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Health Care Reform in Poland After 3 Years; Challenges for New Authorities[1]

Introduction

Health care reform introduced in 1999 together with other reforms rose the biggest expectations of interested parties: both medical environment as well as patients. As probability of becoming a patient is very big in medium term, for three years that have passed since the reform introduction, almost each citizen has developed his own opinion on effects of the changes[2]. According to many researches, public opinion about the changes to the health care system is not good. Facts that are socially most irritating are connected with reduction of accessibility due to the introduction of a gate keeper, i.e. a family physician and growth of treatment costs, including mainly an incredible growth of medicine prices.

The opinion of physicians about the changes is important, even more important than the opinion of patients, for further development of the reform. However, this opinion is also not good. In this case, the fact that disappointed medical environment is inefficient mechanism envisaging that 'money goes after patients'. Budget reductions of health care centres imposed by their contracts with regional health care administration units resulted in complete dissatisfaction with these administration units. It is not strange that there appeared demands, and even political anticipations that these just-established institutions were to be liquidated.

The present experience should make system analysts focus on basic issues that arose most negative emotions:

- reduced expenses for public health care,
- dramatic growth of expenses for medicines,
- limited access to health care system due to new principles for basic health care operation,
- ineffective execution of functions in the system of third-party institutions,
- spontaneous privatisation and cases of corruption.

1. Problem of Public Expenses for Health Care

Health care reform was designed in 1996 including a little bit bigger level of public expenditure for health care than it was realised at its implementation stage. It was assumed that a premium would be 10%, and finally it amounted to 7.5%. A difference of 2.5 percentage points of the personal income tax base was compensated

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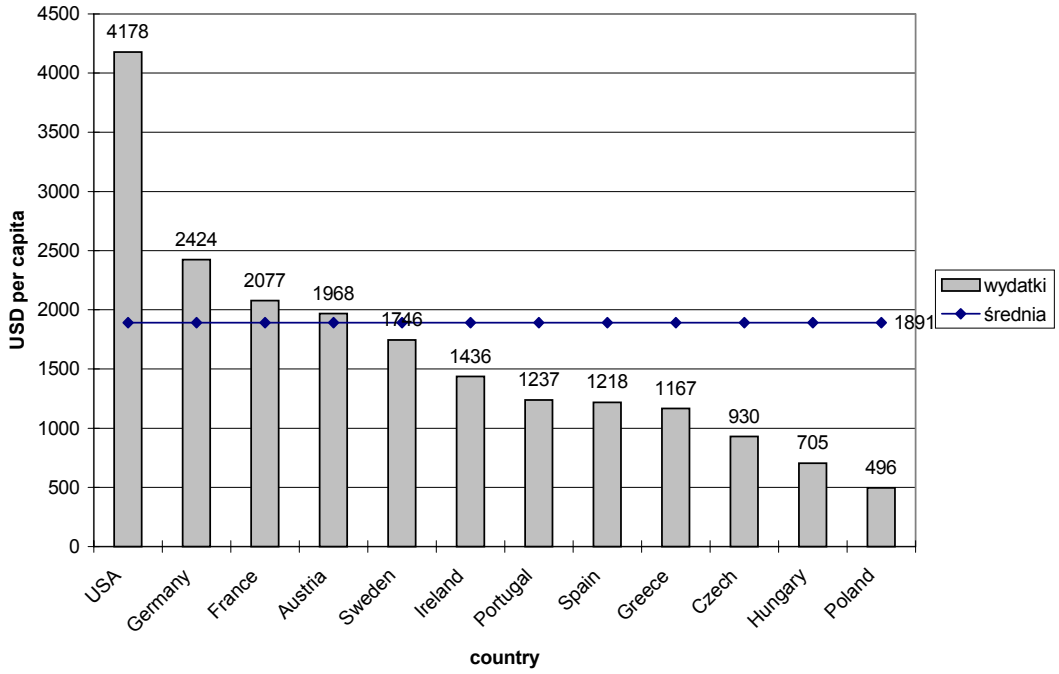
[2] In the case of education or pension benefits, personal experience connected with effects of the reforms is less common, or more distant in time and public opinion depends on personal experience to much a smaller extent than on expert, political and media evaluations.

with expansion of income categories subject to tax, but its relative value (in relation to GDP) decreased already in the first year of the reform.

Public expenditure for health care in Poland comparing to other Western countries which we are trying to join was very low already before the reform introduction (see: table 1). Although a relation of total expenditure to GDP, more than public expenditure, lets us approach Western countries, but as far as absolute figures are concerned, we are at the last place among OECD countries. In Poland, total expenses for health care estimated in 1998 amounted to USD 496 per capita (PPP), whereas in the OECD countries to around USD 1891 (OECD 2000).

In the majority of the OECD countries, the share of public sector in health care increases, which entails growth of the total expenses. Only in Sweden, a trend is different. This country introduced reforms reducing the existing expanded scope of the State care, including health care system, and as a result the share of public expenses for health care decreased.

