MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE WITHIN THE FRAMEWORK OF SOCIAL SECURITY IN POLAND

Dr. BOGUSLAW KOZUSZNIK

Professor of Medical Care
Organisation in the Post-Graduate School
of the Academy of Medicine, Warsaw

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Belgium	(Soc. Sec. 1968/D.5)
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Ecuador	(Soc. Sec. 1968/D.6)
Federal Republic of Germany	(Soc. Sec. 1968/D.7)
India	(Soc. Sec. 1968/D.1)
Poland	(Soc. Sec. 1968/D.2)
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United Kingdom	(Soc. Sec. 1968/D.3)

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A. Methods by Which Members of the Population May Obtain (a) Medical Care in Case of a Morbid Condition or of Maternity, and (b) Other Personal Health Services

1. Statutory Schemes

Medical care in the Polish People's Republic is provided for and guaranteed by the Constitution. This is the result of the setting up, following the Second World War, of a People's Government in Poland under which the entire population is entitled to health protection and assistance in the event of sickness or incapacity for work. The right to health is an integral feature of the People's State. The legal principles of the Polish social scheme are laid down in the Constitution of the Polish People's Republic, as set up on 22 July 1952 by the vote of the Constituent Diet. This fundamental Act, which regulates the basis on which the system is founded, guarantees the right to health and defines the principles and practice for promoting health protection.

Part I of the Constitution - "Political System" - Article 3, paragraph 5, states that "the Polish People's Republic guarantees the continuing improvement of the well-being, health and cultural level of the population".

Part VII - "Fundamental Rights and Duties of Citizens" - Article 60, paragraph 1, states that "the citizens of the Polish People's Republic shall be entitled to health protection and assistance in case of sickness and incapacity for work". Paragraph 2 states that "these rights shall be ensured to an ever-increasing extent by -

(a) the promotion of social insurance for wage earners and salaried employees in case of sickness, old age or incapacity for work, together with the promotion of the various forms of social assistance;

(b) the promotion of public health protection as organised by the State, the development of health services; the development of health facilities in urban and rural areas, the continuous improvement of conditions of industrial safety and hygiene, the application of widespread measures to prevent and combat disease, the systematic extension of free medical assistance together with the development of a network of hospitals, sanatoria, clinics, rural medical centres and services for the disabled".

Finally, Part V specifies that "the local authorities of the State" shall instruct the People's Councils to make use of all local resources and means available in order to extend the communal institutions and facilities in the field of education, culture, health and sport.

In accordance with the principles of the Constitution, a network has been created which includes various forms of health

services, so as to ensure that the entire population has the necessary care. This network constitutes the Social Health Service.

2. Health Co-operatives

Independently of the Social Health Service, there are in Poland two sorts of health co-operatives:

(1) the co-operative health centres, organised by inhabitants of rural areas and financed on the basis of voluntary contributions. These centres have been set up to ensure more readily accessible medical care services. The State assists in building and equipping them. The centres grant entitled persons (insured persons and certain other groups) free medical care, the cost of which is covered entirely by the State;

(2) the co-operative polyclinics, which in principle are organised by doctors (labour co-operatives) in towns and densely populated areas. The medical staff is made up of specialists in several fields, and consultations take place in the appropriate surgeries. A patient may be examined on payment of a fee based on a moderate scale of charges.

3. Private Medical Care

Care may be given in individual private surgeries and private group surgeries organised in polyclinics. The co-operative polyclinics mentioned under 2(2) above and the private group surgeries differ as regards income taxes and fees for consultations. The co-operative polyclinics are regarded as a sort of social institution. In 1965, 7,339 doctors practised privately, i.e. 18.5 per cent. of the profession as a whole; in 1966, this figure had fallen to 6,678.[1]

The co-operative health centres, co-operative polyclinics and private surgeries form an additional link in the organisation of health facilities provided by the Social Health Service. Their activities are supervised and directed by the Ministry of Health and Social Welfare.

Aside from the Social Health Service scheme, other health services exist within the Ministries of Communications, National Defence, Home Affairs and Justice (in respect of prisons). All the essential documents concerning the health activities of these ministries are drawn up in agreement with the Minister of Health and Social Welfare. Persons entitled to free medical care may be treated in the Ministry of National Defence hospitals; the costs of such care are not reimbursed by the Social Health Service.

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[1] See p.31

4. Health Care in Foreign Countries

In certain exceptional cases, patients entitled to free medical care may be cared for in a foreign country at state expense.

B. Summary of the Provisions of the Statutory Scheme, and Actual Practice

The provisions of the Constitution provide for the continuous development of medical care by -

(a) the extension of the social insurance scheme automatically to ensure free medical care;

(b) the extension of the various forms of social assistance;

(c) the development of the Social Health Service, by setting up a scheme to ensure medical care in state establishments.

The social insurance schemes in Poland are general in their application: all employed persons are covered in virtue of the insurance contributions of their employers. The legal principles of social insurance are based on the 1933 Act on sickness and maternity insurance, the 1947 Decree on family insurance, and the 1954 Decree, as subsequently amended, in particular by the 1958 Decree, on universal pension security. The social insurance schemes which existed before the war differed in their scope; there were different old-age insurance schemes for intellectual workers, employees and state employees, the municipal authorities and the banks and agricultural workers were excluded from coverage. In 1938, the number of persons insured represented only 6.8 per cent. of workers, and together with the members of their families they made up only 14.3 per cent. of the population.

The benefit of social insurance and consequently of free medical care has been extended under the Polish People's Republic to all employed persons and their families, to members of labour co-operatives, to barristers, to homeworkers, to apprentices in small craft industries and in industrial undertakings, and to small craftsmen.

The object of the social assistance scheme is to assist those inhabitants who are without means, or who require care because of mental deficiency, chronic disease or infirmity. Social assistance in Poland is organised on the basis of co-operation between the state local authorities and the voluntary social workers pursuing their calling within the framework of the Institute of Social Workers set up by an Order of the Council of Ministers dated 5 March 1959. This Institute is made up of active members of welfare organisations, such as the League of Women, the Rural Housewives' Association, the Polish Red Cross, the Polish Committee for Social Welfare, the Welfare Committee for Anti-Alcoholism, the Association of Retired Persons and Pensioners, the Association for the Disabled, the Association for the Deaf and Dumb, the Association for the Blind, the Union of Polish

Scouts, etc. The number of voluntary social workers rose from 17,466 in 1960 to 44,800 towards the end of 1964. Two different stages must be noted in the development of the social assistance scheme. The first occurred immediately after the war, when more than 25 per cent. of the population received help from "Social Action", which was started at that time to deal with the most urgent cases of malnutrition and lack of food supplies, housing, clothing, etc. In 1955, the activities and development of social assistance entered on a new phase, which marked the beginning of the second stage. The rapid increase in the number of persons entitled to retirement pensions, as compared with the natural increase in population, gave rise to problems which could be only partially resolved by social assistance. The number of pensioners rose from 415,000 in 1945 to 1,213,000 in 1955, and to 1,481,140 in 1965. This sharp increase in the number of persons entitled to a disability or old-age pension made necessary a corresponding extension of social assistance.

C. Medical Care

In accordance with the provisions of the Constitution, a Social Health Service was brought into being. The principles, and methods for operating and improving the Social Health Service are laid down in the Act of 28 October 1948 on the Social Establishments of the Health Service, in the 1952 Constitution, and in the Decree of 14 July 1954 on State Sanitary Inspection. The organisation of medical care as established in Poland is called the "Social Health Service".

1. Contingencies

In the event of sickness, accident, employment accident, occupational disease or other contingencies, all citizens are entitled to all items of medical care provided under the Social Health Service.

Such care includes:

(i) prophylactic and preventive measures;

(ii) diagnosis and treatment of disease in hospital, at clinics, or in the home;

(iii) medical and vocational rehabilitation;

(iv) the supply of medicaments;

(v) the provision of prosthetic appliances, orthopaedic appliances and other aids.

2. Scope

All residents may receive medical care under the Social Health Service. The range of benefits, however, is not identical for all inhabitants. Some groups of the population, together with the members of their families (children during secondary and higher education) and also, in certain cases, other persons

exclusively dependent on them, are entitled to the whole range of free medical care under the Service. Other persons are entitled only to prescribed forms of free care. The latter group, however, may obtain care at minimum payment, which in many cases is well below the real cost, the difference being covered by the State.

(1) Categories of Persons entitled to all Forms of Medical Care without Payment

(a) insured persons, members of their families and their dependants (in 1965, 8,866,000 insured persons and 10,639,000 members of their families and other dependants);

(b) economically active pensioners (in 1965, 250,000 plus 100,000 members of their families);

(c) other pensioners (in 1965, 1,481,140 plus 592,456 members of their families);

(d) members of agricultural producers' co-operatives (in 1965, 78,274);

(e) certain groups of the population (approximately 1 million) (see Appendix II, p. 41).

In Poland at the present time, 23,006,870 persons out of a total resident population of 31,551,000 are entitled to all forms of health care without payment. The former figure represents 72.9 per cent. of the entire population.

(2) Categories of Persons Liable for Partial Payment in Respect of Certain Benefits

The remaining 8,544,130 members of the population, mostly farmers and owners of small holdings, also obtain some forms of care without payment, but they are otherwise liable for partial payment. The State pays the difference between the amount paid and the actual cost of such care. In this group, children up to the age of one year are entitled to all forms of medical care free of charge.

(3) Preventive and Curative Medical Care in Respect of the Certain Social and Infectious Diseases given free to all Members of the Population

Care is free in respect of the following diseases:

(a) Tuberculosis: pursuant to the Act of 22 April 1959, passed by the Polish Diet, and to the instructions of the Minister of Health and Social Welfare, all members of the population are entitled to free preventive and curative medical care and to medical and vocational retraining. Sufferers from tuberculosis are given free medicaments;

(b) Venereal disease: treatment is free and may be compulsory for persons who do not obey the regulations in force. Basis: the Act of 16 April 1946;

(c) Trachoma: in the event of domiciliary treatment not being possible, treatment in a hospital or clinic may be compulsory for patients. When treatment is compulsory the cost of transport is reimbursed to the patient. Basis: the Act of 21 February 1935 and the instructions of the Minister of Health and Social Welfare;

(d) Infectious Diseases necessitating compulsory hospitalisation: these include: smallpox, typhoid fever, bacillary dysentery, acute diarrhoea in children under two years, meningomyelitis, meningo-encephalitis, hydrophobia, diphtheria, epidemic infective hepatitis and serum hepatitis. Moreover, if conditions make home treatment impossible, hospitalisation is compulsory for trachoma, non-toxic dysentery in children and certain complications of measles. Basis: the Act of 7 April 1949.

(4) Medical Care without Payment for Certain Categories of the Population

(a) Pre-school age children and children of school age are entitled to basic medical care in medical and dental clinics. The range of care includes periodic examinations, preventive vaccination, consultations for children at the beginning and completion of school attendance, etc. Dental prosthesis and orthodontic appliances are not free.

(b) Candidates for higher education are entitled to a free medical examination, special examinations and the issue of certificates.

(c) Children suffering from diseases or infirmities of the motor organs are entitled to free treatment in rehabilitation clinics.

(d) Women are entitled to certain items of medical care without payment, namely: examinations and consultations in the event of pregnancy and confinement, special examinations and interventions as ordered by doctors in the Social Health Service clinics and establishments (for pregnant women). Ambulatory treatment is provided free to pregnant women, as are visits from doctors, midwives and nurses to the homes during pregnancy or following confinement, or to new-born children where such visits come under the heading of mother-and-child welfare. Contraceptive care is provided free of charge. Gynaechological care is free for young girls. The management of childbirth and abortion is not free for all women.

(e) Children and adults receive free rehabilitation services after poliomyelitis.

(5) Certain Medical Care given free in Specialised Clinics

(a) Oncological clinics: medical and diagnostic examinations (analyses, radiography, etc.), preventive and curative care (irradiation, dressings, interventions, etc.); issue of health certificates, etc.

(b) Cytological clinics (laboratories): samples taken of cytological substances, certificates issued relating to examinations carried out, etc.

