

## **Public service reforms and their impact on health sector personnel in Poland**

**Alicja Domagala, Ewa Pomykalska, Andrzej Rys,  
Monika Zajic**

**University Public Health Foundation, Kraków**

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## **Preface**

Over the past decade many countries have undergone public service reforms of some kind, however the consequences for employment and working conditions in the health sector have hardly been documented. This gap in information needs to be addressed, as any public service reform should be judged in terms of its influence on various sectors. The health sector is in most countries predominantly a public sector and therefore influenced by public service reforms. Achievement and improvement in the health sector are crucially dependent on the performance of staff at all levels which, in turn, is intimately related to their general employment and working conditions.

In 1998 the International Labour Office (ILO) and the World Health Organization (WHO) therefore launched a joint research programme to document selected reform processes and detail their impact on health care personnel. The lessons drawn from the individual cases are designed to assist international advisers, governments and organizations of civil society to implement more effective health sector reforms. Six countries from different regions of the world were selected as the focus for this international research (Cameroon, Colombia, Jordan, the Philippines, Poland, Uganda) and studies on public service reforms and their impact on health sector personnel in these countries were carried out in 1998 and 1999. Colombia and Uganda served as pilot country studies in 1998 and the other country studies followed in 1999. They all were discussed at an international round table. The Public Administration Promotion Centre of the German Foundation for International Development (DSE), Public Services International (PSI) and the International Council of Nurses (ICN) together with their affiliates assisted this joint effort of WHO and ILO throughout the whole process by providing technical advice and information at national, regional and interregional levels. The reasons for ILO and WHO launching this programme had different origins, but led to the same interest in the theme for the joint programme.

The 1998 sectoral meeting on health services requested the ILO to facilitate the exchange of experiences among countries through regional meetings and network arrangements of representatives of employers, workers and governments and to facilitate research activities on the impact of reform processes on the workforce. The joint programme with the WHO and the round table were a first response to these requests. For the ILO, this programme contributes to the follow-up of a series of sectoral meetings on reforms in both the health services and the public service sectors which concluded that “reforms are most likely to achieve their objectives of delivering efficient, effective and high-quality services when planned and implemented with the full participation of the public sector workers and their unions and consumers of public services at all stages of the decision-making process. Continuing dialogue between governments and the citizenry as a whole, including public sector workers, should be ensured” (1995) and that successful “health care reforms cannot be imposed from above and from outside” (1998).

For the WHO, the study of the impact of public sector reforms on health human resources is part of a programme to better understand the environment, factors and conditions that have an impact on health workers. With these data and information, discussion papers have been developed and disseminated to enable and increase debate on

the key issues. These issues include: education and training, motivation of health care providers, policy development, planning, recruitment, retention and deployment. The research is intended to provide the basis from which policy options can be developed for use by decision-makers in different countries. The WHO's workplan in the area of health workforce, education, performance and policy includes:

- a review of the changing roles of health professionals in many countries, through a reprofiling of different methods of health provider mix under different institutional arrangements;
- strengthening national capacity to use existing computer-based tools for health workforce planning and management;
- development of a set of standards for quality in the education of health workers;
- development of a set of policy options for improving provider performance;
- direct country support in overall human resource policy development and more specifically in nursing educational issues.

The WHO is working with countries as well as bilateral and multilateral partners in forwarding this agenda.

At an international round table of experts hosted by the DSE in October 1999 in Berlin, the experiences documented in the country studies were analysed and complemented. This round table was attended by the authors of the country studies, representatives of governments, private employers' and workers' organizations from the countries, as well as by officials from the organizations cooperating in this programme. The result of the discussions was the formulation of critical questions which were meant to facilitate the design, implementation and evaluation of human resource policies in public service and in particular health sector reform. This set of "Critical questions for initiating and reviewing public service reforms" is published in the report of the round table in Berlin in October 1999 and can be obtained from the organizers. With the present working paper the ILO and the WHO make also available the full text of the country studies which were revised by the authors in the light of discussion at the round table in Berlin. The opinions expressed in the studies are those of the authors and not necessarily those of the ILO and the WHO. Working papers are preliminary documents circulated to stimulate discussion and obtain comments.

Cleopatra Doumbia-Henry,  
Deputy Director,  
Sectoral Activities Department.

Orvill Adams,  
Director,  
Department of Organization of  
Health Services Delivery.

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## Executive summary

This paper presents an overview of the health sector reform in Poland. Poland has the eighth largest population in Europe with almost 39 million people. Ethnic Poles form over 98 per cent of the population. With an increase in GDP of 3.8 per cent, 5.2 per cent and 7 per cent in the years 1995-97 respectively, Poland has one of the fastest growing economies in Europe.

Poland is a reborn democracy, still in the process of renewing itself after 40 years of socialist economy. Renewal has involved many social and institutional reforms, one of which has been the reform of the health system. This reform aims to bring the advantages of the free market to health care, while at the same time ensuring public access. Market implementation will be described in detail: who the actors are, what their roles are, and the mechanisms by which they cooperate. Motivation for, and the visible consequences of, different aspects of this reform will also be examined: employment restructuring, and changes in health care qualification and training. Of course, it is also important to consider the problems faced by health care workers which have been and still are stimuli for change in the sector. Where possible this presentation is illustrated with relevant national statistics.

In the 40 years prior to 1989, Poland was a centrally planned socialist economy. This meant that the production and delivery of goods and services was a response to the often arbitrary decisions of Communist Party leaders and government officials. Among the consequences of this system were chronic overstaffing, as well as low levels of motivation, morale, efficiency and pay (in real terms) throughout the economy. The health sector was no exception.

In January 1990, the new democratically elected Government of Poland began the transformation of the socialist economy into one governed by and benefiting from the free market. Part of this transformation concerned the public health system. A new provider payment mechanism was instituted, certain sections of the system were decentralized and/or privatized, and a family doctor service model was developed, to name but a few of the changes.

During the nineties, and particularly in 1999, Poland saw a number of public sector reforms affecting health sector personnel. In 1999 alone three key steps in the transformation process were initiated. New administrative divisions were introduced. The social insurance system, including pension schemes, was opened to private competition. The school education system has also been restructured. These reforms combine the introduction of competition with changes in education to improve the quality of public services in general and the health care of Polish citizens in particular. The crucial changes focused on:

- the restructuring of economic ownership through privatization in order to create a real basis for the market economy;
- the introduction of market mechanisms, including individual economic stimuli in order to ensure a broad and stable improvement within the public sector; and

- 
- the technical reconstruction of the whole economy through the application of new technologies, followed by decreasing production costs and increasing work efficiency.

Particular changes in the health sector included:

- decentralization – transferring some of the responsibility for health care from the central Government to local governments;
- separation of the payer from the service provider, through the establishment of regional sickness funds;
- improving the efficiency of resource usage, reallocating the limited health sector resources cost effectively.

Some changes were not aimed at the health sector specifically, but have had a considerable impact on it. The most important of these is the reorganization of local government. Until 1998, Poland was divided into 49 *voivodships*. At the beginning of 1999, these were reformed into 16 much larger *voivodships*. Below the *voivodship* is the level of *powiat* and below that, the level of *gmina*. The reform of local government has reallocated responsibility for and ownership of the various kinds of health care institutions.

These changes created an opportunity for restructuring the health sector into a system of fund-holding, using contracts and competition in order to ensure the effective use of limited resources. Workers can be employed by contract: health care unit directors now have particular managerial contracts, while physicians and nurses have their own contracts as well.

Both private and public health service providers have access to public resources for the payment of their services. The competition among health care providers is expected to lead to an improvement in the efficiency and quality of health care services.

On the other hand, sickness funds through their purchasing policies have great influence on health care institutions and the range of services offered. Sickness funds could, for instance, force particular health care units to cease some activities, to change their employment structure, or even to close down. Any of these actions will have an impact on employment. First estimates suggest a loss of approximately 10 per cent of health care jobs. Staff reductions have been necessary, but these are balanced by a government support programme.

The fundamental idea of the 1999 national health insurance reform is to separate the payment for health services from the delivery of those services. The expenditure on health care depends at present on citizens paying insurance premiums amounting to 7.5 per cent of their incomes. Financial resources for health care are distributed to 17 sickness funds. These funding bodies agree contracts with individual health care units for the delivery of

particular health care services. Their remuneration is based on the number of patients treated, the number of services performed, or some combination of the two. At the same time, this reform ensures a free choice of physician for patients. It is expected that the combination of competition for patients and competition for sickness fund contracts will lead to an efficient and satisfying health care through natural market forces.

Other aspects of the national health system have also required government intervention. The ratio of specialized physicians to general practitioners is too high. Successive governments have supported the new generalist specialization of family physician to train and improve the numbers of physicians involved in primary care.

Education and training for health care workers has also been subject to reform. Here effort is aimed at developing nationwide standards with corresponding independent examination boards. Working in conjunction with professional associations, these boards remove the task of examination and awarding qualifications from the educational institutions. In conjunction with new postgraduate courses and a system of accredited training institutions, this change should bring about needed improvements in the quality of staff.

While Poland needs to improve the educational standard of its health care personnel, at the same time it needs to reduce their number. To this end, the Government has successfully controlled numbers of students enrolled in medical schools, with enrolments dropping since 1997.

Other legacies from the old system – low morale and low pay in particular – combined with the new situation of job insecurity lead to a number of strikes and demonstrations by health care personnel. The sources of this dissatisfaction are discussed, and how a system of collective bargaining has been established to allow the various professional groups to negotiate for their wage ambitions.

Although Poland is viewed an economic leader among former communist countries, the development of health care reform has lagged behind. The Czech Republic and Hungary established national health insurance systems in 1992 and 1993 respectively, and put these in effect almost immediately. In contrast, Poland introduced its national health insurance system only in 1999, ten years after the fall of communism. Poland can rapidly create an insurance-based health-financing system with largely privatized care provision.