Total health care expenditure in selected OECD countries in USD (PPP) per capita



(*wydatki* – expenses; *średnia* – average)

Table 1 Expenses for health care in relation to GDP

Selected countries	1980	1990	1998*
USA			
total		12.4	13.6
public	3.8	5.1	6.5
Germany			
total		8.7	10.6
public	6.9	6.7	8.1
France			
total		8.8	9.6
public	5.8	6.7	7.3
Austria			
total		7.9	8.5
public	5.3	5.3	5.8
Sweden			
total		8.4	8.3
public	8.7	7.9	7.2
Great Britain			
total		6.0	6.7
public	4.9	5.0	5.5
Spain			
total		6.9	7.1
public	4.5	5.4	5.7
Ireland			
total		7.0	6.4
public	7.1	5.0	5.3
Portugal			
total		6.4	7.8
public	3.7	4.2	5.3
Greece			
total		7.6	8.3
public	3.7	4.8	5.0
Czech			
total	-	5.0	7.2
public	-	4.8	6.5
Hungary			
total	-		6.8
public	-		
Poland			
total	-	5.3	6.4
public	-	4.8	4.6
OECD countries– average			
total		7.6	8.3
public			5.8

* public expenditure estimation from 1997
Source: OECD health data base

The introduction of a smaller premium than it was estimated in 1996 - 1997 resulted in decrease of public expenditure share in GDP. Estimations for 1999 – 2000 show that the relation of these expenses to GDP decreases and it is around 4%. In all European Union countries, even in Greece and Portugal, this ratio is not smaller than 5 (see: table 1).

What consequences would a lower premium ratio entail? First of all, it would result in growth of private expenses due to shift of a part of services and patients to paid medical sector. Preliminary analyses show that such a shift refers, first of all, to expenses for medicines (Golinowska and others, 2001). Whereas, the lack of regulations on clear separation of public and private sector with regard to medicine supply makes it difficult to estimate, in a reliable way, the share of private funds. Moreover, some of these funds flow to the public sector in an informal way.

Financial restrictions constitute an important factor of the failure of the health care reform. However, it does not mean that there would be no problems with its effectiveness and quality if there were bigger funds involved. To improve health care system operation, it would be necessary to have efficient mechanisms rationalising relations in the system and to liquidate all wastes. Whereas, we may say for sure that the strategy consisting in visible budget reduction without a relevant distribution and allocation mechanisms, because the market was not adequate[3] and regulatory mechanisms were not prepared, appeared to be wrong. Additionally, the very process of institutional changes required new funds. It must have resulted in decrease of funds for service providers and significant shifts in the structure.

Such **structural shifts increase an effect of lack of funds in the public health care.** Especially, that it refers to medicines, i.e. an external sector in relation to the basic health care industry.

Table 2. Public expenses for health care in Poland in the 90s

Expenses	1990	1994	1997	1999
Public expenses for health care as % GDP	5.0	4.8	4.4	4.2
Basic care, share in %	18.9 (1991)	23.8	18.5	20.0
Hospital care, share	48.5 (1991)	52.2	48.3	16.0
Medicines, share	12.0	11.3	8.1	14.0
First aid, share	2.5 (1991)	2.8	2.6	2.8
Rehabilitation and sanatoriums, share	-	2.7	2.2	1.7

Source: estimations and own calculations (see: Golinowska and Hagemejer, 2000)

2. Problem of High And Dynamically Growing Expenses for Medicines

Expenses for medicines come within the group of expenses whose rate of growth is the biggest one, both with regard to private and public finance. Medicines constitute the most important item in expenses of all households. On the average, they consume

[3] It may seem that the assumption on regulated market introduction misled the reforms who were convinced that some automatic rational mechanism would be activated and work related to budget programming and planning would not be required. Thus, informative conditions, standards and normatives were not developed.

55% of all expenses for health care borne by households. To compare it to the macro situation, we may estimate that almost PLN 8 milliard p.a. is spent to purchase medicines from individual income of people, which constitutes around 30% in comparison to consolidated expenses of the government and self-government sector (Golinowska and others, 2001).

Medicines have also a significant share in the structure of public expenses. In 2000, costs of medicine finance constituted 20% (according to the report by the National Health Care Administration Units Association), and expenses for medicines under inpatient care: from 8 to 25% depending on a reference rate of a hospital (on the grounds of preliminary results of research carried out under the project) and according to UNUZ data: 19.35% on the average. (www.unuz.gov.pl).

These shares are very high, although in poorer countries of the West the relation of expenses for medicines to total expenses for health care is also substantial. In such countries like Portugal, Hungary and Czech, it is around 25% to 30%, whereas in the OECD countries, it is around 15% on the average (OECD 2000 - Jacobzone).

A regularity consisting in a higher share of expenses for medicines in poorer countries may be observed when we analyse ratios presented in the table below, which presents expenses for medicines in relation to GDP. In poorer countries, the share of total expenses for medicines in relation to GDP is generally higher than in wealthier countries, independent of the scope and type of the care status of these countries and situation of the public health sector there. In Sweden, they are similar to expenses borne at Great Britain and the USA (1.1% – 1.2 % of GDP).

