006, pp. 90–105).

8. THE PROBLEM OF THE SO-CALLED "BLACK ECONOMY" IN HEALTHCARE

Another problem which has numerous reasons is the corruption in the healthcare system. Public opinion surveys on the reach and the magnitude of corruption based on the opinions and experience of Poles, that were conducted as a part of a Program Against Corruption by the Stefan Batory Fundation, state that in 2000-2004 between 14% and 17% respondents admit to handing in a bribe, in 2004 the same figure is 15%. The bribes are most often paid in healthcare. Another field of public life which is pointed to as the most corrupted is politics and people involved in it – politicians, party members, local government representatives, Members of Parliament, senators – are referred to as corrupt by 64% of the respondents. In 2004 the second position was taken (instead of the Health Services as it was traditionally) by the courts and the prosecutor's office (42% of readings) (Kubiak 2004).

The corruption in the healthcare system is perceived as a special case because it is a domain of public life which has been associated with corruption behaviours for years and because it is a field that concerns everyone. Heath and human life are our most important and priceless possessions and we are ready to do almost anything to protect them. The relationship patient – doctor is highly unbalanced to the patient's disadvantage.

It should also be stressed that the problem of corruption cannot be eliminated by one solution, for example by increasing healthcare employees' salaries. Both organisational and legislative solutions are necessary, but even more needed are initiatives that educate and make the society realise that corruption should be fought with.

The most common corruption fields in healthcare are:

- unofficial payments,
- pathologies in relations between medical and pharmaceutical staff and the representatives of the pharmaceutical industry,
- abnormalities in placing pharmaceuticals on the refunded drug list, cases of evident conflict of interest amongst people performing high public functions,

- the moral crisis amongst people in medical professions and the lack of actions for promoting ethical attitudes and of spreading and enforcing ethical codes of health service employees,
- the lack of patients' knowledge about their rights and the asymmetry of medical knowledge.

The bribes handed in to the public healthcare employees are one of the elements of the so called unofficial payments, i.e. fees paid outside the formal financing routes, that should not be paid at all. These fees are only a part of the abuses in the healthcare system. In the literature on the subject three kinds of unofficial payments (private expenses) are distinguished:

1) payments made during a stay in hospital (different kinds of contributions, payments for night duties etc.);

2) expenses for the so-called tokens of gratitude (payments which are made to obtain services of better quality than the officially provided and/or obtaining them in a shorter time);

3) expenses connected with presents given as tokens of gratitude.

From the research conducted in the Social Diagnosis (Diagnoza Społeczna) we can see that in 2003 the number of households, in which budgets are burdened with unofficial expenses for so-called and for the real tokens of gratitude, is not large in Poland (Czapiński i Panek (2003), pp. 90–106). Amongst the households using hospital services throughout the year only 6,6% households made unofficial payments in order to obtain better care.

The amounts of money spent on unofficial payments by households in 2003 were inferior to those spent by households using private paid healthcare services or private hospital treatment. The value of the culturally conditioned presents given in thanks for the care constituted the 53% of the value of payments in order „guarantee" better care to oneself. Research shows that in comparison with 2000 the value of presents handed in by patients or their families dropped by 10% and the expenses on the so-called tokens of gratitude rose slightly, by 4% in 2003.

Table 4

Annual household expenditure connected with the unofficial routes of payments for healthcare services in Poland (in zł)

	Unofficial payments, so-called tokens of gratitude	Gifts as a real token of gratitude	total
2003	240	121	**361**
2005	169	98	**267**

Source: own calculations based on: J. Czapiński, T. Panek (red.), Diagnoza Społeczna 2006. Warunki I jakość zycia Polaków, Wyższa Szkoła Finansów I Zarządzania, Warszawa 2003.

In 2005 one household spent on average 267 zł on unofficial payments, that is almost 100 zł less than 2 years before.

Burdening the society with privately incurred expenses on medical treatment is not a result of incurring high unofficial payments. The development of the private medical service market, facilitating a quick access to healthcare and healthcare services of higher quality and the possibility of transferring certain costs of privately initiated treatment to the public sector – these are the factors which cause the expenditure on the official purchase of services that are so significant in the total of private expenses.