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## Glossary and abbreviations

|   |  |
|---|--|
| CBOS ( <i>Centrum Badań Opinii Społecznej</i> ) | Centre of Public Opinion Research                                  |
| DES   | German Foundation for International Development                    |
| FP  | Family practitioner  |
| GDP   | Gross domestic product   |
| <i>Gmina, gmini</i>                             | Lowest administrative unit (2,489 subdistricts)                    |
| GP  | General practitioner   |
| HCI   | Health care institutions   |
| ILO   | International Labour Office  |
| PLN   | Polish zloty   |
| <i>Powiat, powiaty</i>                          | Smaller territorial unit (308 districts and 65 towns)              |
| <i>Voivodship</i>                               | Territorial administrative unit with limited autonomy (16 regions) |
| WHO   | World Health Organization  |
| ZOZs  | Publicly owned integrated health care provision organizations      |

## 1. Synthesis of public service reform in Poland

### 1.1. Background

Poland is a republic. Its Head of State is an elected president. The President nominates a prime minister, at whose recommendation, he also selects the government ministers. Both the Government and its programme of legislation must then be endorsed by an absolute majority in the Parliament. Also elected in general elections, the Parliament consists of lower (*Sejm*) and upper (Senate) chambers. It is responsible for creating and controlling laws.

One recent law introduced in 1999 was entitled "Introduction of the fundamental three-tier territorial division". This law divided Poland into 16 large administrative units, departments or regions) – *voivodships* – each having limited autonomy. Within each *voivodship* there are smaller units – *powiaty* (singular *powiat*, 308 districts and 65 towns have this status) and inside these the basic administrative unit – *gminy* (singular *gmina*, 2,489). Each Polish administrative unit (*voivodship, powiat, gmina*) has its own elected government.

Poland has the eighth largest population in Europe with almost 39 million people (1997). Ethnic Poles form over 98 per cent of the population, women 51 per cent, town and city dwellers over 62 per cent. Poland's workforce is one of the youngest in Europe: approximately 23 million (60 per cent) are under the age of 40 (1996).

With an increase in GDP<sup>1</sup> of 3.8 per cent, 5.2 per cent and 7 per cent in the years 1995-97 respectively, Poland has one of the fastest growing economies in Europe. In 1998 GDP growth was 4.8 per cent.

Inflation dropped from 13.2 per cent in 1997 to 9.8 per cent in December 1998. In the same month, 10.4 per cent of the total workforce in Poland were unemployed. In 1997, the public sector employed approximately 31 per cent of the total workforce, 6.7 per cent employed in health services and social work.

The table below shows the basic macroeconomic indicators for Poland 1994-97.<sup>2</sup>

<sup>1</sup> GDP – gross domestic product.

<sup>2</sup> The Polish currency is currently the Polish new zloty (PLN) with a value of approximately a quarter of a dollar (PLN4 = US\$1).

Table 1. Macroeconomic indicators for Poland (in per cent)

| Specification                            | 1994     | 1995     | 1996      | 1997      |
|--|----------|----------|-----------|-----------|
| GDP growth                               | 5.2      | 7.0      | 6.1       | 6.9       |
| Industry production, previous year = 100 | 12.1     | 9.7      | 8.3       | 10.8      |
| Investment outlays, previous year = 100  | 8.1      | 17.1     | 19.2      | 20.0      |
| Inflation (December)                     |          | 18.5     | 13.2      | 9.9       |
| Unemployment rate                        | 16.0     | 14.9     | 13.2      | 10.3      |
| Exports, previous year = 100             | 21.9     | 32.8     | 6.7       | 11.5      |
| Imports, previous year = 100             | 14.5     | 34.7     | 27.8      | 18.3      |
| Public debt/GDP ratio                    | 72.3     | 57.9     | 51.1      | 48.2      |
| <b>Central government budget</b>         |          |          |           |           |
| Revenue in million PLN                   | 63 125.2 | 83 721.7 | 99 674.5  | 119 772.1 |
| Expenditure in million PLN               | 68 865.0 | 91 169.7 | 108 841.7 | 125 674.9 |
| Budget deficit in million PLN            | -5 739.8 | -7 448.0 | -9 167.2  | -5 902.8  |

Source: BMB Promotion: "Business opportunity in Poland", Warsaw, 1999, data from Ministry of Finance, 1998. The breakdown of government budget expenditure for the years 1991-97 is presented in the appendix (table 1).

### 1.1.1. Unemployment: A social policy dilemma

Social policy has faced many dilemmas in the current period of systematic transformation. The first to be tackled concerned the labour market and unemployment. Unemployment has had a negative impact on social and economic life. It has been the main problem in social policy since the beginning of systemic transformation, because it causes poverty.

In Poland, the level of unemployment varies from place to place. There are communities where the level exceeds three times the national average. These communities are mostly to be found in the north-east of the country. This is an agricultural region with a low level of urbanization. There is little chance of rapid economic growth there.

The further problem throughout the country is high rate of long-term unemployment.

To prevent unemployment and its negative effects, Poland requires an active labour market policy:<sup>3</sup>

- creation of new jobs;

<sup>3</sup> Kurzynowski, A.: "Dylematy polityki społecznej i bezrobocie", Akademia Ekonomiczna, Kraków, 1998.

- protection of existing jobs wherever justifiable on grounds of efficiency;
- changes in the education system at all levels;
- intensification of vocational training and occupational requalification;
- closer cooperation between local labour offices and employers;
- response of educational institutions and non-governmental organizations to the needs of the unemployed;
- creation of conditions for increasing the spatial mobility of the population, especially through housing development.

Cooperation between public institutions, non-governmental organizations and employers, is essential for the realization of the above, and the subsequent prevention of unemployment and limitation of its negative effects.

## 1.2. Reform objectives and strategies

In January 1990, the Polish Government introduced a reform package designed to change the centrally planned communist system into a free market economy. The main goal of the changes was to create the institutional, financial and legal conditions necessary for rebuilding and later developing a market economy. As in all the former socialist countries in Poland the market economy was destroyed and market mechanisms were replaced by central planning, controlled by the arbitrary decisions of Communist Party leaders and state officials. The first non-communist Polish Government faced the challenge of rebuilding the fundamental bases of private ownership and the market economy, while at the same time undertaking a stabilization programme. To overcome economic difficulties and create the conditions for the future entry of Poland, the European Union mandated the complete reconstruction of the economy. The tasks included:<sup>4</sup>

- reconstruction of the whole economy by introducing technologies, decreasing production costs and ensuring increased work efficiency;
- modernization of the economic and social infrastructure, and in particular the modernization of the education system to improve its quality;

<sup>4</sup> Muller, A.: "*Sektor publiczny w Europie*", PWN, Warsaw, 1998.

- restructuring company ownership by accelerating and enlarging the privatization process in order to create a sound base for the market economy;
- transformation of patterns and quantity of consumption, with a significant growth in the standard of living, an increase in the average level of education, a total increase in housing, all of which will create new opportunities for recreation and cultural development within the society;
- transformation of international economic relations, primarily with highly developed countries, and a transformation in the material and territorial structure of foreign trade, establishing the conditions appropriate for Poland's future entry into the European Union.

The rapid development of the private sector was most important for the process of transforming the Polish economy. It now dominates the whole economy but, ten years after the beginning of structural change in Poland, the public sector still has great importance in the economy.

At the early stages of the transition, notwithstanding the deep recession, the existence of public enterprises has had positive macroeconomic effects, smoothing budget difficulties by their fiscal contribution and important position in foreign exchange. They have also provided a subsistence income to a large part of the population.

Also since January 1990, the Government of Poland introduced a number of reforms in the financing, management and organization of the health sector: most of these in line with the overall shift from a centrally planned communist system to a free market economy. The legislation led to:

- the establishment of new health care provision units (1991 Act);
- a new provider payment mechanism (1993 Act);
- greater autonomy for hospitals and other public health service providers;
- the decentralization and privatization of the public sector in health;
- the introduction of a family doctor practice model; and
- the introduction of a national health insurance system (1997 Act).

The year 1999 presents a particularly difficult and challenging time, with four simultaneous reforms:

1. reform of the national health insurance system;
2. local and regional government restructuring;
3. reform of the social insurance system (pensions, disability allowance);
4. reform of the education system.

The main objectives of the reform of the national health insurance system are:

1. functional separation of payer and provider;
2. improving the efficiency of resource usage;
3. market incentives (competition among service providers);
4. equal access to public resources for all providers of health services;
5. reallocating the limited health sector resources cost effectively;
6. restructuring health services into a system of fund-holding, contracts and competition;
7. providing all citizens with a choice of health care provider;
8. enhancing management capability.

To realize these goals, the Government has introduced: <sup>5</sup>

- legislation and other initial steps to create and operate hospitals and ZOZs (publicly owned integrated health care provision organizations) as independent units;
- decentralization of ownership, as well as financial and management authority to the *gmina* level (for primary care) and to the *voivodship* for many other services;

<sup>5</sup> Berman, P.; Rys, A.; Roberts, M.; Campbell, P.: "Notes on health sector reform in Poland", Harvard and Jagiellonian Consortium for Health, Apr. 1998.

- extensive, but as yet poorly regulated, private ambulatory medical practices for general and specialist services;
- implementation of a “family doctor” scheme: a new model of the general practitioner role in the delivery of primary care;
- devolution of payment, contracting, management and public health innovation to the local level.

### 1.3. Reform processes and actors

In the late eighties, Poland had already privatized an important part of its economy, a fact that made the process of learning and adaptation easier. Internal changes were accelerated by a systematic worsening of conditions. Firms were reorganized and adapted to market conditions, transferring their focus from the acquisition of resources to the sale of products. At the same time, resource use was improved. The productivity of labour and intermediate goods rose, and costs were better controlled.

This adaptation should be seen in the light of systematic changes. Generally speaking, all economic actors are interested in change and the learning process.

Many restructurings have been undertaken. The evidence from the evolving behaviour of firms and their general restructuring permits the conclusion that systematic factors are more important than the formal transfer of property rights, as incentives for change.

Since early 1990, Poland sought political consensus on a sound strategy for fitting the health care system to the new market economy.

