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Diana Ognyanova (Student, Master of Public Policy, Class of 2008)

Foreword by Prof. Stein Kuhnle (Hertie School of Governance)

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# Health Care Reforms in Poland

## *Foreword*

Diana Ognyanova has written this policy report as part of assignments for the Elective Course on “A New Social Europe?” organized by Stein Kuhnle for the Master of Public Policy program at the Hertie School of Governance during the Fall semester 2007.

The aim of the course was to look at what is happening at the European (EU) level and at commonalities and variations at the national level in today’s European welfare states. The purpose of the course was to give students a deeper understanding of European welfare state development, to study the role of the EU for national developments, and to study to what extent examples of national reforms can be understood as responses to exogenous or endogenous economic, social and political challenges.

As *one* assignment students were asked to write about – and characterize - reforms in different social policy fields – family-, health-, labour market- and pension policy - within one of the following countries, representing different types of welfare states or ‘welfare regimes’: Denmark, Germany, Poland and the United Kingdom. The general research question given was: Is there a new politics of welfare in the (selected) European countries? Is there a change of path of social policy or welfare state development? Students were asked to relate to conceptualizations of types of welfare states and concepts or theories of policy change; to report on major recent reforms; to discuss the contents and implications of reforms in light of theoretical conceptualizations; and, if possible, discuss why and how reforms came about. Thirteen students participated in the course, and reports were written on labour market reforms and pension reforms in all four countries; on family policy reforms in Germany, Poland and the UK; and on health policy in Poland and the UK. The course was very much an interactive, collective undertaking and the other students participating and actively taking part in discussions, and thus contributing to the improvement of single policy reports were: Veselina Angelova, Christine Ante, Simon Bruhn, Nevena Gavalyugova, Ariane Götz, Henry Haaker, Nevena Ivanović, Jan Landmann, Diana Mirza Grisco, Ruth Obermann, Julie Ren, and Lyubomir Todorakov.

Stein Kuhnle

Professor of Comparative Social Policy, HSoG Course Instructor/Convener

## Abstract

Health care reforms carried out in Poland since 1990 have led to the decentralization of ownership and financial and management responsibility of health care establishments; privatization of health care providers; stronger reliance on private expenditure on health care with rising out-of-pocket and informal payments; exclusion of some services from the package of universal health services; and restricted access to some health services in form of waiting lists.<sup>1</sup> Even though the official aim of the reforms was to preserve a state-guaranteed egalitarian health care system while ensuring optimal use of resources by the introduction of market-type mechanisms, smaller than expected gains in efficiency, together with demographic and technological pressure on health care costs and a political and economic climate unable to significantly increase public spending, resulted in a more privatized and unequal system than intended.<sup>2</sup> Hence, the reforms of the health system as part of the general transformation of the economy and the welfare state illustrate a shift towards a hybrid “*post-communist European type*”<sup>3</sup> of welfare state which has inherited some features of the socialist regime, but is increasingly shaped by liberal ideas.

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<sup>1</sup> Kuszewski / Gericke 2005: 29

<sup>2</sup> McMnamin/Timonen 2002: 103

<sup>3</sup> Fenger 2007: 24

## **1. Introduction**

In order to explain welfare state development in the Western world a number of welfare state theories and typologies emerged.<sup>4</sup> Most of them, however, excluded the former socialist countries from their analysis. The collapse of Communism and the following transformation intensified the debate as to whether the old welfare state theories still maintained their explanatory power and also whether new ones were needed to encompass the Eastern European countries in transition.<sup>5</sup>

This paper, based on a case study of Poland and focusing on the health care reforms in the country since 1990, aims to examine if the post-communist country fits into the existing typologies of welfare states, the most prominent one being the Esping-Andersen typology. First the paper examines the main characteristics of the health care system at the beginning of the transformation in 1990 and discusses similarities with Esping-Andersen's social-democratic type of welfare state. By analysing some major reforms in the health care sector the paper, furthermore, seeks to assess the degree of transformation of the welfare state since 1990. Was there a change of path in health care policy, which could be indicative of a fundamental shift in social policy and welfare state development? Has the country entered a new type of welfare state, and if so, to what extent does this type of welfare state resemble the existing Western models?

## **2. The pre-reform Polish health care system**

The health care system that Poland inherited from the communist era offered universal coverage<sup>6</sup> with a comprehensive network of health care services financed by the state budget and distributed through facilities owned and run by the state.<sup>7</sup>

Before 1990 there were three major sets of health sector reforms. The first set of reforms aimed to develop free and universal public health care.<sup>8</sup> Health care services were made accessible to all state employees, and in the 1950s occupational health clinics were set up at workplaces. At that time, only limited free health care was available in

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<sup>4</sup> For a concise overview of the most prominent typologies see Arts/Gelissen (2002)

<sup>5</sup> Fenger (2007), Sengoku (2004), Deacon (2000), Rys (2001), Ferge (2001)

<sup>6</sup> Universal health care refers to government programmes intended to ensure that all citizens of a governmental region (sometimes also permanent residents) have access to a certain package of health care services. The concept of universalism will be further introduced in the Esping-Andersen's typology of welfare states. Esping-Andersen 1990: 73

<sup>7</sup> Girouard/Imai 2000: 4

<sup>8</sup> Kuszewski/ Gericke 2005: 7

rural areas. This improved after 1972 when coverage was expanded to include also agricultural workers.