It means that medicines constitute a group of basic goods, similar to food. Income and price flexibility ratios of demand for medicines are rather close to 0 than 1. Such a regularity is especially important for trends related to public finance. Usually, there are bigger possibilities for public finance when demand price flexibility ratios (small demand changes when prices grow) are closer to 0. While developing a list of reimbursed medicines, we should take into account not only medical aspects, but also flexibility in relation to prices and income.

Table 3. Expenses for medicines in selected countries in relation to GDP

Selected countries	1980	1990	1996
Austria			
total	0.8	0.9	1.1
public	0.5	0.5	0.7
Germany			
total	1.2	1.2	1.3
public	0.9	0.9	1.0
France			
total	1.2	1.5	1.6
public	0.8	0.9	1.0
Great Britain			
total	0.7	0.8	1.1
public	0.5	0.6	0.7
Sweden			
total	0.6	0.7	1.1
public	0.4	0.5	0.8
USA			
total	0.8	1.1	1.2
public	0.1	0.1	0.2
Portugal			
total	1.2	1.6	2.2
public	0.8	1.0	1.4
Czech Republic			

total public	-	1.1 1.0	1.9 1.5
Hungary total public	-	 1.6	 1.9 1.4
Poland total public			
OECD countries – average total public	 0.9 0.5	 1.0 0.6	 1.2 0.7

Source: OECD health data base, 2000

Dynamic growth of medicine costs in recent years in Poland has been caused by several reasons, which are still difficult to weight, but it is important to realise that we may influence only some of them, and that they operate simultaneously, thus actions taken to reduce medicine costs should be complex.

These reasons may be divided into two groups. The first groups includes universal reasons connected with social changes that should be taken into account as explanatory variables, but not as variables that may be shaped.

- The first factor from the group of universal variables is society ageing process (many studies and analyses were devoted thereto, see OECD 1997 and 1998), which is still not that intensive in Poland like in other Western countries, but trend of changes to demographic structure is similar. Another important factor, and maybe the most important one for Poland, is the growth of the society education leading to paying much more attention to health, efficiency and longer life. Such a growth of post-war generations education is also universal (the main factor of so called medium class revolution), but in Poland it is much more important due to great changes, although we have still not reached an average education of developed Western countries. Universal variables characteristic for social and demographic changes to the population, explaining the problem of growth of medicine costs may not, however, be used to calm ourselves down and resign from efforts to increase activeness to reduce this growth.
- The other group comprises reasons connected with principles of operation and construction of the system. Here, at the very beginning, we have to pay attention to the scope of the system. On the one hand, we may refer to the broad public system, on the other hand to the narrower health care system. **In Poland, factors connected with gaps in efficient operation of the public sector as a whole[4], including health care sector, are very important.**

Variables characterising the system may be shaped, but also here, the possibilities of our influence are limited. Specific nature of medicine production, having an impact on high costs of medicines (necessary scientific researches and long period from medicine discovery to its mass production) significantly decreases potential possibilities of changes.

Let's try to have a look at factors coming within the health care service. At first, let's review possible ways of State's interference in production and distribution of medicines.

[4] Political science researches and opinions of some experts show that State control decreases (e.g. Staniszkis- interview in Rzeczypospolita – 16.12.2001).

We know many instruments of State's interference in the medicine market. They may be divided into regulations related to demand and interferences related to supply. In the case of demand, we have to analyse consequences of motivating mechanisms for limiting medicines financed and co-financed with public funds. Methods used here are: positive lists, negative lists, guidelines for prescription, defined budgets for medicines (e.g. pre-defining limit of yearly expenses[5]), and in hospitals, prescribing officers. The influence of these methods is limited as the whole public sector operates wrongly and there are gaps in monitoring, there is no defined basis to control medicine prescription basis, including especially reimbursed medicines. Introduction of monitoring and control actions and relevant means related thereto is an urgent task to improve the reform.