(c) Medical rehabilitation clinics: examinations and advice as to treatment, care (manipulation) in the field of medical rehabilitation, care in respect of vocational aptitude, issue of certificates, and recommendations as to vocation, treatment, etc.

(d) Physical culture clinics: Prophylactic medical examinations, ambulatory treatment of complaints resulting from physical or athletic activities, additional examinations and specialist consultations to permit evaluation of aptitude for the exercise of physical culture or sport and treatment to be followed to eliminate the relevant difficulty; physical therapy, etc.

(e) Anti-alcoholic clinics: medical, auxiliary and special examinations, withdrawal treatment of alcoholism, appropriate medicaments during such treatment, issue of health certificates, etc.

(f) Mental health clinics: medical, auxiliary and special examinations, ambulatory treatment and medicaments administered during treatment.

(6) Treatment and Assistance in certain cases for Injured Persons not Otherwise Entitled

(a) Employment accidents not covered by individual or group insurance giving entitlement to free medical care.

(b) Accidents occurring during measures to combat natural calamities.

(c) Emergency medical care for new-born children, for children up to the age of one year, and for the whole population in the event of a natural calamity.

(d) Transport of patients by ambulance from one medical establishment to another for special examination, treatment, etc.

(7) Other Medical Care, and Issue of Certificates, Free of Charge to the Entire Population

(a) Detection of and preventive measures against particular diseases; vaccination for certain groups, etc.;

(b) Pre-employment examinations, special investigations, etc.

(c) Issue of medical certificates as required for applicants, for a driving licence, etc.

(d) Time spent in hospital for instructional, scientific and other purposes.

(e) Periodic examinations for certain groups: staff in consumer undertakings, hairdressers, staff in food and other stores.

(8) Notification of Death and of Causes Thereof

3. Range of Benefits

(1) Ambulatory and Domiciliary General Practitioner Care

All residents are entitled to all curative and preventive care as given in medical establishments or in the home by doctors employed in the urban district polyclinic, the industrial polyclinics, the health centres in villages and small towns which do not contain a District People's Council headquarters, or other Social Health Service establishments. The local district clinics constitute the basic unit for health protection. The range of benefits provided in or through establishments for out-patient care include:

(a) benefits in the field of prevention and cure: examinations of patients at clinics and in the home, diagnostic examinations (urine and blood tests, X-rays, electrocardiograms etc.). Prescription of medicaments, dressings, orthopaedic appliances, physical therapy care, massage, injections, spa treatment, rehabilitation measures, obstetrical assistance, various surgical and gynaecological operations, stomatological care;

(b) preventive care services carried out by the health authorities - in particular, by the Ministry of Health and Social Welfare - include periodical examinations for various groups of persons, e.g. pre-school and school-age children, pregnant women, infants, workers, etc.; systematic examinations in connection with prevention of diseases giving rise to special problems, such as cancer, rheumatism, mental diseases, tuberculosis, venereal diseases, cardiovasular diseases, diabetes etc. Services which must be provided include, inter alia, measures taken against acute and chronic infectious diseases, immunisation, health measures, etc. Amongst the services provided by these bodies, mention must also be made of the evaluation by the State of the population's health and of medical certification concerning the health of candidates for schools and school age children, health as linked with pregnancy and confinement, disability, sufferers from tuberculosis, health of workers in specific environmental conditions potentially detrimental to health, as well as medical certification in the event of temporary incapacity for work, certificates for tribunals, health certificates

for candidates for a driving licence, certification of the need for a change of vocation, certificates concerning the health of candidates for the teaching profession, certification for treatment in climatic stations and certification concerning the health of persons in particular occupations, such as saleswomen in food stores, waiters, cooks, hairdressers, etc. These services include, moreover, instruction in hygiene and co-operation with administrative bodies such as trade unions and councils in undertakings, etc., and instructions as regards matters affecting the health of the population, workers, personnel in undertakings, etc.

Local district clinics take their particular local conditions into account as regards the curative and prophylactic measures to be taken, thus determinating the quantity and quality of curative and preventive treatment given in such clinics to the whole population.

The range of curative and preventive medical care given to all residents in the urban polyclinics or in health centres is determined in the same way, save for the differences created by taking into account the particular conditions of the district and the people living there. For instance, school clinics take into account the particular conditions of the school and the health of young people. The industrial polyclinics take into account the working conditions and varying needs in the different fields of industry. Domiciliary medical care is also provided at first-aid posts which intervene in cases of accident or of calls from bedridden patients.

(2) Specialist Care

(a) Specialist ambulatory care is given by specialists in the various fields of medicine (internists, pediatricians, surgeons, gynaecologists, obstetricians, opthalmologists, laryngologists, radiologists, psychiatrists, neurologists, orthopaedic surgeons, stomatologists, physiologists, gastrologists, general physicians, pathologists, anaesthetists, surgeon-pediatricians, specialists in infectious diseases, hygiene specialists, epidemiologists, specialists in food hygiene, industrial and school doctors). There are also specialists in physiotherapy, forensic medicine, microbiology, radiotherapy, medical rehabilitation, neuro-surgery, urology, infectious diseases and organisation of medical care. These specialists are employed in the district polyclinics, or in specialised clinics attached to hospitals. From the professional and organisational point of view, the hospital clinics are co-ordinated with the district polyclinics. All inhabitants may obtain all curative and preventive medical care given by such specialists, either free or on payment of a fee. If necessary, a patient may be examined and may obtain more complicated and specialised care in a polyclinic at the regional level, from whence he may subsequently be sent to a university teaching clinic or to a scientific or research institute (e.g. for rheumatology, cancerology, etc.).

(b) In-patient specialist care covers all services provided by specialists in district general hospitals. If necessary, patients may be sent to a hospital at the regional level with better equipment and with more highly qualified specialists in a specific branch of medicine. In appropriate cases, moreover, they may be sent to a university teaching hospital or to the hospital department of an institute where medical care is given to all patients by recognised specialists (scientists and professors).

(3) Pharmaceutical Supplies

In principle, there is no restriction as regards medicaments; all recognised medicaments can be prescribed for any member of the population. Restrictions do exist in time/quantity terms; for instance, a given quantity of pills might have to be prescribed for a week's course of treatment. Certain specialities for a particular disease may be prescribed only by specialists or duly authorised persons. Medicaments for ambulatory or domiciliary treatment are supplied to patients from pharmacies (all of which belong to the State) on the following terms:

(a) Persons Entitled to Medicaments without Payment

(i) pensioners and invalids, together with members of their families; persons discharged from the Army after 1954 as a result of illness; persons not entitled to the prerogatives enjoyed by other groups of disabled persons, such as widows of soldiers, war and military disabled persons, victims of accidents or occupational disease who are not, however, entitled to a pension; persons in receipt of social assistance; persons dismissed by the recruiting board as being temporarily unfit for military service; former soldiers and non-commissioned officers discharged from military service in the event of mobilisation or war; recruits deemed to be temporarily unfit for military service; Czechoslovakian tourists in the event of accident; foreigners undergoing a vocational training course; and foreign pupils in Polish secondary vocational training schools;

(ii) in-patients do not pay for medicaments prescribed while they are in hospital;

(iii) persons covered by social insurance and members of their families, together with persons entitled to free medical care, do not pay for essential medicaments in the case of first aid, sudden illness or accident, provided that such medicaments are issued only at out-patient establishments in cases of emergency, by doctors during home visits, or at first aid posts;

(iv) patients suffering from certain social diseases; namely tuberculosis, venereal diseases, as well as medicaments administered in anti-alcoholic or psychiatric treatment centres.

(b) Persons who Pay 30 Per Cent. or 10 Per Cent. of the Cost of Medicaments

(i) insured persons and members of their families pay 30 or 10 per cent of the price of medicaments. The lower figure applies solely for remedies prescribed to test chronic diseases (e.g. diabetes); the full price is paid for dressings and containers for medicaments as prepared by pharmacies (bottles, flasks, etc.);

(ii) medicaments and dressings are issued on the same conditions to the following members of the population: students undergoing advanced courses and members of their families, pupils following courses preparatory to higher education and members of their families, graduate students in science and members of their families, candidates for a doctorate and members of their families, members of the creative professions and members of their families, members of the Polish Writers' Association, the Association of Painters and Sculptors, the Polish Composers' Association, the Photographic Artists' Association, the blind (members of the Polish Association for the Blind) and members of their families, village mayors and their deputies, and members of their families, persons employed in the animal insemination services, members of the families of persons doing their military service, soldiers discharged from compulsory military service, citizens of Socialist countries (on the basis of bilateral agreements).

(c) Other groups entitled to free medical benefits pay 100 per cent. of the cost of medicaments (e.g. independent agricultural workers).

(4) Hospitalisation

All inhabitants are entitled to hospitalisation in the establishments of the Social Health Service, either free or on payment of a charge according to their prerogatives. Patients are entitled to hospitalisation in all general and specialised hospitals or in other in-patient establishments for medical care, such as specialised sanatoria, preventive sanatoria, semi-sanatoria, and health resorts, provided that they are referred thereto by doctors in the competent out- or in-patient establishments. All benefits connected with hospital treatment are included in the general cost of hospitalisation. Patients obtain, either free or on payment of a relatively low fee (which does not cover the cost borne by the State), all hospital care i.e. medicaments, operations, etc. Patients have no supplementary charges to meet. The charge for hospitalisation for members of the rural population who are not entitled to free medical care varies in accordance with the amount of the patient's annual income.

(5) Dental Care

(a) Dental care is provided free or on payment of a fee, according to prerogatives as regulated by statute.

(b) Dental appliances are issued free to persons entitled according to the instructions which lay down the conditions therefor.

(c) Orthodontic appliances are issued to the following entitled persons:

(i) children up to the age of 9 years who are receiving orthodontic treatment in a Social Health Service establishment;

(ii) children up to the age of 6 years, for preventive treatment;

(iii) children between the ages of 6 and 7 years, solely in cases of inability to masticate correctly and where irregularities cannot be cured by self-regulation.

(6) Medical Care by Members of Professions Allied to the Medical Profession

All residents are entitled, free or on payment of a fee, and in the context of medical care, preventive care, or medical and vocational rehabilitation services, to all care provided by auxiliary medical personnel (nurses, laboratory assistants, midwives, etc.) and by members of professions allied to the medical profession (physical culture instructors, psychologists, biologists, etc.), employed in the establishments of the Social Health Service.

(7) Other Personal Medical Care Provided by the Health Services

All inhabitants entitled to medical care either free or on payment of a fee may, according to their prerogatives, obtain the following additional benefits, either free or on payment:

(a) spectacles with ordinary frames free of charge for entitled persons (should other frames be selected, the purchaser pays the difference in price);

(b) hearing aids. In principle, these are issued free of charge to persons entitled for the period of treatment only, and do not become their property. Spare parts for hearing aids are also supplied free of charge. Hearing aids supplied to patients remain the property of the health section of the People's Council;

(c) contact lenses. These are issued to persons who are entitled if they suffer from a specific sight defect, and not for aesthetic reasons;

(d) orthopaedic care. Orthopaedic appliances, such as artificial limbs, orthopaedic shoes and corsets, abdominal belts, etc., may be issued to the following persons: persons covered by social insurance and members of their families, pensioners and members of their families, convalescents and sufferers from tuberculosis, higher education students, graduate science students, candidates for doctorate degrees and members of their families, beneficiaries of social assistance;

(e) cost of travel to out-patient or in-patient medical establishments for preventive or curative treatment is reimbursed to the following: persons covered by social insurance, persons in receipt of retirement or other pension, war disabled, members of the families of the persons referred to above, village mayors and their deputies, students, post-graduates and candidates for a doctorate who are referred for treatment to a tuberculosis clinic or a health resort, persons compulsorily hospitalised;

(f) reimbursement of the cost of treatment in Poland. Only the following are entitled to reimbursement of the cost of treatment: insured persons and members of their families who are unable, in the event of sudden illness, to apply for assistance to a doctor in a Social Health Service establishment;

(g) treatment in other countries: where there exists adequate justification and in cases where treatment cannot be carried out in Poland for lack of special medical equipment or of doctors in a given highly specialised field, insured persons and members of their families as well as other sick persons may be sent for treatment to another country, either free or on payment of a fee, according to their prerogatives.