The second set of reforms aimed at creating integrated networks for health care and social services in each district. In 1972 integrated health care management units were established, managing hospitals, outpatient clinics, specialist and primary health care, as well as some social services.<sup>9</sup>

The third set of reforms which started in the 1980s aimed at decentralizing the administrative structure of the country by strengthening the position of the local governments (*voivodships* and *gminas*). The powers of the Ministry of Health and Social Welfare were gradually reduced and the voivodships and the integrated health care management units were given greater political and administrative powers.<sup>10</sup> Hence, as Communism evolved, power devolved to constituent units which then bargained with the centre for resources.<sup>11</sup>

The capacity of clinics was often determined by political considerations and not by the actual needs of the population for health care. Strategic sectors, large enterprises, big cities, and the home regions of top leaders had a much higher standard of health care than less favoured industrial sectors and regions. As the Communist regime lost the power to strategically direct the system it merely reproduced a distribution of resources according to capacity that became increasingly removed from the actual needs of the society.<sup>12</sup>

The health care system in Poland was also affected in another fundamental way: both individuals and groups ignored the centre by accepting and requiring illegal side-payments for healthcare services. Both the devolution of power and the growth of corruption were phenomena that affected most communist countries as they aged.<sup>13</sup>

The Polish health care system, however, resisted some characteristics of the Soviet model. For instance, private practice was never formally abolished and private medical cooperatives and dental services continued to exist.<sup>14 15</sup>

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<sup>9</sup> Ibid.

<sup>10</sup> Ibid. p. 8

<sup>11</sup> McMenamín/ Timonen 2002: 104

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Kuszewski/Gericke 2005: 7

<sup>15</sup> In the 1980s, as in most areas of life, the scope for private provision in health care was steadily increased, but was still of marginal significance in comparison with the state system .McMenamin/ Timonen 2002:104

In summary, misallocation of resources, regional inequalities and rationing emerged over time as distinctive features of the socialist health care system, with growing unofficial payments to public health care providers.<sup>16</sup>

### **3. Classifying welfare states: the Esping-Andersen typology**

By surveying international variations in social rights and welfare stratification, Esping-Andersen finds qualitatively different arrangements between the three main pillars of welfare provision: state, market, and the family.<sup>17</sup> The central argument of EA is that welfare states cluster around three distinct welfare regimes: liberal, social democratic and conservative. These ideal types of welfare regimes are distinguished by the degree of de-commodification and the kind of stratification they produce in society.<sup>18</sup>

De-commodification "*occurs when a service is rendered as a matter of right, and when a person can maintain a livelihood without reliance on the market*".<sup>19</sup> According to Esping-Andersen de-commodification is measured by three sets of dimensions: (1) eligibility rules and restriction on entitlements (2) income replacement and (3) range of entitlements which protect from the basic social risks: unemployment, disability, sickness and old age.<sup>20</sup>

Stratification refers to the intensity of redistribution and the level of universality of solidarity that is imposed by the welfare state.<sup>21</sup> It is operationalized through several variables. The (1) degree of status segregation (corporatism) measured by the number of occupationally distinct pension schemes and the (2) degree of etatism, measured by the expenditure on government-employee pensions as percentage of GDP are designed to illustrate the conservative principles of stratification.<sup>22</sup> The (1) relative weight of means-tested welfare benefits, measured as a share of total public social expenditure and the (2) importance of the private sector in pensions and health care, measured as private-sector share of total spending are perceived as attributes of the liberal welfare regime. The (1) degree of universalism, measured as a share of population (labour force between ages 16 and 65) eligible for sickness, unemployment and pension benefits, and the (2) degree of equality in the benefit structure, measured as the ratio of the basic level of benefits to the

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<sup>16</sup> Girouard/Imai 2000: 4

<sup>17</sup> Esping-Andersen 2002

<sup>18</sup> Esping-Andersen 1990: 2

<sup>19</sup> Ibid p. 21-22

<sup>20</sup> Ibid. p. 47-49

<sup>21</sup> Fenger 2007: 6

<sup>22</sup> Esping-Andersen 1990: 73



legal maximum benefit possible, are two attributes most clearly associated with social-democratic regimes.<sup>23</sup>

The following sections aim to critically relate the Polish health care system to the health sector's relevant variables introduced above. In particular, the concepts of universalism and equality, and the importance of the private sector in health care can be monitored more closely throughout the reform period. By referring to qualitative and quantitative research on welfare regimes in Central and Eastern European countries, the paper furthermore strives to identify patterns of welfare state development in Poland.