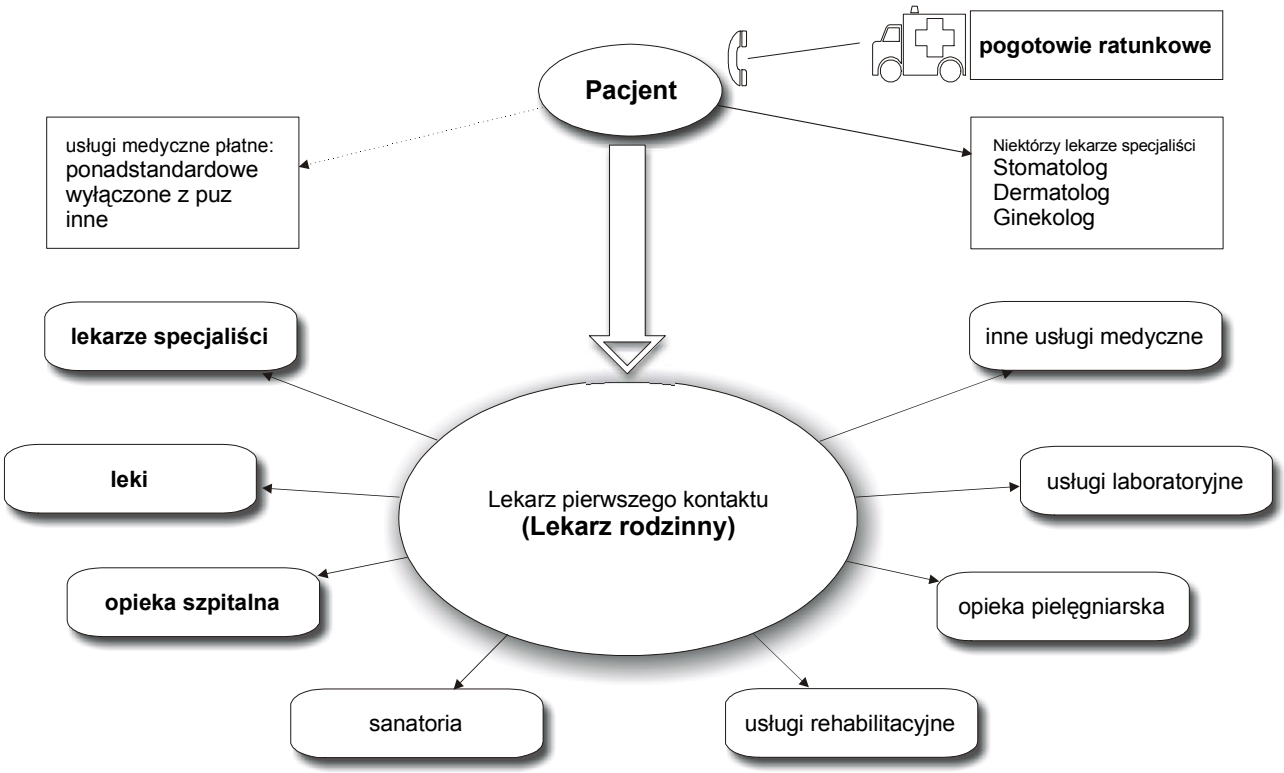
In the case of supply, interference consists in national establishment of prices and control of costs and profits. Since, in the market economy, direct State's interference in free price shaping is considered irrelevant, we should have rather a look at methods of margin and profit „control", e.g. consisting in definition of limits or directions of their purpose. From this point of view, English experience (OECD 2000) may be interesting to analyse.

Referring to counteracting medicine cost growth, actions consisting in motivating to use generics (recreative medicines) instead of original medicines (Bochenek 2001) are mentioned more and more often. However, before such incentive elements are effected, there is a need for education and introduction of a duty of the public health care sector to make pharmacological and economic analyses. Generally speaking, economic analyses of application of various methods of therapy are one of the biggest challenges related to medical education combining medical and economic aspects.

3. Problem of Basic Health Care and Family Physicians

Each health care reform draft covered the growth of an importance of basic health care and introduction of an institution of family physicians (Włodarczyk 1998). This trend of changes seemed obvious with regard to the lack of qualitative and quantitative balance between specialists and physicians in outpatient clinics in Poland. International comparisons showed basic importance of a function of family doctors to define 'entrance to the system', and consequently to shape its costs. In spite of this common property of many proposals of changes postulated already in the late 80s, decisions related to education of family doctors were not made in a relevant time and scale. Only when the reform was introduced, actions to educate family doctors were taken. The reform assumed a solution called fast path. However, the number of doctors entering this path is not sufficient. This specialisation is not appreciated much in the medical environment. However, it is a universal problem. As a result, the doctor of the first contact is not a real family doctor. It is usually a doctor at the outpatient clinic. A difference consists in the fact that the reform envisages that we have to „select" him by means of enrolling, and when we skip him in a more difficult situation, for example when we need faster help, we have to leave the public system and use private services more often than before the reform.

[5] A principle is simple: the more medicines are prescribed by physicians, the less money they receive when the limit is exceeded, because the binding regulations envisage reduction of the budget for physician services in such a case.



Patient's access to health care services in the health care system after the reform

pacjent – patient
pogotowie.. – emergency medical service
usługi .. – paid medical services: non-standard, not included in health insurance, other
niektórzy ... – some physicians specialists: dentist, dermatologist, gynaecologist
lekarze specjaliści – physicians specialists
inne usługi .. – other medical services
leki – medicines
lekarz pierwszego .. – family doctor
usługi laboratoryjne – laboratory services
opieka szpitalna – hospital care
sanatoria – sanatoriums
usługi rehab. – rehabilitation services
opieka pielęgniarska – nurse care

Expectations towards family doctors in relation to the reform goals are clear. These should be real family doctors, treating well patients they know, sending them to specialists and to hospital more rarely. But so far, we have the same, often uneducated, physicians from former outpatient clinics, who send patients with more difficult cases wherever they can, usually to hospitals. Therefore, the first effect of the reform is maintenance, and in some health care administration units even growth of the share of more expensive inpatients treatment in relation to cheaper ambulatory services. Therefore, an effect opposite to the assumed one was obtained.