The need for change in the health care system is agreed by:

- society at large, as health service purchasers;
- health care staff, as health service providers;
- decisions-makers, i.e. politicians and managers.

The population’s level of expectation remains high, despite years of frustration with the low quality of service. The poor economic conditions have exacerbated health problems in the population. Health care providers and managers are accustomed to limited accountability, inefficiency, and powerlessness to effect change. Providers are also

demanding better working conditions and compensation and currently obtain these, at least in part, through private practice and informal payments.

However, the approval for particular reforms differs according to motives and expectations. Groups differ in radical opposition to some of the key issues:

- need for increasing or decreasing financial resources made available for health care;
- need for increasing or limiting access to medical examination (specialist examinations in particular);
- salary expectations of health sector personnel;
- acquisition or not of modern diagnostic and therapeutic technologies and procedures.

The development of the legislation for the national health insurance system led to some contention. The Government of the time was the Democratic Left Alliance. The leading opposition party, Solidarity, put forward an alternative proposal. Another, more pluralistic, alternative was proposed by the Freedom Union. In the parliamentary elections of 1997, these two parties formed a government in coalition.

#### **1.4. The focus and scope of reform implementation (with emphasis on sector policies, structures and institutions, financing)**

Since 1989, consecutive Polish Governments introduced reforms including floating prices, limited money supply and currency devaluation. In introducing health care reform, the Ministry of Health and Social Welfare focused especially on the following:

- Decentralization: Since the political changes of 1989, responsibility for health care held till then entirely by the central Government, has been, in part, transferred to local government. In accordance with the new Act, the majority of obligations concerning financing and delivery of health services were transferred early in 1999 to one corporate fund (concerned with the police, the military and the railway) and 16 regional sickness funds.
- Separation of finances from the service provider: The newly established regional sickness funds sign contracts for medical service delivery with both public and private providers. This separation terminated a long period in which the central Government both paid for and managed health care.

- Introduction of market and quasi-market mechanisms; i.e. the introduction of individual economic stimuli in order to ensure a broad and stable improvement in health care.<sup>6</sup>

Government administration at the *voivodship* level lost most of its responsibility and has ceased to be the funding body for the majority of comprehensive health care clinics. However, they took over the *voivodship* sanitary and epidemiological stations and also pharmacological supervision units. The *voivod* (the appointed head of the *voivodship*) is responsible for keeping a register of health care comprehensive clinics, assessing draft resolutions concerning the liquidation or transformation of comprehensive clinics by local governments, and for the evaluation of health care investment projects.

The *voivod* also has responsibility for specialized hospitals, emergency transport units, and occupational medicine centres. They also became responsible for the training of physicians and nurses, as well as for postgraduate education in these fields.

The reform imposed on *powiaty* the responsibility for specialist clinics, including outpatient clinics, and district, municipal and general hospitals. The obligations of *gminy* include taking over rural and community health centres, which so far have been managed by local governments as ordered works.

The implementation of the new health care system was accompanied by the introduction of national health insurance. The expenditure on health care depends at present on citizens paying insurance premiums amounting to 7.5 per cent of their incomes.

The sickness funds operate under the following principles: the justification of expenses, cost effectiveness, non-profit-taking, and ensuring equal access to medical services. They finance outpatient treatment, both primary and specialist, community care visits to patients' homes, treatment in hospitals, clinical hospitals and clinics at research institutes, nursing services, rehabilitation, the supply of drugs, medical materials, orthopaedic equipment and aids, spa treatment, palliative and hospice care, as well as the assessment of the state of community health. Payments for these tasks originate in the insurance fund and are distributed through sickness funds to the health care units. Some tasks (including *voivodship* blood donation units, pharmacological inspection units, highly specialized procedures, sanitary and medical education) are still financed from the central government monies via governor or *voivodship* budgets.

The basis of health care finance is the contract closed between an independent comprehensive health care clinic, private physician or nurse practice and a given sickness

<sup>6</sup> Kozierkiewicz, A.; Kulis, M.: "Ochrona zdrowia w samorządzie lokalnym. Doświadczenia polskich miast", Uniwersyteckie Wydawnictwo Medyczne "Vesalius", Kraków, 1999.

fund. These contracts are the result of negotiations specifying a number of contracted services and their scope (the number of people in the relevant district).<sup>7</sup>

### 1.5. Working conditions and terms of employment in the public sector (management processes, workforce issues)

In 1997 there was one physician per 425 citizens, one dentist per 2,194 and one nurse per 178. Table 2 presents medical personnel of the civilian health service per 10,000 population.

Table 2. Health service personnel per 10,000 population (31 December/year)

| Specification | 1990 | 1995 | 1996 | 1997 |
|---------------|------|------|------|------|
| Physicians    | 21.4 | 23.2 | 23.5 | 23.6 |
| Dentists      | 4.8  | 4.6  | 4.6  | 4.6  |
| Pharmacists   | 4.0  | 5.0  | 5.2  | 5.3  |
| Nurses        | 54.4 | 54.8 | 55.7 | 56.2 |
| Midwives      | 6.3  | 6.3  | 6.4  | 6.4  |

Source: Central Statistical Office: "Rocznik statystyczny Rzeczypospolitej Polskiej 1998", Warsaw, 1998.

In 1974 the following working conditions<sup>8</sup> were laid down for public health service personnel:

- medical, economical, technical and administrative workers – a 40-hour week (seven hours, 35 minute per day);
- radiologist and workers with radioactive sources, histopathologists, physiotherapists – a 26-hour, 15-minute average working week (five hours per day);
- blind people working with patients – a 31-hour, 30-minute average week (six hours per day);
- other workers – a 42-hour week (eight hours per day).

<sup>7</sup> Bączek, I.: "Trudne początki reformy", Wspólnota, 20 lutego 1999.

<sup>8</sup> Cabinet decision in the matter of some obligations and rights of workers employed in the health service, 27 Dec. 1974.

## 1.6. Overall achievements, constraints and failures

In March 1999, CBOS<sup>9</sup> carried out research on public attitudes towards health care reform, showing that:

- those fearful of reform were fewer (in comparison with earlier research), but were still in the majority (53 per cent);
- most respondents felt poorly informed about how to use the new health care system (68 per cent);
- almost half of those polled agreed that the implementation of health care reform was necessary, but felt that it should be introduced later (49 per cent);
- only 18 per cent thought that the reform was unnecessary;
- many thought that implementation of the reform would be disadvantageous for themselves (46 per cent), while only one-fifth (21 per cent) thought the opposite;
- the remainder either could not estimate the benefits of the reform (19 per cent), or considered the reform unimportant to them.<sup>10</sup>

The reform of the health care sector has been simultaneously conducted in several directions, such as the shift to local government control, the change in form of insurance, the giving of autonomy to some facilities, the reorganization of primary health care. The autonomous nature of these reforms and a lack of coordination has led to conflicts and has dissipated some of the energy of the reform.

Peter Berman in his study: “National Health Insurance in Poland: A coach without horses?” presents on the basis of the observation and analysis the importance of particular determinants of reform success (table 3).

<sup>9</sup> CBOS – *Centrum Badań Opinii Społecznej* (Centre of Public Opinion Research).

<sup>10</sup> Dereczyński W.: *Reforma ochrony zdrowia w opinii społecznej*”, Prawo i medycyna, Nr 2, Warsaw, 1999.

Table 3. The importance of specific health system changes to Poland's reform objectives <sup>11</sup>

| Area where change is needed                         | Health reform objectives |        |                    |                     |
|---|--------------------------|--------|--------------------|---------------------|
|   | Efficiency               | Equity | Health improvement | Public satisfaction |
| Level of resources                                  | +                        | +      | □                  | +                   |
| Allocation of resources                             | ++                       | ++     | ++                 | +                   |
| Structure of health care provision                  | ++                       | □      | +                  | ++                  |
| Motivation and incentives of providers and managers | ++                       | +      | ++                 | ++                  |
| Consumer expectations                               | ++                       | □      | □                  | ++                  |

++ = very important, + = relevant, □ = not so relevant.

The level of resources may not be the most significant factor in achieving reform objectives. Behavioural changes by managers, health care service providers and consumers are also important factors in reform success.

The most important change for medical personnel due to public sector reforms is the low regulation which created the opportunity to work for themselves or in their own companies to provide health services. Now private and public organizations are equally able to bid for health care contracts with the sickness funds.

## 2. The impact of public service reforms on health sector employment and working conditions

### 2.1. Implications for human resources policy in the health sector

#### 2.1.1. General organization of the health sector

The structure and organization of the health service is tightly connected with regional administration. At the higher administration levels, more specialized tertiary services are provided. At the level of *gmina*, primary care (family practice, general practice, paediatric) services are delivered. At the level of *powiat*, ambulatory care should include wider range of specializations and hospitals should offer services at a level of basic specialization (surgery, paediatrics, internal medicine, gynaecology). At the *voivodship* level, narrow specializations are to be found.

<sup>11</sup> Berman P.: "National health insurance in Poland: A coach without horses?", Harvard and Jagiellonian Consortium for Health, Apr. 1998.

In the reformed health care finance system in force since the beginning of 1999, based on the national health insurance system, there is a developing market of service providers. Important here is equal access to public resources. Health services are realized through agreements negotiated between sickness funds and health service providers which are able to provide particular services.

Those types of subjects which are authorized to make contracts with the sickness funds are described in the General Health Insurance Act (July 1998). These are health care institutions (HCI), medical professionals working in individual practices, and others with qualifications for providing health services (physicians and nurses in contract employment).<sup>12</sup>

According to the new health reform regulations, HCIs can be any of the following units:

- hospitals, nursing homes and other institutions providing 24-hour service in fixed accommodation;
- outpatient clinics;
- emergency services;
- diagnostic laboratories;
- rehabilitation institutions;
- dental surgeries.

With the present shape of the health service market there could exist both public HCIs (funded by central administration, *voivod* or local government – *powiat, gmina*) and non-public HCIs (founded by institutions such as private foundations, churches, associations).