(8) Social Services

All inhabitants are entitled to social services organised by the State and the social organisations, on the conditions laid down by law (i.e. free or on payment of a charge). Working women, for instance, may place their children in crèches, nursery schools and similar institutions, retired persons may be placed in old people's homes, etc. and during their sojourn in such establishments, they are entitled to free curative and preventive medical care. Their sojourn may be free, or there may be a charge for it.

4. Qualifying Conditions for Benefit

(1) All persons are entitled to medical care as from the first day of work when they are compulsorily insured. Medical care is given to them and to members of their families during the whole period of employment. The document showing evidence of entitlement to benefit is the insurance card issued by the undertaking or by a branch of the Social Insurance Office.

(3) Division of Poland for the administration of medical care:

(a) at the State level, there are the central health institutions, i.e. clinics attached to scientific research institutes or to teaching hospitals of the academies of medicine, autonomous central clinics, clinics in hospitals, hospital units in scientific research institutes, sanatoria financed by the Ministry of Health, and medical and preventive establishments of the Polish health resort (climatic) stations;

(b) at the regional level, there are the special polyclinics under whose aegis are the specialised clinics, and the regional hospitals which may have specialised regional clinics attached to them, usually connected to the regional polyclinics. Some academies of medicine have their clinics in the regional hospitals;

(c) the districts, towns, ports and urban wards have hospitals and district specialised polyclinics, within which are the specialised clinics. Each district, town, ward or port contains one or more district departments, which include from 40,000 to 60,000 inhabitants. Under these are the local districts, which include from 4,000 to 6,000 inhabitants - sometimes 3,000 in large towns. In the towns, wards and ports, these subdivisions are referred to as medical and preventive urban local districts. They contain clinics, referred to as urban local district polyclinics, whose facilities include at least one clinic for general internal medicine, run by a general practitioner, one pediatric clinic, one clinic for women, and one dental clinic. The local districts in small towns and villages, referred to as rural local districts, contain health centres with an equivalent range of services. The health centres are also responsible for functions in the sphere of environmental sanitation and communicable diseases. By contrast, at district and regional level and in the ports and the towns ranking as districts, environmental sanitation and communicable disease functions are carried out by the hygiene and epidemiology stations, set up pursuant to the decree of the State Sanitary Inspectorate. The districts and regions also have first-aid posts (for emergency treatment), and blood donation stations and posts. Within the framework of the local district clinics, industrial polyclinic health centres may be set up in case of need, with in-patient or out-patient facilities. For administrative purposes, the establishments at central level come under the Ministry of Health and Social Welfare; while establishments at the regional level come under the administrative authority of the Voïvodie Health and Social Welfare Sections of the Voïvodie People's Council. In-patient and out-patient establishments for medical care at district level, together with local district clinics, come under the administrative authority of the health and social welfare sections of the district people's councils. The urban local district clinics and the health centres come under the administrative authority of the district department clinics.

(4) Forms and Methods of Control

The system of control is based on the country's administrative rules at State, regional and district level. Control is carried out by various methods, such as:

1. central control;

2. specialised medical control;

3. control by a group of supervisory officers.

(a) Methods of Central Control

(i) at the State level, control is exercised by the Supreme State Control Board. The Ministry of Health and Social Welfare carries out control in the course of the collegiate sittings in the various regions. These control measures are carried out in accordance with a general plan established for each year. Each region is subjected to control inspection approximately every three to four years, with the participation of all competent departments of the Ministry of Health and Social Welfare, and of the People's Councils in the appropriate region. There is also a special control Board within the Ministry. Inspectors in the legal and economic fields have to inspect the activities of the health and social welfare sections of the regional and district People's Councils, as also - on the order of the Minister - all other questions of health service activity;

(ii) at the regional level the People's Council (the Praesidium) carries out complex control measures every two months in four to six districts, in accordance with a plan based on an analysis of the activities of the various spheres of administration, and at the request of the local authorities. This control is repeated six months later, with a view to ensuring that the necessary provisions have been put into effect.

(b) Method of Specialised (Professional) Medical Control

The transmission of up-to-date scientific information for the day-to-day application in the Health Service is the main object of activity in this type of control. This includes controlling the quality of diagnosis, therapy and medical skill, together with analysis of the effects of professional consultation and treatment. A major part is played by the National and Regional Consultants' Institution. The national and regional consultants are eminent specialists in their own fields of medicine; professors, scientific workers, and persons with wide professional experience. They are recruited from all the major branches of medicine.

In particular the consultants carry out the following duties:

(i) elaboration of methods for the practical application of scientific discoveries in any given field of medicine;

(ii) definition of requirements in the sphere of medical administration concerned with the network of establishments, the number of medical staff and medical equipment;

(iii) elaboration of principles for activities in the field of diagnosis, prophylaxis, therapy and retraining;

(iv) analysis of statistical data concerning ambulatory and hospital medical care in any given field of medicine;

(v) projected planning for prospects in a given field of specialisation, as related to increases in personnel, medical establishments, and ambulatory and in-patient medical care;

(vi) professional consultations and control of local health services in a given field.

(c) The relations between the administrative, scientific and professional authorities of the health service within the medical control system are as follows:

(i) at the State level, there is a liaison between the Ministry of Health and Social Welfare, the Scientific Institute and the National Consultant;

(ii) at the regional level, there is a liaison between the Health and Social Welfare Section of the Regional People's Council, the regional hospital, the specialised regional polyclinics and the Regional Consultant;

(iii) at the district level, there is a liaison between the Health and Social Welfare Section of the District People's Council, the district hospital, the specialised local district polyclinics and the District Consultant, if any.

In addition, at top level, the administrative bodies, scientific establishments, ambulatory and hospital medical care establishments and top-level consultants are responsible for such activities of the Health Service as come under them, and they are bound to supervise them from the professional point of view. Such supervision is always in the nature of control and instruction.

8. Financing

(1) The administration, organisation and functioning of medical care are financed by the State. The Ministry of Health and Social Welfare and the local authorities (People's Councils) have a central budget. In 1965, expenditure under the heading of medical care came to 8.7 per cent. of the State budget.

(2) Persons covered by social insurance bear no part of the costs. Insurance contributions are paid by employers (Act of 29 September 1944).

(3) Only the artisans pay their own contributions.

(4) The Ministry of Health and Social Welfare and the People's Councils are responsible for building and extending Health Service establishments (capital expenditure), save for the establishments of the Industrial Health Service. The Council of Ministers' Order No. 353 of 19 November 1962 requires industrial undertakings to co-operate in improving medical care for workers.

(5) Insurance contributions do not affect the budget of the Ministry of Health and Social Welfare. The budget of the Central Social Insurance Board is independent of that of the Ministry of Health and Social Welfare. There is no inter-relation between the number of persons insured and the development of the Health Service.

9. Right of Appeal in Case of Refusal of Benefit or of Complaint as to Quality or Quantity of Benefit

(1) In either event, patients are entitled to address themselves to the Director of the Health Establishment, who decides whether the contention is well-founded. Moreover, patients are entitled to submit their claims in the first instance to the Health Section of the District People's Council, and in the second instance to that of the Regional People's Council.

(2) Should the Health Section repudiate the complaint, patients may appeal to the President of the People's Council or to the competent Deputy President.

(3) The next authority for appeal is the Minister of Health and Social Welfare, who receives the parties concerned with such matters every Monday. The Minister has the matters examined, either through the intermediary of his own services, or through that of the local services, i.e. the Health and Social Welfare Sections of the relevant People's Councils. In urgent cases, the Minister intervenes directly in the matter under review, on the basis of the regulations in force, and he is bound to give the party concerned a reply after not more than one month.

(4) In particular cases, patients appeal to the Office of the President of the Council of Ministers or to the State Council.

(5) In the last resort, they can appeal to the Supreme State Control Chamber.

C. Application of Statutory Schemes and Discussion of Experience and Problems

1. Ambulatory and domiciliary general practitioner care:

(1) In Poland, the basic units which ensure basic medical care within the framework of the Social Health Service, are the clinics attached to the urban specialised polyclinics, and the health centres operating in small towns or villages. Basic medical care includes: general medical services (provided by trained general practitioners), child care (generally provided by pediatricians), care for women and dental care. These services include both curative and preventive care. The health centres must also supervise environmental sanitation, hygiene and epidemiological activities in their particular area. In towns, this function is performed by the health and hygiene units of the State Sanitary Inspectorate. The doctors employed in these posts (see below E.3), see people once, twice or three times a week and provide assistance in the field of hygiene to all inhabitants of the district served by the local district clinic or health centre. In industrial undertakings, clinics are organised under the industrial polyclinics. Here, medical services (the range of which is described in the section entitled "Range of Benefits" - Chapter B. 3) are provided by medical specialists. Clinics are organised in undertakings which contain about 1,000 workers, while for undertakings which employ a smaller number of workers, inter-undertaking industrial clinics are organised.

(2) Each inhabitant, or each worker, is assigned to the local district where he lives or to the local district of the undertaking in which he works, and receives medical care solely from the doctors employed in the relevant clinic or health centre. Each inhabitant, or each employed person is registered with a doctor who works in the local district polyclinic. Patients are free to choose their doctor from amongst those employed in the district polyclinic or in the local district clinic. They may transfer from one local district to another on specified terms, and an experiment was made in one of the Warsaw quarters enabling a change of local district to be made. The number of persons wishing to transfer revealed itself as minimal (hardly 6 per cent.). In most cases the transfer was not due to inferior quality of care but due to technical reasons such as transport facilities, etc.

2. Specialist Care

(1) Ambulatory - specialist care for out-patients is provided by medical specialists employed in the district specialised polyclinic and in clinics attached to hospitals. The district polyclinics contain clinics in the following medical specialities: general medicine, internal medicine, pediatrics, gynaecology and maternity, dentistry, surgery, eye diseases, E.N.T., industrial medicine, school health, psychiatry, neurology etc. Ambulatory specialist care is also available in separate industrial district polyclinics (organised for 15,000 workers), school polyclinics and other units. Patients must be referred by the local district doctor to the district polyclinic, except as regards venereal diseases, tuberculosis and contraceptive consultations, when the patient may go directly to the appropriate special clinic. If necessary, patients may be referred from the district polyclinic

to the specialised polyclinic at voïvodie (regional) level, or from the regional polyclinic to a polyclinic at state level (Academy of Medicine clinics, scientific research institute, central autonomous clinics). In principle, access to specialist care is available only on referral by the general practitioner or the local district clinic doctor.

(2) Specialist care in hospitals is provided by specialists employed in the hospitals. Patients are not free to choose which doctor shall treat them. If necessary, specialists employed in a district hospital may call in a regional hospital specialist or the consultant. Patients may also, if appropriate, be referred for treatment to the regional hospital, or, where their case requires examination by a top-grade specialist, to the teaching hospitals of the Academy of Medicine, or to the hospital sections of a scientific research institute (the following scientific research institutes include a hospital section: the Institutes of Haematology, Rheumatology, Tuberculosis, Neuropsychiatry, Oncology and its three subsidiary branches, the Circulatory System and Cardiology).

(3) In the context of ambulatory and hospital care, particular emphasis is laid on specialised care in the following fields: mother and child welfare; child welfare (including the welfare of school children); industrial workers' welfare; welfare of sufferers from social diseases such as tuberculosis, venereal diseases, mental diseases, rheumatism, tumours, occupational diseases, alcoholism; protection of the health of the rural population; gerontology and the supervision of the country's health and hygiene conditions. This emphasis is expressed in the setting up of a whole series of institutes for scientific research, which study the problems scientifically and set up consultative and training centres for the lower-level Health Service network. A similar part is played by the Academies of Medicine (senior medical schools). Since the Social Health Service has the senior medical schools at its disposal, it is able to make use of these institutions to control the quality of the modus operandi of the Social Health Service.

The senior medical schools, otherwise referred to as the Academies of Medicine (with 34 teaching hospitals), and 14 institutes for scientific research in medicine, come within the framework of the Social Health Service.