The reform objectives were not met both due to low qualifications of family doctors, as well as wrong incentive instruments.

How may we solve a problem of relatively low qualifications of this group of doctors? Do we need any administrative regulations (on competence verification), or maybe reinforcement of instruments motivating to raise competencies? Persons managing the reformed system hoped that the competition of developing private sector under the basic health care system would contribute positively to qualification improvement. However, we may rather observe a reinsurance function of this area to compensate for the development of private surgeries and clinics, and not a competitive function. The same doctors often work in both sectors. As a result, patients queuing to the family doctor in the public sector may often obtain required help after time in his private surgery. A problem of relatively low qualifications of family doctors is a concern of many other foreign systems. New reformers postulate to introduce obligatory continuous education forms for family doctors and certain forms to disqualify them not only due to errors, but also omissions.

Which economic instruments favour increase of family doctors' activeness in treatment of patients and growth of sense of their responsibility for treatment costs? There is no one good solution here. We may learn on the grounds of German perturbations with basic health care finance. The recent combination of the global budget with a fee for service system was replaced in 1997 – 1998 with definition of budgets for doctor's practices. The evaluation of methods of the budgets of doctor's practices is not positive. It is believed that it neither intensifies competition between doctors nor it creates motivation for more effective combination of various types of services, and especially it does not favour shifting a certain scope of medical treatment from expensive hospital sector to cheaper ambulatory sector. On the contrary, strict limitation of points in the budget resulted in the growth of the number of patients sent to hospitals. Moreover, exceeding of budgets of doctor's practices was not reduced (Sowada 2001).

In Poland, the health care administration units may apply various solutions to basic health care (global budget for family doctors, *per capita* method, or planning based on future trends and dependencies). The problem of the structure of methods applied and their effectiveness does not still constitute an object of comprehensive analysis[6]. Whereas, the effect of the reform consisting in a very high share of inpatient treatment, and often its growth in relation to the period before the reform, is a serious signal of weakness of methods applied to basic health care (in many health care administration units, expenditure for inpatient care both in 1999 and 2000 exceeded 50% of all expenditure[7]).

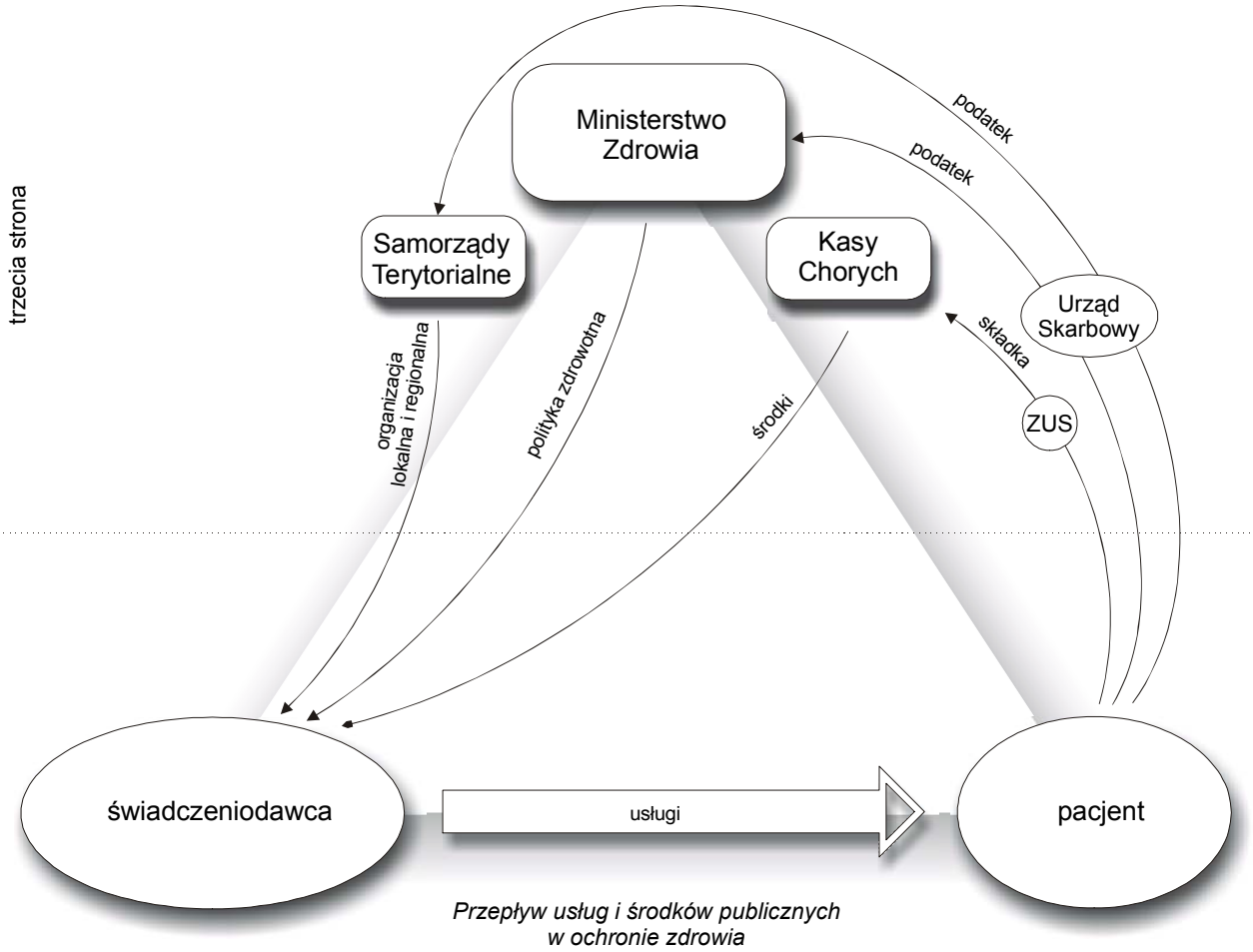
4. Institutional Solutions for Third Parties