#### **4. The socialist welfare state**

The Polish welfare system as it existed until 1990 and the health care system, being a part of it, demonstrates at first glance some similarities with the social-democratic type of welfare state. In the social-democratic type of welfare state, the level of de-commodification is high. The generous universal and highly redistributive benefits do not depend on individual contributions. In contrast to the liberal type of welfare state, this model crowds out the market and constructs an essentially universal solidarity.<sup>24</sup> Countries that belong to this type are generally dedicated to full employment. Only by making sure that as many people as possible have a job it is possible to maintain such a high level solidaristic welfare system.<sup>25</sup>

The socialist welfare system in Poland until the 1990s provided a broad range of social security benefits. Even though limited data availability and measurement problems make comparisons difficult, the social security efforts of the communist countries, relative to the economic output of these countries, are deemed by some researchers to broadly fit with that of the developed market economies.<sup>26</sup>

The socialist social security system was comprehensive at the basic or minimum income level and eligibility was determined by practically compulsory employment of all adults in wage labour.<sup>27</sup> Hence, the predominant form of social protection can be described as both universalistic and employment-related. A redistributive set of mechanisms kept earnings differentials to moderate levels. According to Deacon, communist social policies were characterized by excessively subsidized foods and rents,

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<sup>23</sup> Ibid.

<sup>24</sup> Esping-Andersen 1990: 28

<sup>25</sup> Arts/ Glissen 2002: 142

<sup>26</sup> Fajth 1999: 80

<sup>27</sup> Standing 1996: 228

full employment, the relatively high wages of workers, and the provision of free or cheap health, education and cultural services.<sup>28</sup>

As communism evolved the welfare state became increasingly inefficient along with the economic system in general. Principles of allocative efficiency were neglected and “discretionary” benefits predominated over distributional needs. Elites (party members, union leaders) were allowed to come to the front lines, whether for subsidized goods and services, access to housing, holiday home, health care or various other benefits.<sup>29</sup>

In a nutshell, the system that fell apart in the 1980s combined extensive low-level income security, restricted inequality, system inflexibility, whereas at the same time, Western social-democratic welfare states provided income security, limited inequality, and adequate employment flexibility.<sup>30</sup>

## **5. Polish health care reforms 1990 - 1999**

A range of proposals for restructuring the health care system have been debated since 1989. The major reforms introduced in the 1990s included: the abolishment of state monopoly in the health care sector, further decentralization of ownership and financial plus management responsibility to municipalities and regions, the development of a family doctors model, and the creation of new payment and contracting methods.<sup>31</sup>

The first major piece of health sector legislation after the collapse of Communism, the 1991 Health Care Institutions Act, laid down the foundations for reform. It provided for diversity in the organization and ownership of health care institutions by various sectors: private sector, voluntary sector, cooperatives, central, provincial and local authorities.<sup>32</sup> The law established the legal basis for publicly-owned health facilities to become substantially autonomous and responsible for managing their budgets.<sup>33</sup>

The Ministry of Health and Social Welfare became responsible for health care policy development, the National Health Programme and other nationwide preventive

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<sup>28</sup> Deacon 1993, Deacon 2000

<sup>29</sup> Standing 1996: 228

<sup>30</sup> Ibid p. 226

<sup>31</sup> Girouard/ Imai 2000: 4

<sup>32</sup> Karski / Koronkiewicz 1999: 49

<sup>33</sup> Ibid. p. 11

programmes, manpower training and research, and highly specialized diagnostic and therapeutic facilities. Ownership of a number of health care establishments and the responsibility for their performance was transferred from the central level to the regional (*voivodships*) or the communal level (*gminas*).<sup>34</sup> The changes in the organisation of the public sector are perceived to reflect the unofficial devolution that had taken place under the communist regime.<sup>35</sup>

Prior to the health reform in 1999 the most important change in the Polish healthcare system was the increasing role of the private sector.<sup>36</sup> Pharmacies were privatized, new private hospitals set up, clinics and hospitals that were previously owned by enterprises were fully or partially privatized.<sup>37</sup>

In 1994 the private sector accounted for 25 per cent of total health expenditure and the present figure is much higher.<sup>38</sup> Even before the huge informal sector was taken into account this was one of the highest levels of private expenditure in Europe.<sup>39</sup> While a purely private sector was used by a fairly small number of patients, for the major part of the population, the private sector had an ambiguous relationship with the public sector. Often the most important role of private physicians was their ability to facilitate quicker and better access to public sector treatment than was otherwise available.<sup>40</sup>

In 1993, the Ministry of Health put forward the introduction of a flat-rate fee for the first ten days of a hospital stay. The Ministry argued that such a fee would help to abolish the widespread practice of asking patients for informal payments.<sup>41</sup> This proposal was quickly dropped as politically infeasible and the principle of universal health care has been written into Poland's constitution.