As well as the above-mentioned institutes, there are: the Balneoclimatic Institute, the Institutes of Industrial Hygiene at Łódź and Rokitnica, the Institute of Industrial Medicine of Hygiene and of Rural Medicine, the Institute of Maritime Medicine, the Institute of Medicaments, the Institute of Food and Nutrition, the National Institute of Hygiene and the Institute of Experimental Medicine within the Polish Academy of Science. The National Institute of Hygiene represents a group of Institutes, namely the Institutes of Communal Hygiene, School Hygiene, Microbiology, Epidemiology, Bacteriology, Virology, and Control of Biological Medicaments. The Central Clinic concerned with

questions of medicine in the field of sport is also to be found within the Social Health Service. Lastly, mention must be made of the institutes for specialisation and post-graduate training of medical executives, the doctors' post-graduate training school, and the nurses post-graduate training school. In addition to these, there are other institutes which come under the Social Health Service, namely, the centres for specialisation in the field of rehabilitation at clinic level, the centres for post-graduate courses in pediatrics, etc.

(4) Specialised medical care in sanatoria:

(a) medical care in specialised sanatoria, both for children and adults, (e.g. sanatoria for tuberculosis, diseases of the nervous system, mental diseases, rehabilitation etc.) is free of charge for persons who are entitled, including, inter alia, all insured persons and pensioners;

(b) care in health (climatic) resorts:

(i) persons referred for treatment from in-patient establishments for medical care obtain treatment free as appropriate to their prerogatives (insured persons and pensioners are among those who do not pay);

(ii) persons referred for treatment by trade unions (about 60 per cent. of places), are also treated free of charge;

(iii) other persons entitled to free medical care who are not mentioned under (i) and (ii) above but who are sent to climatic stations by certain competent organisations, for example, persons referred by the Association for the Blind, etc.;

(iv) persons who have been referred by trade unions to climatic stations for prophylactic measures, as part of their holidays, pay a moderate charge according to the amount of their wages.

3. Pharmaceutical Supplies

(1) Persons receiving ambulatory or domicilary treatment obtain medicaments in Social Health Service pharmacies either free or on payment of 10 per cent., 30 per cent. or 100 per cent. of the cost of such medicaments, according to their prerogatives. All pharmacies are state-owned. Persons with a prescription can have it made up in any pharmacy, since in this field, the district rule is not compulsory.

(2) Patients receiving treatment in hospitals or other in-patient medical establishments are given the necessary medicaments free of charge. In principle, hospitals have their own pharmacies.

(3) Independently of the pharmacies, there are pharmaceutical posts, which may function under rural health centres and, less frequently, certain local district clinics.

(4) From the professional point of view, pharmacies come under the Pharmacy Department of the Ministry of Health and Social Welfare, which draws up the general policy directives on medicaments. The Department has a section, inter alia, to deal with pharmacies. The health sections of the Regional People's Councils contain pharmaceutical services, whilst the Health Sections at district level have pharmaceutical posts.

(5) In addition, there is a general directorate of pharmacies to which are attached the directorates of pharmacies and the supply centres at regional level.

4. In-patient Care in Hospital

The principles on which medical care is provided in hospitals have already been outlined in Chapter C.2.2. which deals with specialist care in hospitals. By way of further elucidation, it may be added that in-patient care in hospitals or other in-patient establishments is provided by doctors employed in such hospitals or other establishments. The patients' local district doctor should keep in touch with the doctors in the hospital where his patients are receiving treatment. Patients are under the supervision of the doctor working in the hospital where they are receiving treatment.

5. Dental Care

Since dental clinics and surgeries for dental prosthesis are an integral part of the local district clinics or of the district or regional polyclinics, the district rule is compulsory in this field. Patients obtain dental or prosthetic care in their local district clinics. They have a free choice of dentists from amongst those working in the district department polyclinic or in the local district clinic. In the event of a patient wishing to obtain, for instance, prosthesis in a material (e.g. gold) other than that to which he is entitled, he must pay the difference in cost.

6. Medical Care by Members of Professions Allied to the Medical Profession

In this field, all persons are entitled to care, either free or on payment of a minimum charge, according to their prerogatives. As regards hospital care, the district rule is also compulsory. Patients are referred to hospitals at district or urban level by local district doctors or doctors working in health centres, urban clinics or district polyclinics.

7. Other Medical Care

(1) Prophylactic Measures. In addition to their activities in the curative field, all out- or in-patient establishments giving medical care also carry out individual and collective prophylactic measures (e.g. immunisation, periodic radiological examinations, periodic supervision of particular population groups or occupations). Such care comes under the normal activity of the Social

Health Service establishments, and is in principle, free of charge to everybody. A major role in these prophylactic measures is played by district nurses.

(2) Medical and Vocational Rehabilitation. The Ministry of Health has a department to deal with medical and vocational rehabilitation. The rehabilitation services form part of the regional activities of the Ministry. These services are responsible for the administration and organisation of rehabilitation measures. Rehabilitation clinics operate under the voïvodie (regional) and even the district polyclinics, although as regards the district polyclinics, this is not yet universally applied. There are also in-patient establishments for medical and vocational rehabilitation. Establishments for tubercular patients and persons suffering from diseases of the motor system are especially advanced. There are two faculties with professorships in the Academies of Medicine, which concern themselves with these matters on the basis of scientific research and education. These faculties include hospital sections. Independently of the activities of these faculties, questions of rehabilitation are studied, in co-operation with the Ministry of Health and Social Welfare, by the Association for the Disabled and by the Association of Disabled Persons' Co-operatives, who, among other activities, direct sheltered work places (work in such establishments is carried out under permanent medical control).

8. Social Services

Before 1960, the Social Health Service, as organised by the Ministry of Health, was made responsible for the provision of medical care and social assistance. Pursuant to an Act passed by the Diet in 1960, the Ministry of Health, which had hitherto held office, was replaced by the Ministry of Health and Social Welfare. The new Ministry was made responsible for all health fields, and for all the obligations of the Ministry of Labour and Social Welfare which were directly or indirectly connected with health, such as assistance for children with incurable diseases, protection of the aged, medical and vocational rehabilitation for the disabled and the infirm, provision of prosthetic appliances and lastly, social assistance. In consequence, a scheme for medical care and social assistance was created, which is called the Health and Social Assistance Service. The most important social assistance agency is the Institution of Social Workers, set up pursuant to an Order of the Council of Ministers in 1959. The district rule is compulsory in social assistance as in other fields. The basic unit to this service within the towns is the local district assistance department, usually a town or city block; there are 10,565 such basic units in Poland. In the country, the local district corresponds to the area of the village. There are 40,654 rural district assistance departments. The next link is the commune, whose activities are supported by the Communal People's Councils. In towns and rural districts, the local district departments are served by voluntary social workers. The third link is formed by the district, the town and the ward. Within the fraemwork of the People's Council at district, town and

ward level, there is in any case a Health and Social Assistance Section, within which there is a social assistance service under the direction of a paid social worker. Then there are the health and social assistance sections within the People's Councils at regional level. The entire scheme is under the direction of the Ministry, within which is the Social Assistance Department.

9. System for Supplying Technical Equipment

The Ministry of Health and Social Welfare has a department for the supply of technical equipment. Similar services have been set up under the health and social assistance sections of the Regional People's Councils. Independently of this, there is also a General Board of Supplies, to which the Regional Supply Boards are attached. These organisations are responsible for providing technical equipment, medical apparatus, tools, diagnostic and scientific apparatus, equipment for rehabilitation treatment, etc. for example prosthetic appliances, wheelchairs, hearing aids, both to the Health Service establishments and to patients. The Ministry of Health and Social Welfare has, inter alia, five factories for the manufacture of prosthetic appliances and factories for the manufacture of medical equipment and instruments.

10. Medical Certification of Incapacity for Cash Benefits

Doctors or other duly qualified persons are authorised, in accordance with their functions, to issue medical certificates giving entitlement to sickness allowances.

Industrial doctors decide as to incapacity for work, and vouch for the said incapacity by means of a medical certificate. Where a worker lives far from his place of work, or is bedridden, the basic (local district) doctor decides as to the incapacity for work and vouches for the said incapacity by means of a medical certificate. He notifies the industrial clinic of such incapacity. Workers in small undertakings which do not have their own industrial health establishments obtain medical care in local district clinics where they are issued with a medical certificate of incapacity for work.

The industrial or local district doctor is entitled to certify up to ten days' incapacity for work (stomatologists - four days); specialists, up to 15 days. Should it be necessary to certify incapacity for work for a period of more than 30 days, the senior doctor at the clinic may issue a certificate for up to 40-45 days. In the event that the patient's health requires a further certificate extending the period of incapacity for work, the case is referred to the medical commission attached to the district department polyclinic. This commission is entitled to certify incapacity for work for up to 182 days (for tuberculosis one year), which may be prolonged for a further 13 weeks should the medical commission consider that the patient may be cured and recover his working capacity during the additional period.

11. Medical Record of Persons Protected

Records on the general health and the diseases suffered by each patient are kept at the basic unit of the health service structure, i.e. at the urban district clinic or the health centre. According to the regulations in force, specialists to whom patients are sent for special examinations should inform themselves of the data contained in the records, or should obtain what is referred to as the "health and sickness card"; this procedure is followed when the specialist clinics are in the same building, but it is not always practised when the specialist clinic is in another building. The specialist clinics are responsible for communicating the results of examinations, treatment etc., to the local district clinic or to the health centre; a similar procedure is compulsory for hospitals. However, although the matter has been established in theory, in practice it still gives rise to a number of difficulties (see also Chapter C. 15, "Registration").

12. Professional Secrecy

(1) The Act of 28 October 1950 concerning the medical profession states inter alia, under Article 14, that doctors are bound to treat all information received by virtue of their profession as confidential. Doctors are absolved from professional secrecy in the following cases:

(a) where specific regulations require them to make particular circumstances known to the authorities;

(b) where a patient who has obtained medical aid authorises the doctor or his legal substitute to reveal information;

(c) where the maintaining of professional secrecy may cause actual danger to the life or health of the person receiving treatment or those around him; and,

(d) where they are supposed to notify the authorities, services or institutions authorised by public law of the results of a medical examination carried out at the request of such bodies.

(2) The Act of 20 August 1950 on professional "felchers" states, inter alia, that the "felcher" is bound by the same rules as the doctor, as set out under (a), (b) and (c) above. Aside from this, the "felcher" is not bound by professional secrecy as regards the doctor who is professionally responsible for the establishment in question, or who superintends the activities of the "felcher".

(3) Secrecy in hospitals and other in-patient establishments:

The regulations in force specify, inter alia, that each patient's case history must record the result of examinations and observations, together with the course of treatment, taking into

account the requirements of the Social Insurance Institution, data for returns, and the needs of science. Hospital case histories are confidential, but the hospitals are bound, in confidence and without charge, to communicate extracts from case histories and medical decisions to the proper authorities and public institutions.

(4) Regulations concerning Certain Diseases:

(a) the decree on the prevention of venereal diseases specifies, inter alia, that all registration of and correspondence on venereal diseases must be sent in sealed envelopes and kept strictly confidential. Bills for treatment for venereal diseases sent to services, authorities and institutions, must make no reference to the nature of the disease;

(b) the decree of the Council of Ministers on the prevention of tuberculosis specifies, inter alia, that district tuberculosis clinics must notify the military commissions, in confidence, of the lists of persons liable for conscription who are suffering or convalescing from tuberculosis.

13. Internal Control of Benefits

(1) Control of the quality of medical care, of medical equipment, and of pharmaceutical products and supplies (medical audits).

(a) A special institution known as the National and Regional Consultants' Institution deals with the professional control of qualifications and the quality of equipment and medicaments. The national and regional consultants are eminent specialists in their own fields. Amongst these are professors, scientists, and persons with wide professional experience whose first duty is to check on the functioning of ambulatory or hospital medical care establishments. They fulfil the functions of control and consultation. The consultant doctors are selected from all the major branches of medicine. It is their job to report on the professional quality of services carried out by personnel (they may propose the withdrawal of authorisation for a specialist to practice), on the technical equipment of undertakings, on the provision of medicaments, etc.

(b) Out-patient establishments of high standing are responsible for the professional supervision of qualifications of staff. Thus, for example, the district polyclinic supervises local district clinics and health centres in this respect. Such supervision is always in the nature of control and instruction. Each institution is responsible for raising its standards both as regards the methodology and administration, and as regards professional skills. National and regional consultants (who may also be called district and local district consultants) may be invited to extend their supervision to out-patient establishments. The persons fulfilling these functions submit their proposals and comments.