One could think that a society spending 1.7% of its GDP on privately financed healthcare and medications, would be willing to protect itself from the risk of incurring such costs by purchasing a private healthcare insurance. Research conducted in the Social Diagnosis shows that 42% households in 2005 and 38% in 2003 were not interested in the purchase of any healthcare insurance policies, and 44% (47% in 2003) could not afford such an expense. The remaining households would be interested in such insurance if the price of the insurance policy did not exceed 100 zł per month – 14% of households would buy such insurance (21% amongst the self-employed, 16% amongst employees, but only 4% of pensioners – which was 7% 2 years before). A larger than average interest in the insurance policies of up to 100 zł or even up to 250 zł can be observed in families with 1 or 2 children and in big cities of more than 500 thousand inhabitants.

The number of households which would be willing to buy an insurance policy of a greater value is marginal, insufficient for the insurance companies to distribute the risk amongst a adequately large population. Nevertheless, the monthly health insurance policy of 100 zł is not enough to cover the expenses for the treatment of all household members, not even if all households which declared the will to purchase the policy bought it in reality. According to K. Tymowska the risks connected with the treatment and the financing of this treatment from public and private sources, despite the high expenses incurred by the households, are not yet high enough to anticipate a development of a private market of voluntary health insurances; the healthcare system, although strongly criticised, still does not undermine the sense of health security in the event of an illness and the sense of economic security of households to an extent great enough to purchase private insurance policies. The reason is not only the level of the society's wealth and a weak inclination towards insurances in general, but also the rules of functioning of the healthcare system, including the possibility to shift the costs between the private and the public sector (Tymowska 2006, pp. 94–95.

9. CONCLUSION

Starting from 1998 the number of medical employees in Poland is decreasing, this trend increases after the opening of the labour markets by the European Union member states.

However the number of independent hospitals and institutions for chronically ill people along with the quantity of medical advice given in clinic care rose.

Expenditure on costs of healthcare services from resources from the public healthcare insurance system coming mainly from the health insurance premiums demonstrate an increasing tendency. The premium for healthcare insurance rose faster than the GDP.

Society's direct expenditures represent approximately 30% of the total expenditures on healthcare. This means that Poland – unlike other European countries – is a country with a relatively high share of private expenditure in the total healthcare expenditure. The main factor contributing to the increase of the expenditure of individual households on healthcare is an increase of expenditure on medicine, which in 1999-2005 annually grew by approximately 10%, whereas the average annual growth rate of healthcare expenditure was 6.2%.

The dynamics of healthcare expenses was to a considerable degree shaped by the increase of prices. The price increase index in the field of health was considerably higher than CPI – an index for consumption goods and services, especially in 2002–2005.

In spite of the fact that year after year the expenses on healthcare in Poland have risen faster than the GDP, the system is still financially unbalanced, healthcare institutions are to a great extent in debt, the medical infrastructure is obsolete, the remunerations of employees in the healthcare system remain on a very low level and the medical profession is considered a group most afflicted with corrupt activity.

All these issues give the basis to once again reform the healthcare system in Poland.

There are no perfect solutions in European countries and almost most of them have different problems in functioning the health care system.

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Maria Świderek

OPIEKA ZDROWOTNA W POLSCE – GŁÓWNE PROBLEMY FUNKCJONOWANIA

Celem artykułu jest wskazanie głównych problemów funkcjonowania opieki zdrowotnej w Polsce po reformie ubezpieczeniowej. Począwszy od roku 1999 świadczenia zdrowotne w Polsce są finansowane ze składki na ubezpieczenie zdrowotne. Składka ta opłacana jest przez pracownika i w części pomniejsza podatek dochodowy od osób fizycznych. Celem artykułu jest wskazanie przede wszystkim negatywnych aspektów wprowadzonych zmian. W artykule została dokonana analiza infrastruktury medycznej, wynagrodzeń służby zdrowia, czasu oczekiwania na usługę medyczną, szarej strefy w tym sektorze. Zwrócono również uwagę na finansowy aspekt funkcjonowania regionalnych organizacji powszechnych ubezpieczeń zdrowotnych w Polsce.

Słowa kluczowe: publiczna opieka zdrowotna, świadczenia zdrowotne, sytuacja finansowa NFZ, ubezpieczenia zdrowotne