Another fundamental change in the nature of the Polish healthcare system was the move to a general practitioner system, inspired by the fund holder model in the United Kingdom. Under Communism primary healthcare was provided by teams of specialists in health service centres (*przychodnia*).<sup>42</sup>

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<sup>34</sup> Girouard/ Imai 2000: 5

<sup>35</sup> McMEnamin/ Timonen 2002: 105

<sup>36</sup> Ibid. p.104

<sup>37</sup> Millard 1999: 149

<sup>38</sup> See table 1

<sup>39</sup> Le Grand/ Mossialos 1999: 3

<sup>40</sup> McMEnamin / Timonen 2002: 105

<sup>41</sup> Hausner 1995: 233

<sup>42</sup> McMEnamin / Timonen 2002: 106

## 6. Universal Health Insurance Act

High on the reform agenda of the government for several years, a new national health insurance system was introduced in 1997 and entered into force in 1999. The Law on Universal Health Insurance marked an important shift from a centrally controlled, budget-based system to a decentralized insurance-based system, operating through multiple health funds.<sup>43</sup>

The aim of the reform was to create a system which does not produce the distinctive problems of the pre-1999 Polish system: the politicization of the system, the misdistribution of resources, the ambiguous relationship with the private sector, informal payments, and the excessive number of specialists.<sup>44</sup> The key idea of the reform is to establish a new set of institutions and market-type mechanisms that create incentives to restructure in such a way as to optimize the use of resources. The reform separates the institutions responsible for financing, resource allocation and service provision in order to sharpen the responsibility for these functions.<sup>45</sup>

The financing of health care continues to follow the principle of universality, which means that the entire population will be covered by insurance under the same conditions and no population will be excluded, however the system of financing has been fundamentally reorganized.<sup>46</sup> Since the 1999 reform, health care in Poland is mainly financed through national insurance contributions that currently amount to 9 per cent of taxable income.<sup>47</sup> Strictly speaking the system is not a typical social health insurance system but rather a “quasi-tax system”.<sup>48</sup> It is compulsory for all who are liable to pay income tax and is collected as part of income tax (mandatory principle). In contrast to a typical insurance, there is no relationship between what you pay and what you are entitled to. There is no link between the size of the ‘insurance’ contribution and the health risk of the ‘insured’ (solidarity principle).<sup>49</sup>

Fees for the uninsured, most of whom are farmers, are paid out of the state budget. The fees are collected by the Social Insurance Institution and then transferred to the 16 regional health funds and a ‘branch fund’.<sup>50</sup> These funds purchased medical

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<sup>43</sup> Giouard / Imai 2000: 2

<sup>44</sup> McMenamain / Timonen 2002: 108

<sup>45</sup> Ibid.

<sup>46</sup> Karski / Koronkiewicz 1999: 49

<sup>47</sup> Kuszewski / Gericke 2005: 25

<sup>48</sup> Ibid. p. 26

<sup>49</sup> Karski / Koronkiewicz 1999: 50

<sup>50</sup> The branch fund is a nationwide fund for employees in the defence, interior, justice and railway sectors

services from public and private sector providers. The healthcare contributions paid by the insured cover basic general and specialist medical treatment, as well as many pharmaceuticals and medical materials. Government budgets (state, voivodships or gminas) continue to finance public health services, the hospital costs of all health services, and specialist tertiary care services and very expensive drugs.<sup>51</sup> Owing to its dual financial structure, the system is defined as an insurance-budgetary system.<sup>52</sup>

The system of resource allocation was the major innovation of the reform. The newly created health funds were meant to be completely separate from the central state institutions that finance them and the sub-national governments and private interests which own and manage the service providers. It was envisaged that patients would be able to choose between health funds and that there would also be private sector health funds.<sup>53</sup> A so-called equalisation fund was created in order to even out inequalities in the incomes and health risks of the members of different health funds.<sup>54</sup>

The reform was designed to generate competition between the purchasers and providers of health care. This, in turn, was intended to enhance efficiency and resource allocation by channelling money to the most popular funds and awarding contracts to the most efficient providers. The three main mechanisms intended were: 1) competition between purchasers<sup>55</sup> 2) competition between providers for contracts 3) competition between providers for patients.<sup>56</sup>

## **7. The political genesis of the reform 1999**

Healthcare has been a big political issue in Poland but it has not been a very salient arena of competition between parties. This was partly because there was no clear divide in terms of socio-economic policy between the two largest political blocs: the post-communist bloc and the post-Solidarity bloc. Nevertheless, various plans have at various times been identified with particular parties.<sup>57</sup>

The eventually successful plan was developed and promoted by the liberal

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<sup>51</sup> Kuszewski / Gericke 2005: 24

<sup>52</sup> Ibid.p. 21

<sup>53</sup> McMenamin / Timonen 2002: 109

<sup>54</sup> OECD 2000: 102

<sup>55</sup> When the reform first came into force, all residents of a region automatically became members of that region's health fund. Since January 2000, however, patients have been free to change funds, and funds have been able to register patients outside their region.