(8) Data supplied on information cards from all other Health Service establishments are kept together in individual envelopes at sub-district level.

(9) Child welfare and tuberculosis clinics may, where necessary, have a separate filing system. These clinics must inform the local district doctor of all health problems in the area. These problems are indicated by code symbols on the sub-district card.

(10) Polyclinics attached to industrial undertakings have a separate filing system, containing the records of employees. Employees obtain ambulatory and, in some cases, hospital care from the undertaking, and their records are classified in alphabetical order of names according to the district of the doctor of the undertaking. Should it be necessary to visit a sick employee at home, a visit is undertaken by the local district doctor. The local district doctor notifies the industrial clinic of visits made and of the employee's state of health. The industrial clinic, for its part, notifies the local district doctor of major health problems as regards the domicile of the employee. These comments are entered in the appropriate records.

The same system applies to school clinics and students' polyclinics.

Medical documentation is available to the doctor. Only the doctor is entitled to transmit such documentation to other Health Service establishments empowered to carry out control measures in accordance with regulations.

The doctor may authorise another member of the medical personnel (e.g. the nurse, midwife, etc.) to take note of the contents of medical records.

The application of the system of registration in accordance with the sub-district files indicates to the doctor the exact number of localities containing patients with chronic diseases requiring special care.

The information also shows the number of sub-districts in which permanent prophylactic control is required and enables the precise number of home visits made by Health Service personnel in each local district to be established.

The grouping of data and health problems in the sub-district records enables the doctor to keep himself informed of the living conditions in his local district, thus making it easier for him to direct major prophylactic measures and to carry out health education for the people in his local district.

D. Methods of Remunerating Members of the Medical and Allied Professions and of Paying for Hospital Facilities and Pharmaceutical Products and Other Medical and Surgical Supplies

(See table 16 net average monthly wage in national administration.)

1. Methods of Remunerating Members of the Medical and Allied Professions

(1) All doctors must work seven hours a day in and for the Social Health Service. They are paid by the month. They should be employed full-time (i.e. seven hours) in an establishment. In addition, if they so wish, they may work every day in the Social Health Service for not more than a further three hours. Doctors may, therefore, work ten hours per day. The Wages Fund of the State budget provides for each doctor to be employed in the Health Service for an average of nine hours per day (seven hours compulsory, plus two to three hours optional). The additional hours are paid for by the month, according to the number of hours worked. Doctors are automatically given a first promotion after three years in practice, and following this, after five years, ten years, 15 years and 20 years. Radiologists and pathologists work five hours per day, but they are paid on the basis of a seven-hour day. Doctors may increase their basic seven-hour day salary by performing other duties, such as consultant duties, for which they may be remunerated by a lump sum. A doctor's salary is made up of the basic salary and the additional payments. The fact of working in the Social Health Service does not debar a doctor from private practice, provided that he observes the seven hours of work per day rule. Three basic salary scales are specified by the regulations, in respect of:

(a) hospital directors;

(b) senior doctors; and

(c) other doctors, dentists, and other workers who have completed their higher education.

(2) Pharmacists' salaries are made up of basic salary and various supplements which are granted by virtue of management functions which they may undertake. There are four salary scales for pharmacists, in respect of:

(a) qualified pharmacists;

(b) pharmacists' aids and assistant pharmacists;

(c) pharmaceutical technicians;

(d) pharmacy technicians.

The amount of the basic monthly salary depends on the undertaking's working conditions, which are divided into categories A, B, C, D, and E.

(3) Salaries for nurses and auxiliary staff are made up of the basic monthly salary, plus various supplements. Basic salaries are divided into categories A, B, C, D and E, and are given according to professional seniority and individual qualifications.

(4) Junior assistant medical staff (persons employed for disinfection and sterilisation, dentists' and laboratory assistants, etc.) receive a basic monthly salary according to the nature of their job in the undertaking.

2. Methods of Fixing Rates of Remuneration for Members of the Medical and Allied Professions

(1) Doctors and other workers with higher educational qualifications, e.g. certain specialists such as surgeons, radiologists, neuro-surgeons, etc., are entitled to a special monthly supplement, according to their field and degree of specialisation. Persons appointed to management posts also receive a monthly salary supplement. The amount of the monthly salary is established by various scales, and depends on the degree of specialisation, professional seniority, and responsibilities (e.g. number of beds).

Doctors in the out-patient services receive a relatively high monthly supplement, free of tax. Directors, deputy directors and senior doctors in hospitals are paid a supplement if they are not engaged in private practice. Doctors in rural health centres receive a special supplement for the first two years, at which stage the amount is reduced by half. Doctors working jointly in health centres and State farms are paid a further monthly supplement.

Doctors employed in industrial medical care establishments may receive bonuses from the Central Social Insurance Board for results obtained through prophylactic measures.

(2) Persons working in pharmacies are paid at a standard rate based on a 12-hour working day. A further standardised supplement is payable for emergency services. Workers in pharmacies in difficult localities are entitled to a special supplement.

(3) Hospital nurses and other auxiliary staff are paid a hospital supplement, which is higher for staff working in the department of orthopaedics, casualties and rehabilitation. Senior management staff are paid a monthly supplement.

(4) As regards junior assistant medical staff, employees with not less than five years' professional experience in one establishment are paid a supplement, the amount of which varies according to the number of years' service.

Different salaries are paid to scientific and educational staff who also work in the Social Health Service. In this case they receive a consolidated amount where, for instance, they perform the work of consultants, etc.

3. Payment for Pharmaceutical Products and Other Medical and Surgical Supplies Obtained for Beneficiaries In and Out of Hospitals, from Pharmacies, etc.

(1) All medical and other supplies (such as spectacles, prosthetic appliances, hearing aids, wheelchairs, retraining equipment, etc.) are provided by the Health Service establishments. Patients obtain them free of charge or on payment of the official charge laid down in the state scale of tariff.

(2) Where certain remedies or special appliances have to be imported, the competent bodies of the Ministry of Health and Social Welfare import them and issue them to the patient, provided that they are not manufactured in the country and they are prescribed at a Health Service establishment.

E. Rural Medical Services

Medical care in country districts is an integral part of the Social Health Service scheme. The local district system also applies in rural districts, which cover a large number of inhabitants - about 5,000 to 6,000 - within a radius of about 5 km. The Health Service establishments in the country are the health centres, which are attached to the district polyclinics. Rural health centres are responsible for curative and preventive measures, and for certain functions of the State Sanitary Inspectorate. The rural health centre network is still less than adequate, although latterly, action has been taken to construct the essential minimum number of units. The funds for this programme have been provided by the Ministry of Health and Social Welfare, the Polish People's Councils and the General Insurance Board. A major role has been played in this context by the Social Capital Reconstruction Fund which set aside fairly large sums for building rural health centres. As a result some regions, such as Bydgoszcz, have been able to solve the problem of rural health centres. The difficulties in setting up a suitable scheme for rural medical care are lack of popular awareness of the need for essential medical care, particularly prophylactic care, and the fact that doctors prefer to practise in urban areas. In 1960, the Health Section of the Bydgoszcz regional Health Service established a target to construct 100 health centres by the millenary of the State of Poland. The Polish People's Council supported the probject and the target was achieved in 1966.

The construction of a health centre building implies the simultaneous construction of accommodation for the doctor (3-4 rooms, kitchen and sanitary fittings, bathroom, running water, garage, etc.); accommodation for the dental officer (2-4 rooms, with sanitation); and a large room with kitchen, hall and appropriate sanitation for the nurse.

The rural health service is assisted by health co-operatives, which supplement the medical care facilities provided by the social health service.

In addition, there are the health posts. These health service establishments are visited by doctors for consultations once, twice or three times per week. Assistant doctors or nurses may also treat patients every day, provided that they carry out their duties under the doctor's supervision. There are midwives' posts in the country. There are also rural maternity clinics and infirmaries in country areas, especially those which are remote from hospitals. The health centres also contain pharmacies. First-aid posts (for emergencies) are still a major factor in the provision of medical care. The staff in these units look after accident cases and pay visits to bedridden patients thus ensuring that these patients are given medical attention.

In 1965, there were 437 first-aid posts, with 3,173 ambulances at their disposal. In addition, there are airborne teams with 81 aeroplanes and helicopters at their disposal. The extensive coverage of the first-aid service makes up, in some measure, for the inadequate number of rural health centres. Advances in this sphere are evident in the light of the fact that in 1938, Poland had only 11 emergency first-aid posts. In 1965, 23,509,000 home visits were recorded as having been made from first-aid posts, the greater part of which were in rural districts. During the same year first-aid was given to 2,977,000 accident victims.

F. Relations Between Statutory Social Insurance Schemes and Social Health Authorities including Planning and Co-ordination of Services

1. Planning to meet requirements in the field of medical care is directed by the Ministry of Health and Social Welfare. There is no financial interdependence between the Central Social Insurance Board and the Ministry of Health and Social Welfare. Each of these authorities has its own separate budget; and the Central Social Insurance Board does not pay the Ministry of Health and Social Welfare for medical benefits provided for insured persons.

2. These two authorities co-operate and co-ordinate their activities in those spheres which are common to both as regards the nation's health. Exchanges of information are made, especially as regards absence from work due to sickness. The Central Social Insurance Board is concerned with the health of insured persons and with prophylactic activities.

3. The Central Social Insurance Board has set up its own health service for expert assessment of permanent incapacity for work due to sickness or disability. The Board has a special department for this purpose, together with 242 local medical commissions spread over the entire territory.

4. Collaboration between the Social Health Service and the Central Social Insurance Board as regards expert assessment of temporary or permanent incapacity for work functions as follows:

(1) The Ministry of Health and Social Welfare has, under its Industrial Health Service Section, a unit dealing with expert assessment of incapacity for work, with powers to intervene in disputes.

(2) At regional level, supervision in the matter of expert assessment of incapacity for work is carried out by medical inspectors of the Central Social Insurance Board, and by Social Health Service doctors. Supervision is carried out according to standards based on analysis of the degree of incapacity for work, on medical documentation or on special indications.

(3) At district level, there are parallel commissions for expert assessment, functioning independently of each other, under the Central Social Insurance Board and the Social Health Service. Representatives of occupational trade unions, as well as doctors, take part in the commissions of the Central Social Insurance Board. Should the patient have exhausted all the specified period of incapacity for work on health grounds, the Social Health Service medical commission applies to the Central Social Insurance Board Commission to grant such patient a disability pension.

(4) In the context of collaboration, the Central Social Insurance Board invites the senior doctors in industrial clinics to take part in instructional and scientific conferences.

G. Attitudes of Parties Interested in the Scheme

1. Protected persons are in a position to make their influence felt, primarily, through the Polish People's Councils, the Health Commissions of the People's Councils, the trade unions, the Diet (right of interpellation), the social organisations and so on. Their participation or that of their representatives, in the Polish People's Councils and the Diet can shape medical care policy.

2. As regards the members of the medical and allied professions, an important part is played by the trade unions of workers in the Health Service, which represent various professional sectors, as for instance those of medicine, stomatology, nursing, midwifery and others. All basic documents on health policy, passed by the Diet or the Government, or issued by the Ministry of Health and Social Welfare, must be worked out together with the Health Service workers' unions. This applies also to legal instruments on working conditions for staff in the Health Service. A considerable responsibility also devolves on the Polish Medical Association, with whose agreement basic documents on health policy are drawn up, primarily in the field of professional qualifications, professional conduct, etc. Other specialised associations such as the Polish Stomatologists' Association, the Polish Nurses' Association, etc.

are also asked for their opinion. Thus, the programme for specialisation in a given discipline is examined jointly with the particular specialist association concerned, for example the Polish Surgeons' Association as regards surgeons' conditions of work, etc.

3. The Central Trade Union Council fulfils major functions in respect of industrial medicine, etc., and spends large sums on improving industrial hygiene and safety. In addition a sum is set aside in its budget, independently of the funds allocated for industrial safety, for what is referred to as the "health fund", which is primarily designed for the advancement of industrial medicine and of prophylactic measures.