There are no legal barriers to non-public HCIs or private physician and nursing practices negotiating with sickness funds. As mentioned above, the basis of the reform is equal access to public resources and monies from the sickness funds. The main reason for this is to provoke competition at the health service market, and consequently to improve the quality of services. At present, the field of sickness funds activity is limited to the *voivodship*. After the year 2000 these barriers will be revoked. Competition will be stronger.

<sup>12</sup> Włodarczyk, C.; Sitko, S.J.: *Zarządzanie ochroną zdrowia w powiecie – poradnik dla samorządowców*, Uniwersyteckie Wydawnictwo Medyczne “Vesalius”, Kraków, 1999.

This policy, by which sickness funds buy services from providers, may lead many institutions to change their profile and range of services. Sickness funds may well be able to force a particular health care unit to cease certain activities, change its staff, or even to close. Thus, indirectly, the sickness funds influence employment in this market. It has to be remembered that very often a health care unit is the sole employer of medical professionals in a given local market.

Providers can be public HCIs, non-public HCIs or individual medical professionals. The future of primary care in Poland will be based on the HCI group, group GP (general practitioners), individual GP and nursing practices. These may create organizational structures from small consulting rooms to large companies including some with limited liability and some partnerships. This is also true of dental practices. Private medical activity is regulated by the Economic Activities Act.

Opportunities currently available for nurses need to be highlighted, a group lower in the medical hierarchy than, for instance, physicians. In compliance with health reform guidelines, nurses can create their own companies. They can provide health services according to contracts signed with *gminy*, insurance institutions, family practitioners and GP group practices.

Nursing services (legal and organizational forms):

- individual contract;
- group nursing practice;
- home nursing care;
- family practice nursing.

Managers of health care institutions have a new role in this new system of employment. They are responsible for negotiations with sickness funds and strategy planning.

Such wide responsibility should be linked to proper compensation. Managers negotiate their contracts with the *voivodship* offices, and these specify a basic salary and a system of bonuses in response to the efficiency of the health care unit.

### **2.1.2. Overall costs, fiscal constraints and the availability of resources**

Until 1998, the main source of health care funding in Poland was the allocation from the annual government budget. In 1997, 14.8 per cent of the budget was earmarked for this sector. Public expenditure on health is at 4-5 per cent of GDP<sup>13</sup> (appendix, table 2). Expenditure per person in 1997 was equal PLN488.79. The appendix (table 3) shows government expenditure on health care per person in the years 1991-97 (in compare value).

Until the end of 1998, the health care budget was divided into a central component (15 per cent), managed by the Ministry of Health and Social Welfare, and a regional component (85 per cent) controlled by health departments in each of the then 49 *voivodships*.

The central component provided for care in clinical hospitals, certain centrally financed health spas, and special development programmes. Distributed through the block grants to the *voivodships* and local governments, the regional component provided for networks of public hospitals and outpatient clinics. These latter financial resources were transferred to *voivodships* directly from the Ministry of Finance, bypassing the Ministry of Health and Social Welfare. Together, the central and regional budgets constituted about 90-95 per cent of public expenditure on health care.

Other sources of funds included voluntary fees from patients and their families, donations, payments from non-governmental organizations such as the Red Cross or Caritas, as well as payments from corporations.

#### **Lack of accounting and monitoring mechanisms**

The analysis of health care expenditure in this period faces considerable problems. Large amounts of income were not recorded at all. Public institutions, such as hospitals and outpatient clinics, can receive funds from private sources such as direct payments from patients. At the same time, there is no legal requirement to record such payments, or notify any funding agency. Even data about official income, e.g. from the use of public equipment in so-called "free hours", may not be recorded.

A similar situation arises in the private sector – private clinics and practices are not obliged to keep precise records of their income.

Before the 1999 reform, health care units operated on credit. Their debts amounted to PLN7.3 billion at the end of 1998.

<sup>13</sup> Windak, A.; Chawla, M.; Kulis, M.: *Kontraktowanie świadczeń zdrowotnych od teorii do praktyki*, Uniwersyteckie Wydawnictwo Medyczne "Vesalius", Kraków, 1998.

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### **2.1.3. Intended and unintended staff movements, including reduction, redeployment and migration of staff**

The Polish health sector is overstaffed. This is the topic of the following sections. At the end of April 1999, the Government approved a programme of employment reduction in the health care sector. This programme envisions the loss of 66,000 employees before 2001.

On the basis of questionnaires completed by health care units, the Ministry of Health and Social Welfare estimates a staff reduction of 10.5 per cent (of total workforce in the health sector) – in the years 1999-2000. The data from questionnaires show that:

- staff reduction will primarily affect middle and lower level health care personnel;
- employment loss among physicians will reach 8.26 per cent (that is 6,385 persons), and among dentists 19.18 per cent (2,168 persons);
- employment reduction among nurses and midwives will reach 7.12 per cent (13,550 persons), pharmacists 7.42 per cent (185 persons), and medical technicians 12.13 per cent (6,084 persons);
- employment reduction among technical workers will reach 18.77 per cent (2,868 persons), among other service staff 15.62 per cent (11,326 persons);
- post reduction will be achieved largely through about 14,000 health workers taking the opportunity of early retirement;
- among the health care workers who are likely to take early retirement, the most numerous will be administrative workers, nurses and midwives, other service staff and medical physicians.

To compare these estimations to statistical indicators in the years 1980-97, see table 7 on changes in health care employment, 1980-2000.

Since early 1999 there has been a continuous series of strikes and demonstrations, particularly by nurses. These protests are a response to the low levels of pay, and the current threat of unemployment.

Sickness funds can influence employment in the health service market. Often a given health care unit is the main local employer. For example, if the sickness funds reduce the number of services they buy from a particular hospital, that hospital may have to close a number of wards and consequently make a number of staff redundant.

The implementation of the reforms to health care will result in many changing their place of work, changing their qualifications or even losing their jobs. On the basis of the abovementioned questionnaires conducted in the first two months of 1999, it can be estimated that employment reduction will touch 42,500 persons currently employed in health care institutions. Apart from these, 6,700 ambulance workers face loss of employment. Altogether, 49,200 persons are in this position in the current year, with an additional 16,000 next year. This is from a total health care sector workforce of 605,000 people.

### Retrenchment support programme

The Cabinet has earmarked PLN230 million for a support programme for people with a change in their job situation in 1999-2000 due to the current reform. The main goal of these activities is to provide different forms of help for fired and moved employees.

The first phase of the support programme seeks to maintain jobs within health care units. Part of this effort involves the creation of nursing homes. These institutions will offer jobs for many nurses and other non-specialized personnel. About 70 nursing homes are expected to be created in the current year, with approximately 1,600 positions, primarily for nurses. This part of the programme is supported by credit from the World Bank.

The second phase of the support programme will offer credit to physicians and nurses to open their own private practices. The development of private practices, particularly for primary health care, is one of the key ideas in the current health reform. To support it, the programme offers physicians three-year credit of PLN70,000, and nurses of PLN10,000. It is predicted that 2,000 physicians and 1,000 nurses will take advantage of this offer of credit.

The third phase of the support programme supports the privatization and development of paramedical services. They are to start approximately 200 companies.

The fund includes PLN4.6 million for improving and changing qualifications.

One further component of the programme, starting next year, provides pension fund payments for employees having worked a minimum of 32 (women) or 37 (men) years.

The largest share of the programme's funds are devoted to assist employees made redundant.

Overall, the Government intends to spend PLN161 million on this support programme.

#### 2.1.4. Education

In 1970, 46,399 students were studying medicine. By 1990, this number had grown to 95,907 but in the following seven years fell to the 1997 figure of 41,345. In the same year, there were 12,675 new medical graduates.

From 1970 to 1990, the number of students enrolled at medical schools grew consistently from 22,456 to 36,282. With the change of system, the number begins to fall to the 1997 figure of 26,238. The numbers of graduates in these years were 3,846, 5,380 and 4,775 respectively (see appendix (table 4) for details).

The most popular departments at Poland's 12 medical schools are the faculties of medicine, dentistry and pharmacy. Less popular are nursing, medical analysis, and public health. In 1996, the medical faculty supplied 60.9 per cent of the total graduate population, followed by dentistry with 16.2 per cent and pharmacy with 13.6 per cent (see appendix (table 4)).

Education of medical professionals in Poland consists of:

- five years of study at a medical academy;
- compulsory postgraduate internship for physicians and dentists, as well as in-work training for graduates of the pharmacy department;
- degree specialization (for physicians, dentists and pharmacists).

At present a one-year internship is obligatory (according to the 1950 Act controlling the medical professions) for physicians and dentists. Changes are in progress to the internship system to make the physicians more independent. The primary changes are: the introduction of an internship exam; the restriction of internships to authorized health care units; and possible widening of the internship system to psychiatry and family medicine. The period of internship will be longer (16 months for physicians, 12 months for dentists). This new internship programme will be in force from 1 October 1999. □<sup>14</sup>

The current reform will also introduce changes to the process of specialization. These include:

- (a) one-degree specialization;

<sup>14</sup> Ministry of Health and Social Welfare: "Transformacja systemu ochrony zdrowia w Polsce"; Warsaw, 1998.