<sup>56</sup> McMenamin/Timonen 2002: 109-110

<sup>57</sup> Ibid. p. 106

intelligentsia party, represented by the Freedom Union. This plan won out over a Solidarity plan. The Solidarity plan proposed a large number of small independent insurance institutions, the privatisation of healthcare providers, the strengthening of the decision-making powers of physicians and a clear division between hospital and ambulatory care.<sup>58</sup>

The liberals proposed regional healthcare institutions responsible for planning and finance, limited privatisation, contracting between the regional bodies and providers and emphasized the integration of hospital and ambulatory services.

In 1997 a Solidarity/liberal coalition came to power. The final bill was much closer to the liberal proposal, because of the intervention of the liberal finance minister Leszek Balcerowicz, who was concerned that the fully independent funds of the Solidarity proposal might have greater potential for creating indebtedness.<sup>59</sup>

The funds hence became large regional entities, instead of smaller independent companies. They were no longer entrusted with the collection of premiums. These should be transferred to them via the existing state social insurance system. Physicians were denied the right to collective bargaining with the funds and fee-for-service. The boards of the funds were to be appointed by regional assemblies and not by general election, as originally intended.<sup>60</sup>

Apart from the endogenous factors, such as the specific political constellation in the country, exogenous factors also influenced the health care reforms in Poland. External pressure on the budget was created by the conditions for EU membership and Poland's exposure to international financial markets, which did not allow substantial increases in public expenditure.<sup>61</sup> To a certain extent it can be also argued that the adoption of the 1999 reform was influenced by policy-learning from other countries with contributions-based health insurance systems and the desire to restore to the pre-war type of the domestic health care arrangements.<sup>62</sup>

## **8. The pitfalls of the reform 1999**

The financing of the health care system after the reform 1999 began in chaos. On the one hand, there were delays in channelling money from the government to the Social

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<sup>58</sup> Bossert / Włodarczyk 2000: 11

<sup>59</sup> McMnamin / Timonen 2002: 107

<sup>60</sup> Bossert / Włodarczyk 2000: 17-18

<sup>61</sup> Deacon 2000: 159, Osveiko 2002: 22-29

<sup>62</sup> Mihályi /Petru (1999): 8, Osveiko 2002: 25

Insurance Institution to the health funds. On the other hand, health funds frequently overspent the resources generated through contributions.<sup>63</sup>

The level of funding was widely perceived as inadequately low.<sup>64</sup> (See Annex I and II). Given the high level of public dissatisfaction, the necessarily high costs of a fundamental reform, and political commitment to universalism in the context of a worldwide trend of higher healthcare costs caused by longer lives and more sophisticated treatments, it appeared inevitable for public healthcare spending to rise.<sup>65</sup>

A huge hindrance for the proper functioning of the system was the lack of clear separation between resource allocation and service provision on which the system of bargaining was supposed to be based. Sub-national governments provided the majority of the personnel for health funds and were the owners of most public sector healthcare institutions. The health funds were, therefore, not institutions dedicated to the enforcement of hard-budget constraints. Rather they were subject to the same political interests which have made it very difficult for sub-national governments to act as the agents of restructuring.<sup>66</sup>

In 1999, the health funds were obliged to sign contracts with public sector hospitals regardless of the state of their finances and performance. The idea behind this was to prevent a crisis in the public sector, which was feared to result from the rise in contracts with private service providers.<sup>67</sup>

The healthcare reform proved to be deeply unpopular during its first year.<sup>68</sup> The reform caused a lot of confusion and controversy during its initial stages. Patients were unsure which hospitals and health centres they could visit and how their bills would be paid. Considerable differences in the number and quality of services in individual regions caused by different service contracting principles in each health fund and different prices for the same service further aggravated the situation.<sup>69</sup>

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<sup>63</sup> McMenamín / Timonen 2002: 110

<sup>64</sup> The Polish health care system demonstrates one of the lowest public expenditure rates on health care in Europe. Kuszewski / Gericke 2005: 45

<sup>65</sup> McMenamín / Timonen 2002: 111

<sup>66</sup> The benefit of restructuring for regional governments is uncertain and marginal, (i.e., a better health service leading to more votes), but the cost is certain and substantial, (i.e., the opposition of highly organised health workers with strong links to both main political blocs).