The trade unions give close attention to the standards of living, working conditions and wages of health service workers. Those unions which have their headquarters in Warsaw run rest homes and preventive centres where workers can spend their holidays, either free or on payment of a small charge. The same unions have built a home for pensioned health service workers who have given meritorious service. The medical science associations, about 30 in number, also concern themselves with professional refresher courses for staff. They organise lectures and conferences and edit periodicals in their own fields of specialisation.

H. Special Problems

1. Mal-distribution of the Medical and Allied Professions and of Medical Facilities as between Urban and Rural Areas and as between (a) Large Towns or Urban Centres and (b) Smaller Towns, etc.

(1) The problem of mal-distribution exists, with a high concentration of skilled persons in the large towns. Up to 1963, various remedies were attempted. Young doctors who had completed their studies were sent to villages to undergo a period of professional training. The results were unsatisfactory; after a compulsory two-year period, they sought employment in hospitals in large towns and villages. The Act of 1948, on the Health Service establishments, and the economic planning in the Health Service, made it possible for the Minister to send physician specialists to district towns, small towns etc., for a period of two years. The results were not very satisfactory. After their compulsory service the doctors returned to their former domicile. One measure in the policy aiming at an equitable distribution of medical personnel was compulsory registration, for each Health Service worker within the regional Health Section. As from 1963, a scheme of established posts has been introduced under which doctors can get a job only if the establishment still has such posts vacant. This scheme has given positive results. Every year, the Ministry of Health and Social Welfare grants, in the framework of the budget and in ratio to the number of new doctors coming out of the schools, a certain number of regional established posts. The regions allocate these posts to the districts, and the latter then allocate them amongst the various establishments of the Health Service. Experience has shown that in rural districts, an important initial factor is the provision of housing accommodation. Doctors who set up in country

practice are mainly married couples. In many cases, one is a general practitioner and the other a dentist or pediatrician. Another factor, no less important, is that doctors employed in small towns or in rural districts should be given an opportunity to improve their knowledge.

(2) A difficult problem in organisation is the integration of clinics and hospitals, so as to ensure continuity of medical care for all residents. Such integration would be achieved if the hospitals could direct the out-patient services.

(3) Other problems include the following: the continuing increase in the numbers of old people, whose requirements in medical care and social assistance are relatively very high; the increase in certain "social" diseases, such as cardiovascular diseases and neoplasms; the increasing number of accidents; and finally a continuous increase in consumption of medicaments.

(4) Medical personnel, including doctors, do not sufficiently appreciate the importance of prophylactic measures in maintaining health. The source of this lacuna lies in the system of education formerly practised. For the last three years, medical studies have been reformed to include much fuller instruction on the importance of prophylaxis and social problems in medicine.

2. Special Features

(1) Further training scheme: (a) there is in Warsaw a "post-graduate training school for doctors". Its object is to draw up programmes for specialisation and to organise various types of post-graduate courses. Throughout the duration of the course, doctors receive their full salary at their place of work, as well as accommodation and maintenance in the place where they are attending the course; (b) the post-graduate training school for qualified nurses is organised in accordance with the foregoing practice; (c) the whole system of post-graduate training is linked to the courses and the educational and scientific activities of the medical science associations which currently number 32; (d) Furthermore, there is a publishing house for medical books and periodicals, under the Ministry of Health and Social Welfare.

(2) The senior and secondary medical schools also come under the Ministry of Health and Social Welfare, thus facilitating both the education of personnel in accordance with requirements as seen in the light of practical experience, and the management of hospitals and university teaching hospitals in providing health services.

(3) The activities of the Health Service are extremely complex. Doctors are given specialist training in the organisation of health services. They may qualify for a diploma on the basis of examinations and, in addition they have four years of practice work in the organisation of medical care.

I. Final Comments

The Social Health Service in Poland was formed in the difficult conditions of destruction existing in the immediate post-war period (in some towns, e.g. Warsaw, 80 per cent. of

hospitals were destroyed, equipment destroyed or removed, etc.) as well as a serious shortage of trained personnel (almost half of the doctors in Poland fell during the war) and of buildings etc. The progress made by the Health Service is illustrated by the statistical data given in the appendix. The process of creating and developing the Health Service is not yet ended, and is still facing a whole series of difficulties. The procedures and forms by which the Social Health Service develops proceed in accordance with the directives of the Constitution.

The account which we have given, sets out only the most characteristic features of the Social Health Service and of the directions in which it is developing.

APPENDIX I

Categories of Persons Entitled to All Forms of Health Care without Charge

1. Deputies of the Constituent Diet.
2. Disabled persons; pupils in educational establishments for the disabled.
3. Blind persons; members of the Polish Association for the Blind.
4. Students in higher education and members of their families.
5. Candidates for a doctorate and members of their families.
6. Persons attending teachers' training courses and members of their families.
7. Post-graduate students in scientific establishments and members of their families.
8. Members of the creative professions (artists, painters, actors etc.) and members of their families.
9. Village mayors and members of their families.
10. Peasants with an annual income not exceeding a specified ceiling and members of their families.
11. Volunteer members of teams for the social assistance of agricultural workers.
12. Peasants installed on their new holdings.
13. Repatriated persons (for a period of 6 months, or 12 months in exceptional cases).
14. Recruits who have been called up and who have been directed by the recruiting board to undergo treatment.
15. Members of families of persons enrolled in the army for temporary service.
16. Soldiers temporarily incapable of performing their military service.
17. Persons exempted by the recruiting board (for a specific period).
18. Persons receiving social assistance.
19. Persons undergoing a period of vocational retraining.
20. Prisoners (in accordance with the instructions of the Minister of Health and Social Welfare).

21. Citizens of certain foreign States (Bulgaria, Czechoslovakia, Yugoslavia, the German Democratic Republic, the Soviet Union, Rumania and Hungary).

22. Foreigners taking a vocational training course in Poland.

23. Foreign pupils in Polish secondary schools.

24. International transport workers.

25. Foreigners - on the basis and within the limits of the International Convention of 1 December 1924 on the treatment of venereal diseases.

26. Volunteers in work camps organised by the Socialist Youth Union and the Rural Youth Union.

27. Active members of the Association of Fighters for Freedom and Democracy.

28. Journalists - members of the Polish Association of Journalists and members of their families.

APPENDIX II

Table 1

Current Expenditure[1] from State Budget for Medical Care and Social Assistance

	1961	1962	1963	1964		1965	
	State Budget				of which central budget	state budget	of which central budget
	in million zlotys - current prices						
T o t a l	15,280.0	16,683.8	17,829.1	19,068.8	3,509.5	20,248.2	3,669.9
Health protection	13,819.6	15,060.8	16,222.2	17,388.0	2,850.7	18,578.7	3,046.1
Of which hospitals	4,171.0	4,490.4	4,886.1	5,366.5	930.3	5,714.0	959.6
Establishments for mentally ill and persons suffering from neuroses	636.3	706.3	764.8	821.4	285.9	888.2	290.6
Spa and climatic stations	34.7	37.5	42.1	48.1	48.1	56.0	56.0
Rural maternity hospitals	118.7	122.9	124.8	125.4	-	122.6	-
Medical care in hospitals in connection with factories	22.4	23.3	25.5	26.4	-	26.4	-
Medical care in hospitals in climatic sanatoria	184.4	192.4	208.7	218.9	218.9	236.7	236.7
Centres of anti-TB hospital care	793.2	842.3	905.4	959.1	61.9	848.1	58.1
Centres for children's medical care	55.7	54.3	55.5	59.1	-	87.0	-
Nurseries	92.5	95.2	102.5	103.9	-	106.5	-
School hygiene	110.3	121.3	131.6	138.5	1.8	131.3	9.0

Table 1 (Continued)

Layettes	21.4	17.5	18.1	14.7	---	12.2	---
Obstetrical posts	56.1	51.8	48.6	47.2	---	45.7	---
Crèches	452.0	476.5	495.5	521.4	7.4	520.5	7.9
Ambulatory care Central and of Voivodie	2,449.3	2,675.0	2,505.8	2,637.0	252.7	2,954.8	273.9
Emergency posts	281.0	302.1	321.8	341.8	21.2	362.6	22.2
Transportation for health purposes	418.8	453.9	480.6	506.9	---	543.0	---
Blood donor posts	148.5	180.6	189.7	197.4	---	202.3	---
Health and epidemiologic posts	277.1	297.5	318.2	335.7	---	353.5	---
Hygienic and epidemiologic activities	81.4	99.9	83.7	82.2	53.1	60.4	34.2
Medico - prophylactic activities	152.4	178.4	174.9	188.6	71.1	191.4	79.9
Medicaments and auxiliary resources	2,491.6	2,835.8	3,129.9	3,353.3	257.5	3,681.6	281.4
Prosthetic services	76.1	84.1	97.4	102.6	18.2	108.8	19.4
Social assistance, including:	1,460.4	1,623.0	1,606.9	1,680.8	658.8	1,669.5	623.8
Establishments for hospital care	322.4	343.3	390.1	427.1	3.5	454.3	3.6
Various gifts[2]	741.4	737.7	634.7	636.0	632.8	595.9	592.6
Cash benefits, subsidies[3] and benefits in kind	245.2	275.9	342.7	362.4	---	367.8	---

Table 1 (Continued)

[1] Including expenditures for general maintenance.

[2] Includes, among other items, subsidies from the savings banks and subsidies from the workers and cafeterias in the workplaces (undertakings).

[3] The data do not include benefits to injured persons and the sums allocated to the campaign against alcoholism.

Evolution of the Budget of the Ministry of Health and Social Welfare from 1961 to 1966

Percentage of the State Budget

Years	1961 %	1962 %	1963 %	1964 %	1965 %	1966 %
Total Budget of the Ministry	6.9	6.9	7.0	7.2	7.2	7.7
Budget for Health Protection	5.9	5.9	6.0	6.2	6.2	---

Table 2

Expenditures for Medical Care
in 1965

A

Expenditure	Total	Medical Care	Social Assistance
	in zlotys		
Per inhabitant	581.15	544.92	36.21
Per insured person[1]	796.97	747.32	49.65

B

Expenditure for Treatment

Hospital Care		Ambulatory Care	
Expenditure for treatment for one day of sickness		The total expenditure at the national level represents 15% of budget of the Ministry	
in zlotys			
General hospitals	111.86	Expenditure for one medical consultation	22.95
Special hospitals	154.90		
Anti-TB centres	105.93	Expenditure for one emergency service	177.59

[1] Insured population includes all employees and their dependants.

Table 3

Annual Expenditure for Medicaments in 1965

Kind of Expenditures	For Medicaments Consumed		
	Total	In Ambulatory Care	In Hospital Care
	in million zlotys		
Total	7,742	6,300[1]	1,442
	in zlotys		
Per inhabitant	245	200[3]	45
Per sick person	-	-	465
Per insured person[2] treated in out-patient centre	-	193[4]	-

[1] 95.5 per cent. of the expenditure is for proprietory preparations.

[2] 4.5 per cent. of the expenditure is for preparations made up according to medical prescriptions.

[3] Includes dependants, pensioners and non-insured patients.

[4] Average expenditure for medicaments sold at a reduced rate or without charge.

Increase in Expenditure on Medicaments

in million zlotys

	1955	1960	1965
Total Expenditure	1.928	4.708	7.742
Paid by State	1.077	2.807	5.150
Paid by Patients	851	1.901	2.592

Table 4

Health Service Personnel. Absolute figures and per 10,000 Inhabitants.