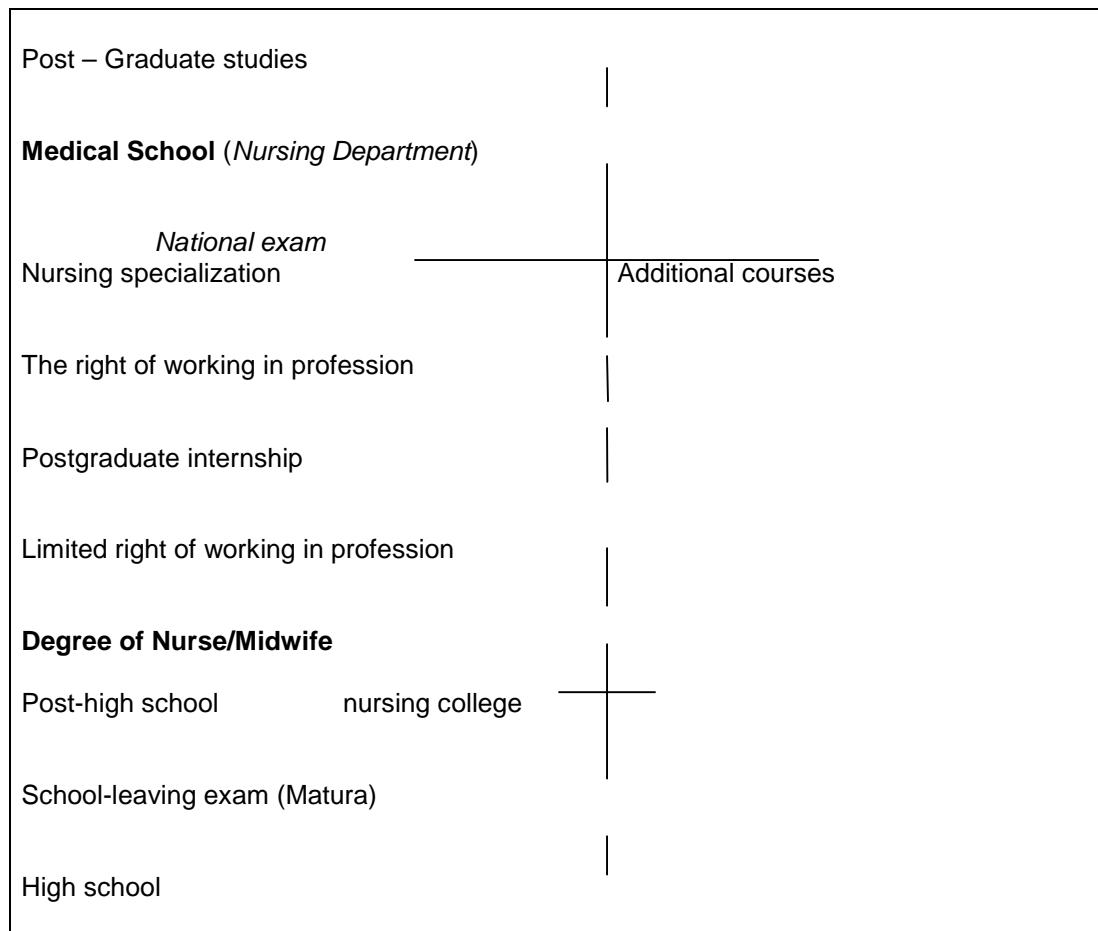
- (b) a residential system (regular specialization posts);
- (c) accreditation (a system of authorizing health centres for specialist training);
- (d) separating the educational institution from the qualifying body.

Nurse and midwife education is provided at nursing schools. Before gaining the right to work in the profession, graduates need to take a 12-month postgraduate internship in a health care unit.

Recent changes in the education of nurses and midwives stem from a 1996 Act. This document defines the starting point of training as graduation from high school. The first step along the educational track then is training at the nursing school followed by an obligatory one-year internship in a health care unit.

The principal changes in postgraduate education for nurses and midwives include: widening the subjects available for postgraduate education; allowing private institutions to offer postgraduate courses after meeting appropriate conditions; implementation of a standard compulsory national specialization exam; and involving regional nursing organizations in the process of authorizing postgraduate education (figure 1).

Figure 1. The structure of nursing education after reform



Source: Ministry of Health and Social Welfare: "Transformacja systemu ochrony zdrowia w Polsce"; Warsaw, 1998.

The Act, published by the Ministry of Health and Social Welfare in September 1998, founded a new institution to coordinate these changes in the educational system: the Postgraduate Educational Centre for Nurses and Midwives. This institution is also responsible for preparing the national specialization exam.

### 2.1.5. Professional standards, registration, code and scope of practice

Until now there is no required standards governing the number of citizens which can come under the care of a given health care worker.

In preparing the principles to guide ambulatory health care, the Ministry of Health and Social Welfare presumed the numbers in the following table (table 4). It should be noted that these are neither statistics nor legal requirements on the number of citizens per health worker. The new principles will be in force some time in the near future.

Table 4: Appropriate levels of medical staffing

| Service provider | No. of citizens |
|------------------|-----------------|
| 1 physician      | 2 500           |
| 1 dentist        | 3 000           |
| 1 nurse          | 1 250           |
| 1 midwife        | 10 000          |
| 1 school nurse   | 800 pupils      |

Other sources<sup>15</sup> suggest the following appropriate levels of staffing to ensure an adequate level of nursing and health care in Poland:

- in rural areas: one nurse should cover 1,000 people;
- in urban areas: one nurse should cover 1,500 people;
- in rural areas: one midwife should cover from 3,500 to 7,000 people;
- in urban areas: one midwife should cover from 7,000 to 14,000 people;
- school medicine: one nurses should cover on average 700 pupils.

In 1987 parameters were defined to establish appropriate levels of nursing in the public health sector. These describe the number of beds per nurse or midwife:

- in hospitals: 2.3 beds;
- in clinical hospitals, and at clinics in research institutes: 2 beds;
- in *voivodship* and highly specialized hospitals: 2.2 beds;
- in paediatric hospitals: 2.2 beds;
- in neurological and psychiatric hospitals: 3 beds.

<sup>15</sup> *ibid.*

There are standards on working hours per day and week appropriate to particular kinds of health work. These are reported above in section 1.5. There are also standards governing minimum and maximum rates of pay, as well as bonuses, for workers on ordinary employment contracts in public institutions.

**Table 5. Salary ranges for health sector positions**

| Position                       | Salary (PLN) |
|--------------------------------|--------------|
| Manager                        | 940-1 815    |
| Accountant                     | 810-1 595    |
| Head of nurses                 | 810-1 595    |
| Nurse                          | 495-995      |
| Physician – first year of work | 580-1 155    |

In 1998 the Minister for Health and Social Welfare proposed standards for procedures in anaesthesiology and intensive care, but there is still a lack of standards for procedures for the other medical specializations.

There are, at the moment, no standards for technical equipment in health care units. A document providing such standards is currently in preparation.

### **2.1.6. Labour relations (unionization, collective bargaining, dispute)**

Since the implementation of health reform in early 1999, Poland has seen a continuous series of strikes and demonstrations. Protests have been caused mainly by the threat of unemployment and the low level of pay. It is necessary to mention that protesting health care workers have always sought to consider patient needs.

Worker satisfaction is closely linked to working conditions. These working conditions are determined by the technical equipment available in health care units, by the organizational structure, and by the level of wages.

Unions and labour associations play an important role in negotiations over health reform, particularly in matters of payment, employment conditions, and support programmes. The payment system in particular has been established in cooperation with the relevant trade unions.

Among the leading professional organizations are: the National Trade Union of Nurses and Midwives, the Main Chamber of Physicians, and the Trade Union of Physicians.

The National Labour Union of Nurses and Midwives has been engaged in a class action against the Ministry of Health and Social Welfare from July 1998. The action is

primarily concerned with extremely low wages paid to nurses. Currently, a nurse at the beginning of his/her career earns about PLN540 (US\$138 per month), a sum considerably lower than the average salary in Poland. Nurses therefore demand a rise in wages beyond the increase in the national average salary. From January 1999, the Government promised rises at 2 per cent above inflation in all health care institutions. As a matter of fact, sickness funds budgets are limited and insufficient allocations for nursing services can be observed.

In addition the National Group of Nurses and Midwives demands legal remedies to improve the standard of living of this professional group.

The protest of the Anaesthetics' trade union took a particularly strong form. The lower status of this profession led to significant social problems in 1998. As a result of negotiation, the Anaesthetics' trade union and employee confederation achieved many of their goals.

At the end of 1998, after a series of strikes, the Government promised to raise levels of pay in the health care sector. The root of continuing problems is overlapping responsibilities of the Government and the sickness funds. The relevant trade unions forged an agreement with the Ministry of Health. The Ministry claims that now sickness funds, as the primary financial institutions in the health sector, should pay the promised amount, in total approximately PLN700 million. Sickness funds naturally disagree with this decision, underlining that no such payment was mentioned when their budgets were crafted. An additional source of conflict is the difference in wages between health care personnel and sickness funds staff.

After negotiations between the Association of Employees in Health Care and trade unions, new payment levels were established. One crucial aspect of the new payment system is to establish a motivational link between wages and the quality of health service. Salary levels will be constructed from a minimum rate, with extra payments for additional service provision. The level of remuneration will vary between physicians, nurses and other medical personnel, and be determined as a percentage of the amount of money (per capita) received from the sickness funds. In the future this provision will vary in response to the costs of individual medical procedures.

### Collective bargaining

In Poland, collective bargaining between employees and employers takes place at two levels: at the national level and at the workplace. At the national level, employees are represented by the relevant trade organization, either a trade union or a professional association. Employers are represented by an organization of their own, or, in the case of public sector employers, by the responsible minister. These collective agreements determine the minimum levels of pay which can be set within workplace agreements.

Workplace agreements result from negotiations between the employer, usually represented by the local director, and the workplace trade organization. Both sides have the

right to initiate bargaining. Agreements reached at this local level cover working conditions such as:

- employment conditions;
- qualifications for certain posts;
- time of work (including health hazardous environment);
- level of remuneration;
- social benefits;
- personnel policy;
- safety and hygiene of work.

Workplace bargaining with trade unions presents a number of problems for managers. For example:

- the necessity of satisfying the needs of all the trade unions existing in the organization;
- the low number of members required in order to register a trade union (ten members);
- the lack of resources to make severance payments.

### **2.1.7. Gender policy and gender outcomes**

The Polish health care sector employs significantly more women than men. For example, it is estimated that 80 per cent of the workforce in this sector in Masopolska (one of 16 *voivodships* in Poland) are women. This is not due to discrimination, but rather individual choice of profession. Men, for example, rarely become nurses (nearly 100 per cent of nurses are women).

Pay levels do not depend on sex but on qualification, experience and function. The only difference is in the age at which men and women are able to take retirement. Women can retire at 60, men at 65. This is a common feature of employment conditions throughout the workforce.