<sup>67</sup> McMenamín / Timonen 2002: 112

<sup>68</sup> According to a survey carried out in January 2000, 77 per cent of the respondents thought that the healthcare system was worse than before the reform. This figure is higher than the level of dissatisfaction with any other individual reform and is higher than the level of dissatisfaction with the government. Warsaw Business Journal, 7–13 February 2000: 13

<sup>69</sup> McMenamín / Timonen 2002: 113

## 9. Recentralization and the creation of the National Health Fund

The above described pitfalls of the reform, together with high public dissatisfaction, led to the adoption of the *Law on general insurance in the National Health Fund* in 2003. With this law the health funds ceased to exist. They were replaced by the National Health Fund (Head Office with Branch Offices), which was expected to develop uniform health service contracting and pricing principles across the NHF regional branches. This move not only increased the central control of the health system, but also made possible the introduction of new executive managers in the new fund. Some argue that the change of government and Minister of Health in 2001 was the main reason for the recentralization of the 17 sickness funds into the National Health Fund, and not the technical problems associated with the reform.<sup>70</sup>

In 2004 the Constitutional Court ruled that the law does not stand in accordance with the Constitution. As a result of work by the Sejm Commission of Health, the Sejm passed the *Law on health benefits financed from public means*, which meets the Constitutional Tribunal's requirements concerning the list of health care services financed by the National Health Fund. It also introduced transparent regulations for the management of waiting lists for scheduled interventions and hospitalizations. Furthermore, the question of who bears the cost of health services for the homeless and other uninsured people was clarified.<sup>71</sup>

## 10. A new path of welfare state development

Health care reforms in Poland need to be regarded as part of the very difficult process of transformation in Central and Eastern Europe. According to Hall's concept of policy change, the transformation from command to market economy represents a fundamental paradigm shift, a third order change which entails "*simultaneous changes in all three components of policy: the instrument settings, the instruments themselves, and the hierarchy of goals behind policy*".<sup>72</sup>

Even though the health reforms introduced in Poland cannot be characterized as a radical change because of the half-hearted attempts to fundamentally restructure the system, they certainly demonstrate some clear trends towards the attributes of the liberal

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<sup>70</sup> Kuszewski / Gericke 2005: 99

<sup>71</sup> Ibid. p. 12

<sup>72</sup> Hall 1993 : 279



welfare state. Despite the official aim of the reforms, which was to preserve a state-guaranteed egalitarian system, the reforms have led to an increase in the share of private health care providers; stronger reliance on private health care expenditure with rising out-of-pocket and informal payments; exclusion of some services from the universal package of health care services; and restricted access to some health services in form of waiting lists.<sup>73</sup> Table 1 demonstrates the rise in private health expenditure for the period between 1998 and 2002. (Illegal envelop payments are not taken into account.)

*Table 1: Average private expenditure on health per capita and month, 1998 – 2002*

Years	1998	1999	2000	2001	2002	Change 1998–2002
Average private expenditure on health per capita and month (in PLN)	21.35	23.69	26.63	27.58	28.32	+33%
of which:						
– Pharmaceuticals and medical devices	12.25	14.92	17.71	19.33	20.39	+66%
– Health services including non-conventional medicine	8.48	8.08	8.37	7.67	7.44	–12%
– Hospital care and resort treatment	0.63	0.69	0.55	0.58	0.48	–24%

*Source: Kuszewski / Gericke 2005: 30*

These developments can be perceived as a shift away from the attributes of the socialist welfare regime towards the principles of the liberal welfare state.<sup>74</sup> Nevertheless, it is difficult to say if the trend observed in the health care sector is indicative of a general welfare state development of the country towards any of Esping-Andersen's welfare state regimes.

By using hierarchical cluster analysis Fenger empirically assesses if the post-communist welfare states of Central and Eastern Europe can be classified according to any of Esping-Andersen's welfare types. Even though the set of variables which Fenger

<sup>73</sup> Kuszewski / Gericke 2005: 29

<sup>74</sup> Sengoku 2004: 244

uses, are not identical to those used by Esping-Andersen and, therefore, may account for different results, they seem empirically more extensive and well suited as a basis for classifying welfare states into certain typologies.<sup>75</sup> Fenger's analysis shows that there are clear differences in the governmental programmes and the social situation between traditional Western welfare states and post-communist welfare states. Hence, he argues that the post-communist countries cannot be reduced to any of Esping-Andersen's (or any other well-known) types of welfare states.<sup>76</sup> Furthermore, he subdivides the post-communist countries into three different categories.<sup>77</sup> While the three Western welfare regimes clearly represent different perspectives on the welfare state and the government's role in it, the post-communist subtypes principally mix elements of the ideal types of welfare states.<sup>78</sup> If the Eastern European Countries will eventually enter one of Esping-Andersen's distinct types of welfare state remains an unanswered question.

It is often perceived that exogenous factors have a crucial role in the development of the welfare state in Central and Eastern Europe.<sup>79</sup> Deacon, for example, argues that political globalization has had an impact on welfare state development in the sense that global actors – primarily the IMF and the World Bank – have insisted, as conditions for lending money, on the adoption of privatization and residualization strategies for reforming welfare systems.<sup>80</sup>

Also, EU-membership is expected to have an impact on the future welfare state development in the Eastern European countries. Even though social policy is not a subject of direct European policy, and there is no consensus on what European social policy should look like, EU integration might lead to some kind of convergence both between the Central and Eastern European countries, and between these countries and the

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<sup>75</sup> Fenger (2007) uses three sets of variables: 1) **Characteristics of governmental programs**, which consist of: total public expenditures, total health expenditure, public health expenditure, public spending on education, number of physicians per 1000 persons, spending on social protection, revenues from social contributions income and corporate taxes, individual taxes, payments to government employees 2) **Social situation variables**, which include: inequality, female participation, GDP Growth, fertility rate, inflation, life expectancy, infant mortality, unemployment 3) **Political participation variables**, which include the level of trust.