One of the basic changes to the health care sector brought about by the reform was change to the model of operation of so called third party. A specific nature of the modern health care sector consists in the fact that direct bilateral relations between a doctor and patient were replaced with trilateral relations. The third party appeared as a payer and formal purchaser of services for patients already in the 19th century.

In socialistic Poland, functions of the third party were performed by the State and its administration. As a result of the 1999 reform, these functions were divided between territorial self-governments, specially established administration units and

[6] This problem is an element of the research started at CASE.
[7] Based on reports of the National Association of the Health Care Administration Units.

government's agency in the form of the Health Care Ministry, but the administration units became its strongest representative.



Przepływ usług i środków publicznych w ochronie zdrowia

Flow of services and public funds in the health care sector

trzecia strona – third party
Ministerstwo Zdrowia – Health Care Ministry
Samorządy – Territorial Self-governments
Kasy – Health Care Administration Units
podatek – tax
organizacja ... – local and regional organisation
polityka... – health policy
środki – funds
składka – premium
Urząd Skarbowy – Revenue
ZUS – Social Insurance
świadczeniodawca – service provider
usługi – services
pacjent – patient

Reformers assumed that the operation of the health care administration units may be based on internal market mechanisms, an important element of which is competitive relation between third parties and service providers. But, from the

beginning, a monoposonistic model was constructed with actual monopolistic position of the payer. The establishment of private health insurance and possibility of diversification of premiums defined separately by the administration units were postponed. In practice, it appeared that there is also another form of the monopoly in the sector. It refers to relations between the health care administration units, service providers and the patient, as well.

The most important property of each market system is free pricing. In the case of regulated market, it is limited, but a degree and form of the limitation have an impact on system quality of tasks. In health care system reform designing process, an approach to pricing was not clear (instead of pricing, it is better saying definition of fees for services, here), and reformers did not pay sufficient attention to its importance. In 1998, it was said that this problem had to be solved, certain solutions were proposed and there even appeared some regulatory initiatives (draft by MPs of the Freedom Union). But the reform was introduced on the assumption that the market would generate automated actions as then reformers perceived regulated market rather as a *per se* market than a regulated market.

What was a problem in the reformed system of the third party?

At first, responsibility[8] for the whole operation of the public health care system was diluted. The role of government in health policy management was decreased, and self-governments did not take an active role of establishment bodies.

Secondly, standard, including infrastructural, IT and administrative, conditions for health care administration units operation were not defined. As a result, the administration units organised their base and operating conditions on their own. Some of their solutions, which were too expensive (or even luxury), were often subject to criticism.

Thirdly, fees for services defined in the agreements of the health care administration units with service providers were imposed by the administration units as the market conditions were no regulated, although we could indicate certain arrangements between service providers who forced the administration units to accept their fees. Independently of the fact which party enforced its rate more, the market situation was not defined and regulated without any reasonable justification. Consequently, the health care administration units became entities running autonomous and diversified policy towards its service providers (independent „princedoms" in the health care sector). There was some work taken to develop standards of proceeding and define minimum service rates, but no institutional responsibility for this work and regulations was finally defined. Whereas, an attempt to construct a base for uniform operation, by means of establishing the National Association of Health Care Administration Units failed due to fast liquidation of this new institution due to use of political slogans on administrative surplus.

Thirdly, the health administration units failed to execute effectively their functions related to budgetary reductions because they did not stop health care units indebtedness. On the contrary, they started paying debts of some outlets, giving a signal that debts may be still accepted without any drastic consequences for health care centres.

[8] see: Golinowska, Włodarczyk , IPiSS 2000

Fourthly, the health care administration units, as the main place of public funds distribution, became prone to political pressure related to position filling and contracts, which favours contracts hiding.

What were positive results of the establishment and operation of the health care administration units?

Although budgetary reductions did not work fully (a problem of further indebtedness of outlets), the health care administration units, for the first time in Poland after the war, forced service providers to calculate their costs. For years, we did not manage to introduce even a basis for application of any cost account. Only the system of contracts with the health care administration changed behaviour of service provider in this area significantly.