Table 6 shows the percentages of women employed in various professional groups in the years 1980-97. The appendix (table 6) shows the distribution of physicians according to gender and place of work.

**Table 6. The percentage of employed women in medical professions 1980-97 (in per cent)**

| Professional group     | 1980 | 1990 | 1995 | 1996 | 1997 |
|------------------------|------|------|------|------|------|
| Physicians             | 53.5 | 54.1 | 55.2 | 55.0 | 54.9 |
| Dentists               | 81.8 | 79.8 | 79.7 | 78.8 | 78.4 |
| Pharmacists            | 85.2 | 83.4 | 88.9 | 88.9 | 88.9 |
| Laboratory technicians | –    | 88.2 | 90.3 | 91.2 | 90.2 |

Source: Ministry of Health and Social Welfare: "Biuletyn Statystyczny", Warsaw, 1998.

## 2.2. Impact on the health workforce (private and public sector)

### 2.2.1. Changes in pattern of employment (structure and levels, decentralization)

Under communist rule, employment was guaranteed. Despite popular frustration with the existing health care system, there remains strong reluctance among health care managers and the public to use staff reductions as a means of saving resources and increasing efficiency.

Until 1997 all the medical professional groups were increasing in size. The higher employment ratios for health care personnel can be explained by the lack of medical resource planning, and by the late introduction of limits on the number of medical school places. Table 7 presents percentage changes in employment (increase or decrease) in the period 1980-2000 (see point 2.1.3. – intended and unintended staff movements, including reduction, redeployment and migration of staff).

**Table 7. Changes in health care employment 1980-2000 (in per cent)**

| Professional group     | 1980-90 | 1990-95 | 1995-96 | 1996-97 | 1999-2000*              |
|------------------------|---------|---------|---------|---------|-------------------------|
| Physicians             | 28.4    | 9.5     | 1.6     | 0.3     | 18.26                   |
| Dentist                | 8.1     | 12.2    | 10.4    | 11.4    | 119.18                  |
| Pharmacists            | 11.9    | 28.7    | 3.6     | 2.6     | 17.42                   |
| Laboratory technicians | –       | 58.7    | 11.0    | 7.5     | 112.13                  |
| Nurses                 | 32.4    | 1.9     | 1.7     | 0.9     | 17.12<br>(and midwives) |
| Midwives               | 49.2    | 1.8     | 0.8     | 0.7     |                         |

\* Estimate based on questionnaires completed by health care units.

Source: Ministry of Health and Social Welfare: "Biuletyn Statystyczny", Warsaw, 1998.

In 1997, 60 students graduated from public health departments in medical schools.

In 1997 there were the following counts of medical personnel per 10,000 people. There were 23.6 physicians of whom 77 per cent or 18.3 were specialists. There were 4.6 dentists, a figure which has not changed since 1995. At the same time 56.2 nurses were employed (per 10,000 people).

The Polish health care system is overstaffed. Until 1990 the nurse to physician ratio was rising (in 1985, 12.45 and in 1990, 2.54). Since 1990 this ratio has been systematically decreasing (in 1995, 2.38 and in 1997, 12.37). It seems that in the period of uncontrolled health care staff reduction, nurses were the most frequently reduced profession. □<sup>16</sup>

### **2.2.2. Legal status of staff**

Since 1999, the sickness funds have been purchasers of health services. As has been said earlier, such services can be provided both by comprehensive clinics (public and non-public outpatient clinics, health centres, and other clinics) and by individuals. The latter, already working in the medical professions and practising alone do not have to register a new clinic; the Business Operations Act and regulations concerning professional qualifications apply to them instead. However, they must report the commencement of their operation as a business to the register kept by the Department of Trade and Services.

Until now, in the public health care system, all professional groups (physicians and nurses) have been paid on the basis of an employment contract and received a fixed salary. Physicians and other medical professionals were required to work for a limited number of hours as specified in their contracts. Remuneration was determined on the basis of qualifications, number of working years, and often by comparison with pay levels in other public sectors. As such, the salary did not depend on the number of visits made, the number of cases seen, the severity of the cases, etc. In addition, the personnel employed in public health care units were entitled to an annual bonus, called "the thirteenth salary".

Following the changes to the health care system, more private physician practices and non-public health care units have come into operation. They function on the basis of a contract and receive public funds designed for ensuring specified health services. Physicians work "on their own accounts", and patients receive the services specified in the contract free of charge: payment is made by the entity managing the government funds.

Many recent changes in the Polish health care system are aimed at privatization. The long-term goal is to improve the quality of medical services and to provide patients with

<sup>16</sup> Włodarczyk, C.: "Reforma opieki zdrowotnej w Polsce", Kraków, 1998.

better and more efficient access to care. One change in this direction has been the introduction of family doctor practices or dental contract practices. A contract practice operates a business which can be conducted by an individual, or by a company established as a civic company, a partnership, a limited liability company, a listed company, or very rarely, a foundation or association. While running such operations physicians may receive – depending on the nature of their contract – remuneration in one of the following forms:

- per capita;
- fee-for-service;
- fee-per-case;
- mixed systems.

Until now, all employees in the health care sector have been employed on the basis of standard employment contracts. At the moment, some workers are signing contracts as self-employed professionals, or on behalf of their own companies, with the new health care units or sickness funds for specific services – for example, as anaesthetists, family doctors, nurses. Because the change is currently in progress, it is difficult to determine the share of the health care workforce who are now self-employed, or working for their own companies.

### **2.2.3. Training, and retraining, career opportunities, mobility**

For health care reform to be a success, trained and skilled health care personnel are crucial. This has been the reason for a number of changes in the systems of internship, specialization and postgraduate qualification.

A new internship programme came into force in October 1999<sup>17</sup> in order to make physicians more independent. The main changes are the introduction of an internship exam; the restriction of internships to authorized health care units; and possible widening of the internship system to psychiatry and family medicine. The period of internship will be 16 months for physicians, (12 months for dentists). The first internship exams for physicians will be held in 2001 and for dentists in 2000.

The transformation of postgraduate education for physicians and nurses began in 1994. The guidelines for the change point to the importance of training primary care staff.

<sup>17</sup> Ministry of Health and Social Welfare: “*Transformacja systemu ochrony zdrowia w Polsce*”; Warsaw, 1998.

One of the biggest problems in the Polish medical system is the high ratio of specialists to primary care staff. Too many physicians have narrow specializations. For this reason, a broad programme for training more primary care staff has been a priority.

The first step in this process was establishing the possibility of undertaking a specialist qualification in family medicine within the resident system. This three-year training programme takes place in certified medical units after internship. For physicians with longer experience, already employed in primary care, a new intensive, short-term (six months) course has been created. During the last five years, more than 3,000 have taken up specialization in the field of family medicine, most using the short programme. It is intended that in the future this kind of GP training will be lengthened from three to four years, after internship and from six months to one year on a short-term course.

Physicians with this new qualification in family medicine (hereafter called family practitioners – FPs) together with physicians with the second-degree specialization in general medicine (GP) form the “core” of primary care staff in the new system. According to data shown in the appendix (table 5), from the end of 1997 there were 1,014 family medicine specialists and 723 physicians with the second-degree specialization in general medicine employed in primary health care. Many trained FPs are employed outside primary health care, in, for example, schools, health care administration, pharmaceutical companies. Only 12.3 per cent of all full-time physicians are employed in primary care.

In 1998 approximately 900 physicians specialized in family medicine, most of them employed in primary care. At the end of 1998 and beginning of 1999, 103 physicians completed their specialist training in general medicine; 90 per cent of these are employed in outpatient clinics.

The balance of medical qualifications has improved greatly in the last few years.

There are, of course, regional differences. *Voivodships* vary from 0.4 per cent to 10.4 per cent in the percentage of urban physicians who are FPs employed in outpatient clinics. Similar variations can be found in the country: 0.6 -15.1 per cent.

The health reform programme envisions training about 20,000 FPs.<sup>18</sup> En route to this target, it is important to maintain a balance between FPs and other specialists, taking into account that half of all medical graduates now choose to train as FP.

The physician training system now includes a one-degree specialization, a residency system, and a programme of accreditation of specialist training centres, as well as the separation of the accreditation system from the educating institutions. Accreditation will be based on a national specialization exam organized by an independent institution.

<sup>18</sup> *ibid.*

Additional education is needed also for dentists, especially in the country. Only 38 per cent of dentists have postgraduate specialist training.

Our new health care system also depends on a highly qualified nursing staff. The present postgraduate system is based on an 1981 Act published by the Ministry of Health and Social Welfare concerning specialized training for nurses and midwives. According to this document, nurses were limited to a range of seven specializations, and midwives to five. With this limited form of education available, only 10 per cent of nurses have undertaken specialist training.

The new situation in the health service market, with its changes in the organization of health centres, in contracting, in family medicine, etc., forces nurses to look for additional qualifications or to update existing ones. Of all the medical staff, they are called on to provide the widest range of health services.

It is especially important to provide advanced training for nurses and midwives employed in primary care. In our vision of family medicine, it is essential to increase the number of family and environmental nurses. From a total of 14,000 general nurses, only 3,000 were trained in family medicine. This was achieved thanks to PHARE resources.

The changes to the nursing education system stems from a July 1996 Act. This document specifies that nurses must start their professional training by graduating from secondary school. From here they attend nursing school, and then spend a compulsory year as an intern in a health care unit.

Postgraduate training for nurses and midwives has also changed: a wider group of subjects are authorized for postgraduate education; an obligatory national specialization exam has been introduced; regional nursing organizations are involved in the process of authorizing providers of postgraduate education.

A September 1998 Act of the Ministry of Health and Social Welfare instituted the Post-Graduation Educational Centre for Nurses and Midwives as the controlling body for changes to the nursing education system. It is also responsible for preparing the national examination.

### Lack of managerial skills

Private health care units, in competition for contracts from the sickness funds, require effective and flexible health care managers, drug management specialists, and public health specialists. Under the new system, these must not only think about health care itself, but also its economic nature. Directors of hospitals and outpatient clinics must know something of business, law, planning and human resources.