<sup>76</sup> Fenger 2007: 27

<sup>77</sup> Fenger differentiates between 1) Conservative-Corporatist type 2) Social-Democratic type 3) Liberal type 4) Former-USSR type 5) Post-communist European type 6) Developing welfare states type

<sup>78</sup> Fenger 2007: 26

<sup>79</sup> Deacon (2000), Ferge (2001) Sengoku(2004), however, argue that the most important factors which have affected the system formation are not exogenous factors such as the influence of the international financial institutions or European integration, but endogenous factors, especially the political ones of each country

<sup>80</sup> Deacon 2000: 159. This point of view is connected to the "social dumping" phenomenon, which means a reduction in the social protection level of the working population in the interest of a long-term reinforcement of the national economy. Rys 2001: 181-182

Western welfare states.<sup>81</sup>

## 11. Conclusion

The analysis of key health care reforms in Poland indicates a shift away from the principles of the socialist welfare regime towards a more liberal system. Although the official aim of the 1999 reform has been to rescue a system nominally based on universal and equal access to state-guaranteed healthcare by means of efficiency enhancing market-type mechanisms and a greater involvement of the private sector, the early experience of the reform pointed towards numerous adverse outcomes.

With an ageing population, the constantly increasing cost of health care and a political and economic climate unable to significantly increase public spending and enhance the efficiency of the system, the official public sector in Poland is endangered to become increasingly residual service for the underprivileged people who cannot afford the legal private sector or the illegal envelop payments of the informal sector.<sup>82</sup>

Even though the post-transition welfare state in Poland cannot be reduced to any of Esping-Andersen's types of welfare state, the reforms of the health system as part of the general transformation of the economy and the welfare state demonstrate a shift towards a new and hybrid "*post-communist European type*"<sup>83</sup> of welfare state which has inherited certain features of the socialist regime, but is increasingly influenced by liberal principles.

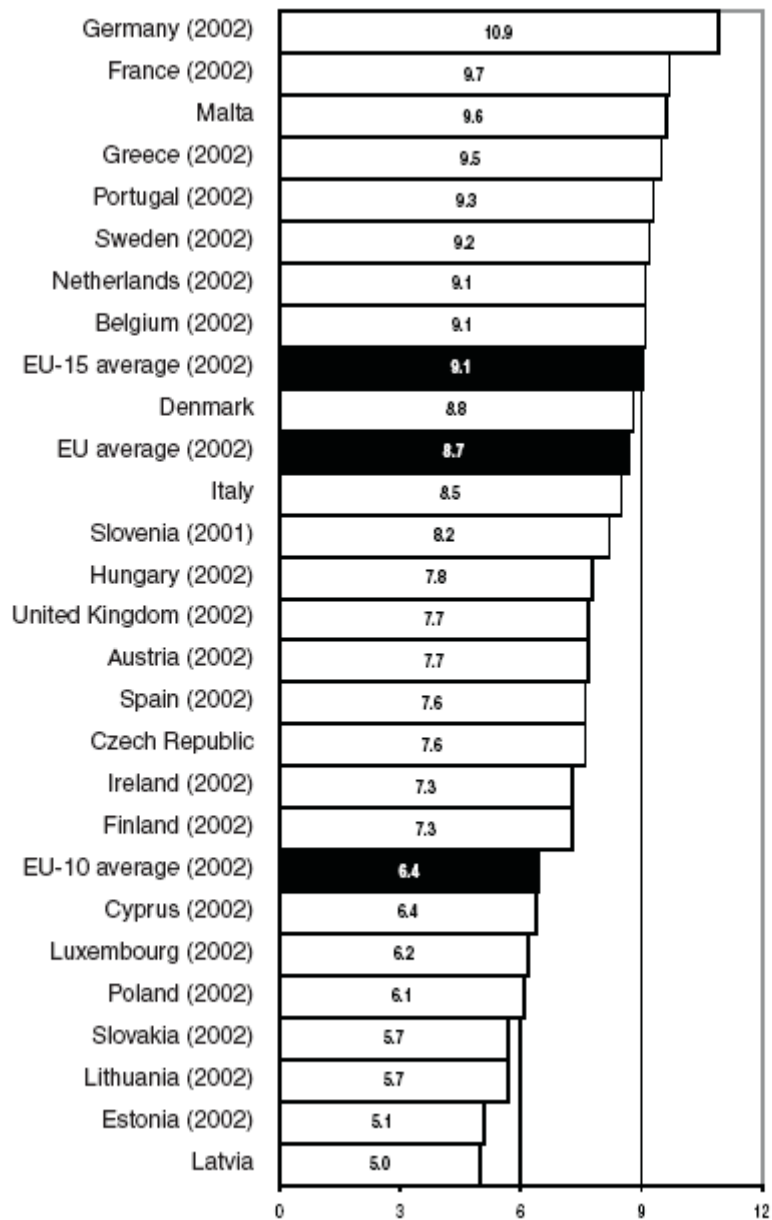
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<sup>81</sup> Fenger 2007: 15