Based on contradictory interests, the health care administration units broke the solidarity of medical environment, which made the supervision of funds flow very difficult. A part of the health care administration may be now a reliable partner of public services. They acquire additional management, economic and legal qualifications allowing for professional dialogue.

Although for service providers, the health care administration units are a positive solution. A budgetary sack where a part for the health care was taken from by every-year's decisions was a solution which was not accepted in the medical environment. That is why so called insurance relations, where a relation between a premium and funds for the system are clear, were that appreciated. Such a big acceptance of transparency of financial relations in the insurance system surprised even experts, who often called it a „myth of social insurance" (Tymowska 1998). Due to that reason, so called self-government solutions do not arise any enthusiasm. The health care does not want to compete for funds also at the self-government level. It trusts direct decisions of the society much more, including bigger eagerness to submit to taxes or insurance premiums[9], when it refers to health.

Replacement of the health care administration units with any other third party institution (so called funds, or transfer of payer's functions to territorial self-governments) will not change the situation in the health sector as the quality payer's functions execution conditions will not be improved. The problem consists in not **who will perform this function, but what instruments he has to perform it.** Development of these instruments and their enforcement (demographically and epidemiological information base, service standards, rates, quality and contract evaluation methods, etc.) still are not of a priority. We may even say that there were many actions taken making systematical work in this area difficult, especially by means of anticipating needs for liquidation of administrative surplus and privatisation necessity. Already political message to liquidate the health care administration units stopped work over rational management instruments in the health care sector.

5. Spontaneous Privatisation

The health care reform in Poland did not define borders between public and private sector and it is a great disadvantage of it. Consequently, there is a great discrepancy between constitutional entries on right to common health care and

[9] By the way, the latest proposal of the new minister of finance (10.2001) was also based on such a perception of the problem of funds for public health care in order to establish a „real premium" independent of income tax from individuals.

possibilities of its realisation. It does not consist only in limited volume of funds, but also operating mechanisms.

Let's have a more systematical look at privatisation. In the health care sector, there are two sides of the privatisation. On the one hand, from the point of view of units providing services, and on the other hand, from the point of view of sources of finance, which may be public or private. The chart below presents possible combinations of application of these two sides.

Ownership / Source of finance	Private funds	Public funds
Private ownership	1. market situation	2. regulated market
Public ownership	3. co-finance, but also corruption	4. only national health care service

The situation of the health care from the point of view of relations between public and private sectors is depicted in fields 2: public funds and private ownership and field 3: public ownership and private funds. We have to define clearly relations for these situations.

Moreover, we have to take into account the fact that the health care system operates in the market environment and its various parts are defined by many commercial mechanisms. As a result, public funds are used to pay for services for which there is a price with not controlled profit (e.g. medicine supply).

A source for privatisation intentions is further indebtedness of health care units. To stop the process, establishment bodies, i.e. self-governments often make initiatives to transform public health care units into commercial companies. However, the initiation of such a process means taking over of debts by self-government or another entity. Therefore, one will have to pay first to obtain future effect of not paying. Maybe, some self-governments, which are determined to cut down on increasing debts, may afford to do that more than the others.
However, looking globally, we have to ask about alternative costs. What will be a result of such a decision for execution of other public needs in the area of a given self-government's operation? Some reports on the course of privatisation process initiated by self-government authorities show how many conflicts may be caused by these problems[10].

Conflicts related to ownership privatisation are generated also by concerns of medical employees to keep their workplaces. These concerns are justified. They are mostly visible in regions and local centres with a high unemployment rate[11].

To evaluate fully this type of privatisation of health care units, including especially hospitals, the most important elements are future effects of accessibility and quality of health services and level of costs, assuming that the effect consisting in stopping lack of financial balance will be achieved. It is difficult to force clearly and estimate consequence of privatisation. Because, what would be the base for such forecasts? Researches on privatisation of hospitals or comparisons on operation of public and private hospitals presented rarely in literature do not let us draw uniform conclusions (Savas 1992). However, we may state that a private hospital being a

[10] An example may be privatisation of a hospital in Ełk described in Rzeczypospolita no. 232 of 4.10.2001 and commented by the Ełk Society President Mr. Stanisław Fietkiewicz in No. 258 of 5.11.2001.
[11] Podlaskie Province – see: Gazeta Prawna No. 119 and 122 of 2001.

monopolist operating for profit has got two drawbacks: it generates high operating costs, which in case of poor patient treatment (or treatment patients insured in public system) are transferred to the public sector. Because benefits from privatisation are visible in specific conditions: competition of service providers and great readiness of patients to pay for services (growth of the share of private funds). When such conditions are difficult to met, private hospitals operate well under defined State regulations the purpose of which is to reduce trend of unlimited growth of costs and counteract reduction of accessibility. Therefore, it is very important that self-government privatisation initiatives should be supported with regulations related to operation of private hospitals.