	Medical Practitioners		Dentists		Pharmacists		Assistant Practitioners		Nurses				Midwives	
									Total		Fully Qualified Nurses			
Years[1]	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000	Absolute Figures	Per 10,000
1936	12,917	3.7	3,686	1.1	3,737	1.1	1,403	0.4	6,674	1.9	--	--	9,356	2.7
1946	7,732	3.2	1,581	0.7	2,414	1.0	644	0.3	5,840	2.7	--	--	6,311	2.6
1950	9,200	3.7	2,370	0.9	3,817	1.5	633	0.3	18,361	7.3	9,329	3.7	6,920	2.8
1955	18,373	6.7	6,876	2.5	6,276	2.3	5,447	2.0	49,273	17.9	22,182	8.1	7,689	2.8
1960	28,708	9.6	9,316	3.1	7,924	2.7	6,650	2.2	61,907[2]	20.7	39,635	13.3	9,199	3.1
1961	30,855[3]	10.8	9,670	3.2	8,265	2.7	6,670	2.2	63,614[2]	21.1	42,610	14.1	9,477	3.1
1962	32,331[3]	10.6	10,251	3.4	8,747	2.9	6,409	2.1	65,505[2]	21.5	45,829	15.0	9,850	3.2
1963	35,234[3]	11.4	10,611	3.4	9,132	3.0	6,161	2.0	67,892[2]	21.9	49,297	15.9	10,051	3.2
1964	37,726[3]	12.0	11,105	3.5	9,595	3.1	5,906	1.9	73,127[2]	23.3	53,131	17.0	10,456	3.3
1965	39,613[3]	12.6	11,510	3.6	10,072	3.2	5,606	1.8	77,049[2]	24.4	56,276	17.8	10,676	3.4

[1] As at 31 December.

[2] Including unregistered nurses: 1960 - 3,517; 1961 - 4,820; 1962 - 6,747; 1963 - 8,437; 1964 - 12,256; 1965 - 15,974.

[3] Including trainees: 1960 - 1,784; 1961 - 2,352; 1962 - 2,217; 1963 - 3,282; 1964 - 4,026; 1965 - 4,154.

Table 5

Specialists[1]

(31 December)

Year[2]	Total	Internal Medicine	Surgery[3]	Pedia-trics	Gynaecology and Obstetrics	Phtis-[4] lology	Dermatology and Venereology	Psychiatry	Neur-ology	Laryng-ology	Ophthal-mology	Radiology
T o t a l												
1955	8,169	1,592	1,232	1,283	827	638	369	255	215	324	353	286
1960	15,336	2,715	2,291	2,446	1,576	1,021	505	464	351	559	546	504
1961	16,499	2,904	2,517	2,638	1,718	1,061	513	483	387	605	586	572
1962	17,827	3,025	2,738	2,983	1,978	1,093	569	518	434	673	640	621
1963	19,480	3,222	2,944	3,267	2,156	1,228	598	600	444	731	664	629
1964	20,948	3,411	3,051	3,422	2,254	1,327	618	646	471	781	713	724
1965	22,594	3,643	3,204	3,638	2,400	1,393	656	708	530	855	783	747
Specialists of the First Degree												
1955	4,106	901	526	841	400	293	159	119	130	156	146	151
1960	7,868	1,604	1,016	1,564	895	487	239	216	175	261	226	266
1961	8,504	1,708	1,159	1,692	954	503	238	224	193	295	235	298
1962	9,154	1,739	1,283	1,909	1,099	480	262	232	204	333	277	352
1963	10,205	1,854	1,403	2,111	1,208	546	287	311	212	367	285	336
1964	10,812	1,977	1,431	2,204	1,244	597	305	297	221	406	321	378
1965	11,588	2,084	1,505	2,327	1,308	608	309	330	256	452	365	389

Table 5 (Continued)

[1] Practitioners holding a specialist's certificate: the first grade certificate authorises the holder to obtain the second grade certificate.

[2] At 31 December.

[3] Includes specialists in general surgery, pediatrics, thorax- and neuro-surgery, orthopedics and traumatology.

[4] Specialist in lung diseases.

Table 6

Health Service In-patient Establishments[1]

	1930	1950	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Establishments													
Hospitals	632	516	579	589	620	620	636	653	664	664	669	677	671
including Psychiatric Hospitals	35	15	22	23	27	27	27	27	27	26	26	27	28
Nursing homes	--	--	198	220	211	191	182	170	158	152	141	139	118
Rural maternity homes	--	250	755	788	799	813	813	812	809	802	795	753	733
Anti-TB sanatoria	45	83	83	83	84	83	84	86	86	89	88	87	85
Semi-sanatoria[2]	--	--	12	14	17	18	17	15	15	16	15	15	15
Preventoria	29	54	59	61	62	61	60	59	58	59	59	57	56
Sanatoria for persons[3] suffering from neuroses	--	2	2	2	2	3	3	3	3	4	5	4	4
Rahabilitation sanatoria[4]	--	23	35	32	24	23	22	22	22	23	22	22	24
Beds per 10,000 Inhabitants													
Hospitals[5]	69.4	99.8	136.6	140.9	149.0	159.1	199.7	165.0	169.8	173.5	178.3	183.8	187.0
including Psychiatric Hospitals	16.3	12.6	22.6	23.3	26.2	27.5	28.8	30.0	30.4	30.1	30.8	31.7	32.6
Nursing homes	--		2.6	3.0	3.0	2.8	2.7	2.7	2.6	2.7	2.6	2.6	2.2
Rural maternity homes	--	1.6	5.1	5.5	5.8	6.0	6.1	6.2	6.3	6.3	6.3	6.0	5.8

Table 6 (Continued)

	1930	1950	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965
Anti-TB Sanatoria	5.6	17.1	22.0	22.1	22.7	23.1	23.4	23.8	24.3	24.7	24.9	24.9	24.0
Semi-sanatoria[2]	--	--	1.3	1.4	1.6	1.5	1.5	1.4	1.4	1.4	1.3	1.3	1.3
Preventoria	2.5	7.0	7.7	7.9	8.4	8.1	7.7	7.5	7.2	7.3	7.3	7.0	6.8
Sanatoria for persons suffering from neuroses[3]	--	0.7	0.8	0.8	0.9	1.0	1.0	1.1	1.1	1.5	1.5	1.5	1.6
Rehabilitation sanatoria[4]	--	1.7	3.4	3.1	2.2	2.1	2.0	2.0	2.0	2.0	2.0	2.0	2.5
Beds for 10,000 Inhabitants													
Hospitals[5]	20.1	39.9	49.6	50.2	52.2	53.2	54.2	55.2	56.3	56.9	57.6	58.5	59.3
including Psychiatric Hospitals	4.7	5.1	8.2	8.3	9.2	9.5	9.6	10.0	10.1	9.9	10.0	10.1	10.4
Nursing homes	--	--	0.9	1.1	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.8	0.7
Rural maternity homes	--	0.6	1.9	2.0	2.0	2.1	2.1	2.1	2.1	2.1	2.0	1.9	1.8
Anti-TB Sanatoria	1.7	6.8	8.0	7.9	7.9	8.0	7.9	8.0	8.0	8.1	8.0	8.0	7.6
Semi-sanatoria[2]	--	--	0.5	0.5	0.6	0.5	0.5	0.5	0.4	0.5	0.4	0.4	0.4
Preventoria	0.8	2.8	2.8	2.8	2.9	2.8	2.6	2.5	2.4	2.4	2.4	2.2	2.2
Sanatoria for persons suffering from neuroses[3]	--	0.3	0.3	0.3	0.3	0.4	0.3	0.4	0.4	0.5	0.5	0.5	0.5
Rehabilitation sanatoria	--	0.7	1.2	1.1	0.8	0.7	0.7	0.7	0.7	0.7	0.6	0.6	0.9

Table 6 (Continued)

[1] At 31 December of year shown.

[2] Centres generally intended for patients or convalescents whose health status does not oblige them to interrupt their studies or work. These centres provide the patients with the necessary regimen and permanent medical care outside working hours.

[3] Moreover, from 1957 on, there have been sanatoria for child neuro-psychiatry: in 1957 - 1 sanatorium with 47 beds, in 1960 - 3 sanatoria with 795 beds, in 1965 - 6 sanatoria with 1,964 beds; after 1958 centres for habit breaking: in 1958 - 1 centre with 30 beds, in 1965 - 6 centres with 458 beds of which 25 hospital beds were annexed to the polyclinic; after 1958 centres for mentally deficient children under 3 years of age included: in 1958 - 2 centres with 130 beds, in 1965 - 2 centres with 95 beds.

[4] For children and adolescents; until 1958 there were "Maisons de Santé" for children and in 1965 there were Medico-Educational Centres also for adults.

[5] Does not include the beds for newborn babies: in 1965 - 13,195 beds, including hospital beds annexed to the emergency posts and polyclinics, (in 1965 - 1,698 beds).

Note: For beds in spa and climatic stations, see Table 9.

Table 7

Patients Admitted To and Discharged From
Hospitals[1] or Dying Therein

Poland - total

Year	Patients at 1 January	Admitted	Total of Treated Patients	Discharged	Dead	Patients at 31 December
1955	84,947	2,193,593	2,278,540	2,134,516	56,734	87,290
1960	94,179	2,470,741	2,564,920	2,414,946	53,578	96,396
1961	96,396	2,513,336	2,609,732	2,455,729	56,350	97,653
1962	97,653	2,554,322	2,651,975	2,492,350	59,966	99,659
1963	99,648	2,644,073	2,743,721	2,576,892	59,588	107,241
1964	107,137	2,745,957	2,853,094	2,680,210	61,544	111,340
1965	111,371	2,819,255	2,930,626	2,753,311	63,351	113,964

[1] Does not include psychiatric hospitals.

Table 8

Some Indices of Hospital Activities[1]

Poland - Total

Year	Number of Patients Treated Per Bed During the Year	Average Length of Hospitalisation Per Patient Treated	Bed Occupation Rate During the Year	Number of Beds Per Doctor[2]	Number of Beds Per Nurse[3]
		in Days		at 31 December	
1955	20	16	312	12.0	4.9
1960	19	16	297	9.8	4.7
1964	19	17	305	8.0	4.6
1965	19	17	308	7.8	4.5

[1] Does not include psychiatric hospitals.

[2] The data refer to doctors employed in the hospitals.

[3] The data refer to nurses employed in the hospitals.

Table 9

Spa and Climatic Stations[1]

Year	Beds[2]		Patients Under Treatment[3]		Therapeutic Care	Medical Consultations in Spa and Climatic Clinics
	Total	For Children	Total	In Spa and Climatic Sanatoria		
			in Thousands			
1955	11,675	1,956	216.9	126.1	6,802.3	209.4
1960	14,280	2,525	290.2	153.0	8,038.3	233.7
1961	14,056	2,672	301.4	160.3	8,686.2	224.1
1962	15,524	2,643	337.0	169.2	9,241.3	230.4
1963	16,233	2,523	350.7	177.8	9,487.6	240.1
1964	17,291	2,510	377.6	187.9	10,250.2	246.4
1965	17,833	2,680	398.0	200.1	11,061.0	259.1

[1] These data refer to the spa and climatic stations dependant on the Central Direction of spa and climatic stations and on the Ministry of Transport.

[2] Average number of beds available during the year.

[3] These data refer to the patients under treatment during the year.

Table 10

Health Service Centres for Ambulatory Care

Total for all Poland

Year[1]	Polyclinics[2]		Health Centres[2]		Posts				Co-operative and private polyclinics in the towns	Co-operative rural health centres
					Health[3]		Obstetrical			
	Total	In connection with workplaces	Total	Rural	Total	Rural	Total	Rural		
1955	3,486	1,619	1,134	821	2,338	1,598	3,618	2,170	--	--
1960	4,064	2,198	1,688	1,318	2,378	1,861	2,880	1,587	191	76
1961	4,203	2,332	1,790	1,410	2,286	1,812	2,697	1,464	234	90
1962	4,363	2,198[4]	1,884	1,454	2,239	1,783	2,522	1,337	243	121
1963	4,256[5]	2,313[4]	1,911	1,547	2,118	1,694	2,386	1,238	267	169
1964	4,250[5]	2,260[4]	2,099	1,665	1,957	1,577	2,270	1,164	294	209
1965	4,257[5]	2,253[4]	2,214	1,784	1,812	1,486	2,187	1,115	314	238

[1] At 31 December.

[2] Not including co-operatives and private centres.

[3] Doctors, assistant-practitioners, nurses; including the posts in connection with workplaces and students' polyclinics.

[4] The data include only the polyclinics in connection with workplaces.

[5] Not including the polyclinics in connection with workplaces which are not dependent on the clinics of the industrial health service.