<sup>82</sup> McMenamán / Timonen 2002: 117

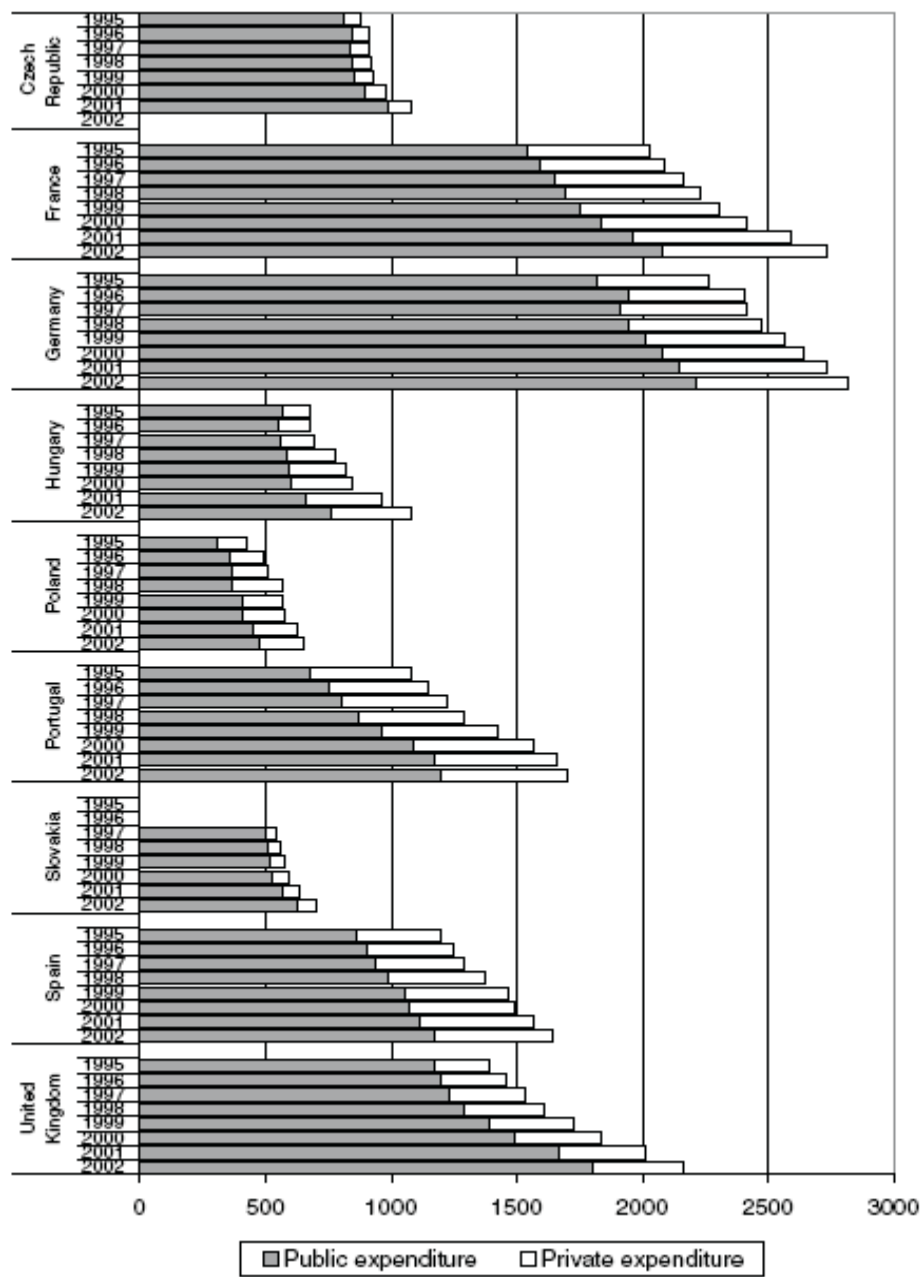
<sup>83</sup> Fenger 2007: 24 -25

**Annex I: Total expenditure on health as a percentage of GDP in the European Union, 2003 or latest available year (in parentheses)**



Source: Kuszewski / Gericke 2005: 45

**Annex II: Trends in public and private expenditure on health care 1995-2002, in US\$ PPP per capita**



Source: Kuszewski / Gericke 2005: 42

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