To make the operation of the health care sector clear, it is absolutely necessary to define borders between the public and private sectors in the context of rights to services financed from public funds.

These borders may be established in two different ways: by means of directing a part of patients (e.g. well-off and / or small-risk patients, like in Germany or more radically in the USA) to private finance, or by means of defining a part of services as non-public (to be financed from private funds) by determining a basket of public guaranteed services. There is also a third solution which is more decentralised (much more difficult to realise and entailing high transaction costs) consisting in negotiation of public and private scope of health care finance based on readiness to pay. Definition of border of rights to public services is one of the most important political decisions that were not taken when the reform was introduced, which contributed mostly to problems with the reform doubtful effects.

6. Corruption

The problem of corruption was highlighted due to work of international organisations (Transparency International and World Bank), which try to prove, especially to poorer societies, that common corruption actions materially reduce their development opportunities. Corruption in the health care sector is treated as one of types of the corruption as a whole.

A discussion on the above in Poland is based on several premises, some of which are connected with the reform, although it should be underlined that this phenomenon was present already much earlier, only it was not disclosed publicly, especially in the People's Republic of Poland.

At the beginning, we should mention that the problem of corruption does not negate patient's right to gratitude. The custom of giving flowers, sweets or even alcohol to physicians in Poland is that strong that any bans on it would constitute a act of reducing personal freedom to express one's feelings.

The problem of corruption is reflected in many other, more serious ways: (1) monopolisation of rights to develop regulations and managed the sector by groups of medical professions for their own particular benefits opposite the public sector and not submitting to external control, (2) charging informally patients with fees for services and (3) use of resources of public health sector for private purposes.

Sometimes, the corruption in the health sector is trifled. On the one hand to justify reasons for corruptive behaviours, and first of all, relatively small salaries of physicians, and on the other hand due to the fact that health service, i.e. treatment, which is a basic goal of the activity in the sector, does not suffer of that. Benefits are shared by two parties: physicians and patients (Włodarczyk 2001). The patient subjectively feels that the service is performed better, and patient's family paying

additional resources fees that they do their best for their relative. This good feeling of patient and his family disappears when the physician requests openly higher amounts, or when a high fee does not entail better treatment.

Has the health care reform intensified corruption? It seems that tensions in the health care sector increased. Open budget reductions imposed by the health care administration units and unequal pays in the health (pays in certain administration units) and public sector (e.g. pays in self-government units) and in the economy increased a temptation to charge additional fees, and gave a serious argument to justify corruptive activities.

In the debate on corruption, the medical environment is not eager to accept a thesis that corruptive behaviours of some of its representatives are harmful to public interest. Additional money flowing informally in the sector do not contribute it, but is used for consumption, usually luxurious, purposes of physicians who „take". Whereas resources of health care centres are either excessively used or egoistically saved due to needs of an individual practice of publicly hired doctors.

Radical solution for the corruption problem in the health care sector, proposed by some experts (e.g. of the World Bank) would be increase of the privatisation. Thanks to that, patients would be empowered to request their rights to be respected (because they pay openly) and social control in the sector would be intensified. For sure, to a certain extant, it would bring about an expected result. Definition of space for formal privatisation instead of maintaining spontaneous (wild) privatisation and allowing for cases of corruption is an urgent task for those who want to „correct" the reform.

Summary

In spite of a long period of the health care reform preparation, the health care sector was changing itself as it was influenced by parameters resulting from external market mechanisms: prices of medicines, prices of non-medical services and supply fees. The introduction of the reform with substantial budget reduction forced the sector to calculate costs. However, the lack of sector co-ordination in new conditions resulted in inconvenient structural shifts leading to conflicts. Diagnosing the reform failures, main experts noticed lack of definition of goals of the project (Włodarczyk 2000). The catalogue of the reform objectives was accurate („we want to be healthy, beautiful and rich"), but groups of goals were mutually contradictory and unfeasible. Was is a result of unprofessional approach, or rather hypocrisy of the environment of reformers? The answer to this question is important to define a subsequent step for changes. We cannot afford such costly and painful experiments any more.

While repairing or correcting the reform, we must appreciate the impact of specific properties of the health sector, which would generate irrational or non-ethical solutions if not regulated. These specific properties are asymmetry of professional information between a physician and patient and agency relation between them, these are also a big power of health needs and civilisation right to equal access to health care, reduced, but unquestionable[12].

Health is both a private and public good. The experience shows that definition of borders for individual and social responsibility for health is a very difficult task. The health care reform is one of the least excellent activities of many governments and practically, there has been no reform that was fully successful. Nicholas Barr said

[12] We have to admit that more and more often a principle of equal access to health care is questioned as unreal (due to high costs) and it is replaced with a thesis that it has to be divided as a challenge for near future.

that reforming is an eternal run after the Saint Graal, which does not decrease the necessity to introduce changes (Barr 2001).
Even serious difficulties may not justify lack of professionalism in the reform realisation, advantage of party interests over public interest and advantage of interests of certain groups of medical professions over others, and especially medical environment over the interest of patients.

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