Table 11

Activities of Preventive Medicine Centres in Cities and Towns[1]

Year	Total[2]	Children	Women	Anti-T.B.C.	Dermato-venereo-logy	Surgery	Cancer[3]	Rheuma-tology	Laryn-gology	Ophthal-mology	Anti Alco-holics	Dentis-try
		A. Consultations in Dispensaries[3]										
1960	18,642	2,130	1,093	528	547	704	69	281	591	533	289	3,421
1964	22,891	2,632	1,204	580	567	782	41	350	681	598	356	4,734
1965	23,291	2,708	1,202	569	562	775	43	371	691	617	365	5,034
	Total[4]	B. Patients Treated[5]										
1960	111,199	11,665	4,502	4,057	3,154	6,172	371	1,000	3,343	3,466	306	20,422
1964	124,932	14,031	5,150	4,516	3,163	6,954	281	1,200	3,769	3,791	280	21,653
1965	128,413	14,699	5,614	4,406	3,333	7,028	353	1,216	3,734	4,154	284	21,356

1 At 31 December.

2 Includes consultations in dispensaries and polyclinics in connection with workplaces and in polyclinics for students; does not include medical clinics in connection with the schools (in 1965 - total of 5,814); does not include the orthodontic consultations (in 1965 - total of 105); does not include consultations in the polyclinics of the industrial health centres and in the students' polyclinics (in 1965 - total of 5,345); in 1960 it does not include consultations in the polyclinics in connection with workplaces.

3 The data include only dispensaries employing specialists in oncology, surgery and gynaecology. The data of 1960 include, moreover, the dispensaries which do not correspond to present-day oncological dispensaries.

(footnotes 4 and 5 continued on p. 57)

4 Patients in the care of practitioners and dentists in the polyclinics and health centres; includes patients undergoing medical care in the polyclinics in connection with work places, in the polyclinics for students and consultations in the co-operative and private polyclinics; does not include patients undergoing treatment in the school dispensaries and patients treated in orthodontic consultations (in 1965 - 482,000).

5 Does not include patients undergoing treatment in the health industrial service polyclinics and in the students' polyclinics (in 1965 - total of 21,951,000); in 1960 does not include patients undergoing treatment in polyclinics in connection with the workplace. Moreover, it does not include patients undergoing treatment in the co-operative and private polyclinics (in 1965 - ?,859).

Table 12

Activities of Preventive Medicine Centres[1] in Rural Areas

	Year	Patients treated (by thousands) in							
		health centres and posts[2]			co-operative health centres			obstetric posts	
		by							
		Medical Practitioners	Dentists	Assistant Practitioners	Medical Practitioners	Dentists	Assistant Practitioners	Total	Of Which Delivered
Poland	1960	7,564	4,769	3,641	191	179	21	90	76
	1964	8,082	5,261	3,253	521	418	77	53	33
	1965	8,724	6,452	2,985	594	439	87	47	27
Voivodie of:									
Bialystok		266	173	109	19	13	6	7	1
Bydgoszez		482	289	189	11	4	-	3	2
Gdansk		311	280	141	-	-	-	1	0
Katowice		1,197	541	268	-	-	-	5	4
Kielce		567	759	183	60	60	28	2	1
Koszalin		197	173	171	-	-	-	0	0
Krakow		1,117	675	42	160	96	6	4	3
Lublin		548	339	129	111	113	21	2	1

Table 12 (Continued)

Lodz	613	503	120	29	19	6	2	2
Olsztyn	188	156	143	-	1	1	1	1
Opele	506	285	108	-	-	-	2	2
Poznan	721	421	277	18	12	-	8	6
Rzeszow	551	417	277	120	74	15	2	1
Szczecin	56	73	183	4	1	-	0	0
Varsovie	796	714	243	54	40	2	3	2
Wreclaw	432	476	282	4	2	-	3	1
Zielona Gora	176	178	170	4	4	2	2	0

[1] Includes the mobile teams of interns, headed by medical practitioners and assistant practitioners, and also the mobile dental teams.

[2] Does not include the co-operatives.

Table 13

Emergency Medical Posts, Blood Donor Centres and Posts, and Health and Epidemiologic Stations

Year	Emergency Medical Posts					Blood Donor Centres and Posts						Health and Epidemiologic Stations
				Transfers in thousands[1,2]				Blood donors		Litres of blood received[1]		
	Medical posts	Ambulances	Medical planes	Sick cases	Accident cases	Centres	Posts	Free of charge[1,3]	Paid	Total	Offered by donors free of charge[3]	
1955	314	1,149	---	1,387.9[4]	153.6[4]	22	146	---	77,762	68,492	---	431
1960	405	2,093	76	1,778.7	229.4	22	220	108,740	120,520	112,668	19,476	473
1961	418	2,311	77	1,914.0	247.6	22	254	169,887	120,869	120,874	33,193	473
1962	419	2,710	85	2,171.4	261.2	22	287	212,108	108,430	141,453	46,263	459
1963	422	2,947	86	2,255.8	278.5	22	317	260,052	86,150	142,833	54,623	447
1964	432	3,130	90	2,234.2	274.5	22	344	296,219	129,615	147,709	69,553	435
1965	437	3,173	81	2,359.9	297.7	22	365	455,199	101,778	171,314	99,068	426

[1] During the year.

[2] Does not include the transportation of the patients by order of the health service centres (in 1965 - 1132.2 thousand) and the transportation in medical airplanes (in 1965 - 7.9 thousand). The number of ambulatory services in the emergency medical posts in 1965 was 1979.3 thousand.

[3] Includes the donors belonging to the patient's family.

[4] Does not include transfers by ambulance of State Railway medical posts.

Table 14

Pharmacies and Pharmaceutical Posts

Year[1]	Pharmacies	Number of inhabitants per pharmacy[2] in thousands	Pharmaceutical posts[2]	Personnel of the pharmacies and of pharmaceutical posts		
				Total	Graduate pharmacists	Pharmaceutical technicians
1955	1,840	15.0	1,853	15,254	5,816	1,785
1960	1,936	15.4	2,259	18,735	5,494[3]	1,289[4]
1964	2,178	14.4	2,719	19,926	6,190[3]	1,766[4]
1965	2,237	14.1	2,816	20,203	6,405[3]	1,858[4]

[1] At 31 December.

[2] Posts for sale of prepared medicines.

[3] Does not include the pharmacists' aids (in 1960 - 1,078, in 1964 - 917, in 1965 - 879).

[4] Does not include the pharmaceutical technicians (in 1960 - 912, in 1964 - 793, in 1965 - 751).

Note: These data do not include the pharmacies in the health service centres (for instance, in the hospitals, sanatoria) and the pharmacies of the State Railway Health Service (in 1965 - 56 pharmacies).

Table 15

Personnel and Salaries in the Health Service Establishments[1]

	Average number of persons employed, in thousands		Funds for the payment of salaries in millions zlotys		Average monthly salary in zlotys	
	1964	1965	1964	1965	1964	1965
	Total					
T o t a l	335.0	345.0	5,622	5,926	1,399	1,431
Personnel, which includes:	239.6	247.4	4,179	4,416	1,453	1,488
medical practitioners	30.0	31.8	751[2]	819[2]	2,502[2]	2,531[2]
dentists	8.9	9.5	240	264	2,242	2,311
auxiliary personnel	125.5	120.6	2,137	2,262	1,419	1,444
non-qualified auxiliary personnel	63.1	63.1	687	694	908	917
administrative and office personnel	23.5	23.9	455	476	1,616	1,659
maintenance and service personnel	71.9	73.7	988	1,034	1,145	1,169
	Hospitals[3]					
T o t a l	143.7	148.4	2,278	2,398	1,321	1,347
Personnel which includes:	106.3	110.2	1,756	1,856	1,375	1,403
medical practitioners	14.2	15.0	272	294	2,323	2,324
dentists	0.1	0.1	3	3	2,133	2,209

Table 15 (Continued)

auxiliary personnel	47.7	50.6	888	956	1,552	1,574
non-qualified auxiliary personnel	40.6	40.5	430	431	883	887
administrative and office personnel	9.3	9.5	177	184	1,596	1,629
maintenance and service personnel	28.1	28.7	345	358	1,025	1,038
Anti-TBC Sanatoria, semi-sanatoria, preventoria						
T o t a l	17.2	16.8	285	283	1,380	1,403
Personnel which includes:	9.8	9.6	174	173	1,479	1,505
medical practitioners	0.6	0.7	24	24	3,051	3,080
dentists	0.1	0.1	2	2	2,631	2,747
auxiliary personnel	3.6	3.6	73	74	1,701	1,729
non-qualified auxiliary personnel	4.0	3.9	47	46	976	980
administrative and office personnel	1.5	1.5	32	32	1,763	1,799
management and service personnel	5.9	5.7	79	78	1,117	1,132
Dispensaries, Polyclinics and Health Centres						
T o t a l	95.0	98.4	1,708	1,819	1,498	1,541
Personnel which includes:	77.5	80.5	1,475	1,576	1,587	1,632
medical practitioners	13.1	14.6	410	455	2,593	2,647
dentists	8.4	9.0	227	249	2,228	2,297
auxiliary personnel	52.7	54.1	772	816	1,221	1,257

Table 15 (Continued)

unqualified auxiliary personnel	1.0	0.9	10	10	888	906
administrative and office personnel	6.0	6.1	112	118	1,557	1,605
maintenance and service personnel	11.5	11.8	121	125	875	885
Other Centres[4]						
Total	79.1	81.4	1,351	1,426	1,423	1,460
Personnel which includes:	46.0	47.1	774	811	1,403	1,435
physicians	2.1	1.5	45	46	2,627	2,636
dentists	0.3	0.3	8	10	2,617	2,682
auxiliary personnel	21.5	22.3	404	416	1,561	1,556
unqualified auxiliary personnel	17.5	17.8	200	207	951	971
administrative and office personnel	6.7	6.8	134	142	1,665	1,717
maintenance and service personnel	26.4	27.5	443	473	1,397	1,437

[1] Full-time personnel: full-time medical practitioners and dentists refer to those in actual full-time employment of seven hours per day, and in some cases to those whose actual hours of work are reduced, but who are considered by law to be in full-time employment.

These data on the number of employees also include physicians in training as well as medical practitioners employed in posts for five working hours who are considered to be in full-time employment. These data do not include persons employed in pharmacies or in pharmaceutical posts.

[2] These data refer only to medical practitioners employed on a full-time basis (seven working hours); they do not include physicians in-training or physicians employed on a five-hour working basis.

[3] Includes hospitals in connection with the scientific institutions as well as centres for the mentally ill and persons suffering from neuroses.

[4] Includes, among others: nursing homes, rural maternity homes, rehabilitation sanatoria, preventive health establishments, obstetrical posts, nurseries, "gouttes de lait" and "lactarium", school health posts, emergency stations, blood donor centres and posts, health and epidemiologic stations, medical transportation, prosthetic services, spa and climatic stations and disinfection, disinfestation stations.

Table 16

Average Monthly Salary in National Administration

	1961	1962	1963	1964	1965
	in zlotys				
TOTAL	1,589	1,631	1,711	1,758	1,805
Total, not including apprentices	1,607	1,659	1,750	1,804	1,859
Industry	1,722	1,754	1,842	1,886	1,923
Architecture	1,841	1,906	1,958	2,020	2,085
Agriculture	1,300	1,337	1,402	1,459	1,508
Forestry	1,180	1,244	1,309	1,320	1,397
Transportation and communication	1,573	1,621	1,761	1,795	1,852
Commerce	1,340	1,368	1,416	1,459	1,540
Municipal and housing administration	1,517	1,545	1,620	1,660	1,685
Instruction, science and culture	1,479	1,544	1,608	1,660	1,702
Health protection, social welfare, and physical culture[a]	1,271	1,307	1,374	1,426	1,463
Public administration and institutions of justice	1,662	1,746	1,830	1,953	2,026
Financial and insurance institutions	1,512	1,577	1,644	1,689	1,736

(a) The average salary of a medical practitioner for seven hours per day working schedule is 2,331 zlotys per month. The average salary for a nurse is 1,417 zlotys per month. In 1966 the total sum for salaries was increased by 840 million zlotys annually; consequently, the average monthly salary of a full-time medical practitioner was increased by 367 zlotys to a monthly average of 2,698 zlotys and the average salary for a nurse was increased by 164 zlotys to a monthly average of 1,581 zlotys.