In Poland, health care units are generally run by physicians without any training in management or finance. Currently, there is a trend towards the competitive employment of

professionals with the relevant qualifications. It is still unusual, though, to have a hospital director who is not a physician. One of the main goals of health sector transformation is to hire managers for managerial positions in the health sector, even if they lack medical qualifications. Few public medical schools have postgraduate programmes in areas such as health care management and administration. The first school of public health was funded in 1991. It later became a department of the Jagiellonian University (Kraków). This school offers two-year postgraduate courses in health care management.

Outside postgraduate studies, there is dynamic development in the market for courses and training programmes. Since the beginning of 1998, many conferences, seminars, courses and training programmes have been held. They were organized by: private institutions such as consulting companies, publishing houses, etc.; NGOs such as foundations, associations, unions, etc; international enterprises such as the Harvard and Jagiellonian Consortium for Health project; and local government health departments, health commissions, etc.

The training of medical personnel is essential, and it has to be recognized that there are impediments to it. First of all, the cost of training is still increasing. This is especially true of courses organized by private companies and accredited centres.

Other problems include the following: there is a limited number of regular specialization posts; there is also a problem with delegating physicians' responsibilities so that they can pursue further education, for example, physicians in outpatient clinics must leave their posts in order to specialize; most of this group are women (70 per cent). The difficulties in continuation of education for women (appendix (table 6)) are closely connected with motherhood.

Our main point here is that changes aimed at improving qualifications in health care began a number of years ago. Their implementation is time consuming, but indispensable for the success of health reform.

#### **2.2.4. Organizational change and participation of workforce**

Since January 1999, all health care providers in Poland are part of a typical internal market. This serves, amongst other things, to make managers more responsible for their decisions than has been the case in the past. While negotiating with sickness funds, they must represent the interests of their populations. They also have to allocate resources, budget expenditures as well as keep up with changes in human resource management. In line with their new duties, there is a new employment mechanism for them: the managerial contract. This contract links their responsibilities to suitable monetary rewards.

Physicians in public health care have been working under an archaic system which did not offer motivational levels of pay, appropriate to the nature of their work. From this situation grew a new form of financing for services – contract provision. Physicians can provide health services according to contracts signed with their employer. These contracts

provide for remuneration on the following bases: per capita, per service, or a mixed system.

Shift work (including night shifts) has been a contentious issue. Recently, the Constitutional Tribunal decided that shift work should be treated as extra hours. This means 150 per cent of the normal pay rate for the first two extra hours, 200 per cent after that. The higher rate also applies at night or on Saturday or Sunday. A maximum of four hours of extra work per day is allowed by employment law.

The new model of primary health care has marked out new tasks for GPs, general and family nurses. Physicians can sign contracts with nursing practices, or cooperate with such practices, to deliver health care services.

#### **2.2.5. Staff performance, remuneration, incentives and other entitlements**

Historically, Polish health care workers have been relatively poorly paid in comparison, for example, with industrial workers. This is true even of doctors. Most primary care workers in Poland are paid a fixed monthly salary. They also receive an annual bonus (“the thirteenth salary”). Other benefits include social security, a financial bonus for special postings, social benefits, further bonuses for every five years exceeding 20 years of service, and payment on termination of employment.

Physicians at outpatient clinics are typically required to work 40 hours per week. Physicians and ancillary staff are employed under permanent work contracts, and are paid a fixed salary. Because wages in the public health system are low, many physicians take up employment positions at private surgeries or consulting rooms.

Medical personnel complain of low wages, and many look for alternate employment to complement their government salaries. It has been estimated that about 30 per cent of Polish physicians and about 90 per cent of dentists already engage in at least part-time private sector work. □<sup>19</sup>

Motivation among medical personnel is poor, in part because of the long hours required of some of them and in part because there is no incentive to work more than a minimum amount.

<sup>19</sup> NERA – National Economic Research Associates (1997): “The health care system in Poland”.

Table 8. Average monthly gross salaries and wages in 1998

| Sector                                     | Average gross salaries and wages |   |
|--|----------------------------------|---|
|  | In PLN                           | Corresponding period of the previous year = 100 |
| Average monthly wage and salary in sectors | 1 206                            | 119.6   |
| Health and social work                     | 1 097                            | 119.8   |
| Education                                  | 1 195                            | 117.7   |
| Public administration and defence          | 1 718                            | 116.5   |
| Hotels and restaurant                      | 956                              | 120.1   |
| Financial intermediation                   | 1 773                            | 123.1   |
| Agriculture, hunting and forestry          | 1 152                            | 120.4   |

Source: Central Statistical Office: "Biuletyn Statystyczny" (Statistical Bulletin), Warsaw, 1998.

### 2.2.6. Work environment, staff perceptions, equal opportunities, attitudes, absenteeism

Stress is a problem in the Polish work environment. It is connected with the changes in the workplace. These include changes in the hierarchical organization, for example privatization, which has led in part to greater job insecurity. One contributing factor is confusion about the changes, due in part to having to cope with several reforms simultaneously. Another factor is the temporary breakdown of regulation while changes are being implemented. The fear of losing a job also preys on the mind of many health workers.

There has been a constantly increasing level of dissatisfaction among physicians. This has resulted from the following factors:

- gradual loss of social prestige for the profession;
- low pay and frustration with the stressful work environment;
- overstaffing in the public health sector;
- excessive administrative duties in connection with in-house accounting and dealing with insurance companies;
- increasing professional costs, such as the increasing price of professional liability insurance.

Nurses have problems as well:

- one of the lowest levels of pay in Polish society, much lower than the average wage;
- excessive workloads;
- inconvenient working conditions;
- lack of opportunity for professional advancement;
- nurses are still regarded as medical assistants and their role is determined by physicians.

### **2.2.7. Workforce occupational safety and health**

Many health care units use premises in poor conditions. Often they also face inadequate standards or availability of equipment. Not all units share these problems, but they are particularly prevalent in public health care facilities. Harassment, racism and violence in the workplace does not seem to be of concern in Poland. Part of the reason for this is the homogeneity of the Polish community: 98 per cent of Polish residents are ethnic Poles. No problems arise in the treatment of those minority groups which are present.

One major problem for Polish medical staff is jaundice. Since 1990 vaccination for this disease has been compulsory for all health personnel.

## **2.3. Reform effects on public-private mix in health sector**

Private medical practices were legalized in 1990. These operate as small businesses. As such, they must register with the local authorities, provide financial statements, and, of course, pay tax on their income.

In the past, private and publicly owned health care institutions were linked by various forms of cooperation, which established a kind of order on the health system. The public sector was ineffective, but did not collapse, and maintained strong links with the private sector. Formal and informal regulations, among which market forces were of minor importance, controlled the behaviour of various actors. Households had to spend an increasing proportion of their income on health care, while public health care institutions became debt-ridden. Public dissatisfaction with the health care system grew.

By December 1996, Poland had 51,000 registered private health service providers. By 1997, this amount had risen to 63,000 comprised of 45,000 physicians and 18,000 dentists.

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In the public sector in 1997 there were 109,000 doctors (91,000 physicians and 18,000 dentists).<sup>20</sup>

The national health insurance system includes regulations which slightly increase the financial responsibility of various actors for their decisions. The National Health Insurance Act gives private health service providers the opportunity to obtain public money in the same way that the public providers do.

Local governments' difficulties in applying "soft" budget cuts, employees' fears of losing their jobs, and the necessity of finding capital in order to offer competitive quality of service will cause some public health care institutions to go private. On the other hand, many will remain public. Some of them will find sources of income outside government money, but many will put pressure on their government owners to use soft budget cuts.<sup>21</sup>

The privatization of the health care system will still consist mostly in the establishment of new firms. It is planned, however, that the liquidation of public health care institutions and the capital privatization of others will increase in importance. Special rent rates, as well as a lack of start-up capital will make partial ownership of government health care institutions, while the property remains government owned, an attractive option for health care units.

The privatization of health care units has been planned in accordance with the privatization guidelines of the Polish Government, and with reference to European Union law.

Among the benefits of privatization in ambulatory health care are:

- smaller units have lower administrative costs;
- opportunities for better contact between patient and physician;
- improving access to health care services; and
- the guarantee of free choice of physician.

Personnel in private institutions are more motivated to work than their public-salaried counterparts. The number of services supplied by private physicians, dentists and

<sup>20</sup> Central Statistical Office: "Biuletyn statystyczny służby zdrowia", Warsaw, 1998.

<sup>21</sup> Tymowska, K.: "Sektor prywatny w systemie opieki zdrowotnej", Public Affairs Institute, Warsaw, 1999.

paramedical staff working on contract is significantly higher than salaried staff. For example, the number of consultations and visits provided by dentists on a fee-for-service contract was more than double that provided by salaried dentists.<sup>22</sup>

Quality monitoring of primary health care services in Krakow shows that patients are more satisfied with private care physicians (GP) than public outpatient clinics. Access to health services is regarded better in GP than in outpatient clinics (results in table 9).

**Table 9. Results of quality monitoring in the Krakow *Gmina* (scoring by patients at outpatient clinics and GP surgeries: 100 = very good, 0 = very bad)**

|                | Outpatient clinics | GP   |
|----------------|--------------------|------|
| Access         | 64.3               | 91.7 |
| Communications | 88.4               | 92.5 |
| Satisfaction   | 84.7               | 93.8 |
| Quality        | 78.4               | 92.7 |

Source: Czarniecka K, Rózański B.: "Jakość usług zdrowotnych", Służba Zdrowia, May 1999.

### 3. Lessons learned: Comparison and transferability of reform experiences

The public sector saw a number of major changes in the last decade:

- the restructuring of economic ownership through privatization in order to create a real basis for the market economy;
- the implementation of market mechanisms, including the introduction of individual economic stimuli in order to ensure a broad and stable improvement within the public sector;
- the technical reconstruction of the whole economy through the implementation of new technologies, decreasing production costs and increasing work efficiency.

Particular changes in the health care sector included:

- decentralization – transferring some of the responsibility for health care from the central Government to local government;

<sup>22</sup> Chawla, M.; Berman, P.; Dudarewicz, D.: "Innovation in provider payment system in transitional economies: Experience in Suwałki, Poland", Harvard and Jagiellonian Consortium for Health, May 1998.

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- separation of the payer from the service provider, through the establishment of regional sickness funds;
  - making changes to payment, contracting, management and public health techniques at the local level, and then extending these to the nation.<sup>23</sup>

The changes listed have created an opportunity for restructuring health services into a system of fund-holding, using contracts and competition in order to ensure the effective use of limited resources. Workers can be employed by contract: health care unit directors have particular forms of managerial contract, while physicians and nurses their own as well.

Private providers have the same access to public resources as public health care providers. The competition among health care providers leads to an improvement in health care service efficiency and an increase in the quality of services.

On the other hand, sickness funds through their purchasing policies have very great influence on health care institutions and the range of services they offer. Sickness funds could, for instance, force particular health care units to cease some of their activities, to change their employment structure, or even to close. Any of these actions will have an effect on employment. First estimates suggest a loss of approximately 10 per cent of health care personnel.

Although Poland is viewed an economic leader among former communist countries, the development of health care reform has lagged behind. The Czech Republic and Hungary established national health insurance systems in 1992 and 1993 respectively and put these into effect almost immediately. In contrast, Poland only introduced its national health insurance system in 1999, ten years after the fall of communism. Poland can rapidly create an insurance-based health financing system with largely privatized care provision.

<sup>23</sup> Roślewski A :” Nowy podział ról - samorząd lokalny i ochrona zdrowia”, Służba Zdrowia, Nr 15-16/99.

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## Appendix

Table 1. State budget expenditure by budget divisions in years 1991-97

| Specification                                       | 1991<br>(million PLN) | 1995<br>(million PLN) | 1996<br>(million PLN) | 1997<br>(million PLN) | 1997 (%) |
|---|-----------------------|-----------------------|-----------------------|-----------------------|----------|
| Science   | 612.9                 | 1 437.6               | 1 855.0               | 2 192.6               | 1.7      |
| Education   | 2 812.8               | 10 309.8              | 5 322.7               | 6 477.1               | 5.2      |
| Higher education                                    | 665.0                 | 2 174.7               | 3 002.4               | 3 752.2               | 3.0      |
| Culture and art                                     | 243.4                 | 703.6                 | 829.7                 | 1 036.7               | 0.8      |
| Health care   | 3 885.4               | 13 132.6              | 16 742.0              | 18 891.9              | 15.0     |
| Social welfare                                      | 1 329.0               | 8 518.9               | 10 779.5              | 10 888.8              | 8.7      |
| State administration                                | 704.4                 | 3 115.8               | 3 950.0               | 4 927.1               | 3.9      |
| Administration of justice<br>and prosecutors office | 339.9                 | 1 713.1               | 23 455.0              | 279.2                 | 2.2      |
| Public safety                                       | 849.3                 | 3 380.0               | 4 318.3               | 4 901.8               | 3.9      |
| National defense                                    | 1 807.1               | 5 249.4               | 6 003.3               | 7 275.0               | 5.8      |

Source: "Statistical Yearbook of the Republic of Poland", Warsaw, 1998.

Table 2. Public expenditure designed for health care in Poland

| Year | GDP (%) | State budget (%) |
|------|---------|------------------|
| 1991 | 4.71    | 16.0             |
| 1992 | 4.96    | 14.8             |
| 1993 | 4.58    | 14.2             |
| 1994 | 4.58    | 13.8             |
| 1995 | 4.59    | 14.4             |
| 1996 | 4.61    | 15.4             |
| 1997 | 4.24    | 15.3             |

Source: Ministry of Health and Social Welfare, "Biuletyn statystyczny", Centrum Organizacji i Ekonomikiv Ochrony Zdrowia, Warsaw, 1998.

**Table 3. Government expenditure on health care per person**

| Year | Expenses in PLN | %      |
|------|-----------------|--------|
| 1991 | 456.64          | 100.00 |
| 1992 | 464.19          | 101.65 |
| 1993 | 431.06          | 94.40  |
| 1994 | 434.35          | 95.12  |
| 1995 | 468.81          | 102.67 |
| 1996 | 498.09          | 109.08 |
| 1997 | 488.79          | 107.21 |

Source: Ministry of Health and Social Welfare, "Biuletyn statystyczny", Centrum Organizacji i Ekonomiki Ochrony Zdrowia, Warsaw, 1998.

Table 4. Medical schools – students and graduates by department

| Specification    | Total     | Department          |           |          |                  |         |               |
|------------------|-----------|---------------------|-----------|----------|------------------|---------|---------------|
|                  |           | Faculty of Medicine | Dentistry | Pharmacy | Medical analysis | Nursing | Public health |
| <b>Students</b>  |           |                     |           |          |                  |         |               |
| 1970             | 22<br>456 | 14 458              | 3 591     | 4 288    | –                | 119     | –             |
| 1980             | 34<br>456 | 24 212              | 3 925     | 3 753    | 678              | 1 888   | –             |
| 1990             | 36<br>282 | 23 602              | 5 764     | 4 289    | 1 304            | 1 413   | –             |
| 1992             | 32<br>295 | 20 597              | 5 114     | 4 045    | 1 285            | 1 254   | –             |
| 1994             | 28<br>798 | 17 326              | 4 378     | 4 465    | 1 024            | 1 384   | 221           |
| 1996             | 27<br>107 | 14 775              | 4 193     | 4 770    | 1 186            | 1 698   | 485           |
| 1997             | 26<br>238 | 14 649              | 4 133     | 5 077    | 1 219            | 855     | 305           |
| <b>Graduates</b> |           |                     |           |          |                  |         |               |
| 1970             | 3<br>846  | 2 372               | 804       | 670      | –                | –       | –             |
| 1980             | 5<br>380  | 3 376               | 740       | 856      | –                | 408     | –             |
| 1990             | 5<br>149  | 3 179               | 842       | 697      | 215              | 216     | –             |
| 1992             | 5<br>981  | 3 719               | 1 089     | 643      | 208              | 322     | –             |
| 1994             | 5<br>937  | 3 580               | 1 125     | 729      | 216              | 287     | –             |
| 1996             | 5<br>571  | 3 392               | 904       | 758      | 243              | 274     | –             |
| 1997             | 4<br>775  | 2 802               | 783       | 709      | 193              | 228     | 60            |

Source: Ministry of Health and Social Welfare: "Biuletyn Statystyczny 1998", Centrum Organizacji i Ekonomiki Ochrony Zdrowia, Warsaw, 1999.

Table 5. Physicians employed in primary care by specialization and place of living (1997)

| Specialization         | Area  |      |       |      |       |      |
|------------------------|-------|------|-------|------|-------|------|
|                        | Urban |      | Rural |      | Total |      |
|                        | No    | %    | No    | %    | No    | %    |
| Family medicine        | 609   | 3.8  | 405   | 6.8  | 1014  | 4.6  |
| General medicine       | 511   | 3.2  | 601   | 10.1 | 1112  | 5.0  |
| Internal medicine      | 3860  | 24.0 | 1243  | 21.0 | 5103  | 23.2 |
| Paediatrics            | 4525  | 28.2 | 1262  | 21.3 | 5787  | 26.3 |
| Gynaecology            | 2073  | 12.9 | 753   | 12.7 | 926   | 12.8 |
| Other                  | 1751  | 10.9 | 881   | 14.8 | 2632  | 12.0 |
| Without specialization | 3034  | 18.9 | 1099  | 18.5 | 4133  | 18.8 |

Source: Ministry of Health and Social Welfare: *Monitoring oczekiwanych efektów i korzyści zdrowotnych wynikających z realizacji Narodowego Programu Zdrowia na lata 1996-2005*, State Hygiene Department, Warsaw, 1999.

Table 6. The number of physicians according to gender and place of work (1997)

| Gender | Area  |      |       |       |       |       |
|--------|-------|------|-------|-------|-------|-------|
|        | Urban |      | Rural |       | Total |       |
|        | No.   | %    | No.   | %     | No.   | %     |
| Men    | 5     | 32.8 | 3     | 56.1  | 8     | 39.1  |
|        | 271   |      | 32    |       | 595   |       |
| Women  | 10    | 67.2 | 2     | 43.9  | 13    | 60.9  |
|        | 781   |      | 60    |       | 387   |       |
| Total  | 16    | 100  | 5     | 100.0 | 21    | 100.0 |
|        | 052   |      | 93    |       | 982   |       |
|        |       |      | 0     |       |       |       |

Source: Ministry of Health and Social Welfare: *Monitoring oczekiwanych efektów i korzyści zdrowotnych wynikających z realizacji Narodowego Programu Zdrowia na lata 1996-2005*; State Hygiene Department, Warsaw, 1999.

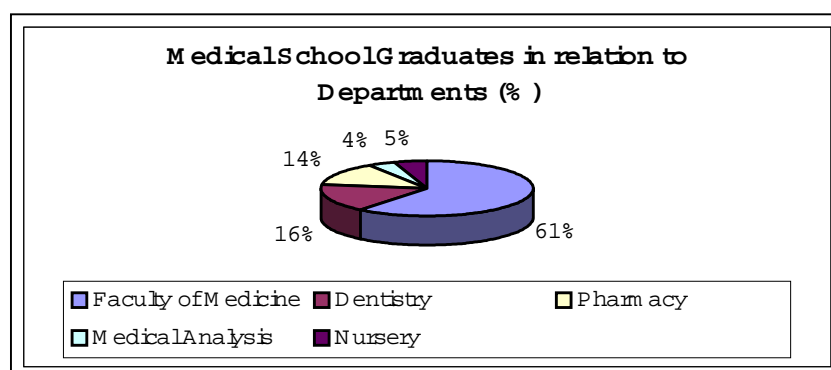


Figure 1. Medical schools – Graduates by department (%)

Source: Ministry of Health and Social Welfare: "Biuletyn Statystyczny 1998", Centrum Organizacji i Ekonomiki Ochrony Zdrowia; Warszawa, 1999.