

Notes on Health Sector Reform in Poland

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Introduction

Since the early 1990's Poland has been seeking political consensus on a sound strategy for transforming the health care system in the new market economy. The Harvard-Jagiellonian Consortium for Health (Consortium) has been requested to contribute views on the current health reform strategies. This note provides an overview of the Consortium's perspective, which could be expanded into a more comprehensive document if desired.

Reform in Poland's health care system is required at many levels. Financial resources are severely limited. The population's level of expectation remains high, despite years of frustration. Weak economic conditions have exacerbated health problems in an aging population. Health care providers and managers are accustomed to limited accountability, inefficiency, and powerlessness to effect change. Providers are also demanding better working conditions and compensation and currently attain these in part through private practice and informal payments.

Many hope for a dramatic solution in the adoption of a new national health insurance (NHI) scheme. The design of such a scheme has been debated intensely. In February, 1997, legislation was passed to establish NHI, with a two-year preparation period. Now, the new government is reconsidering many of the elements of that scheme. But there seems to be a widespread belief that the "right" health insurance strategy is critical to successful health system reform in Poland. An exclusive focus on the design of insurance arrangements will leave critical problems unaddressed. Even with a new insurance scheme an inequitable system segregated by income as well as geography, worsening health conditions and increased popular frustration and disappointment are still possible. These risks are greatly increased when even the "right" health insurance scheme is implemented without adequate attention to and preparation of the essential preconditions for successful health financing reform. Designing a program for reform must include therefore comprehensive strategies to assure an effective transition. This must include managing changes in four major areas: financing, provider payment, health care delivery, and consumer behavior.

- **Financing:** the capacity to collect, organize, and distribute resources for health care;
- **Provider payment:** the use of financial resources in ways to gives providers incentives for quality and efficiency;
- **Structure, function and regulation of the provision of health care services:** the establishment of modes of health care delivery which can manage resources effectively, achieve quality and satisfaction, and adapt to the health needs of the future; and,
- **Consumer expectations and behavior:** creating a new public sense of responsibility, solidarity.

Issues in Health Insurance

We note that national health insurance satisfies a strong political imperative to create a new contract between the Polish government and the Polish people. Many feel that this contract must create a system that is visibly different from the past, must break the link between the unitary state and health care, and must offer the promise of a modern health care system. We accept that such a political imperative may be a pre-requisite for any successful reform proposal in Poland today.

There has been extensive review of proposals for unitary regional or multiple public and private health care funds, as well as of related issues including contribution rates and the organization of governing bodies. We agree with many of the conclusions put forward in the recent Phare paper. In principle, we favor the original Polish legislation which establishes unitary regional health funds, with some important modifications and clarifications. Without wanting to repeat the extensive commentary that is already available on these matters, we feel the most important issues include:

- The risks of high administrative costs and regulation difficulties with multiple insurance funds;
- Inequities and financial difficulties arising from selection problems ("opting out", "cream-skimming", etc.) in enrollment in multiple funds, for which technical solutions may be insufficient;
- Governance of new insurance funds, including the need for more consumer representation; and,
- The difficulties inherent in specifying a feasible and politically acceptable benefits package.

We feel that these issues have been laid out in significant detail for decision makers in Poland, such that the positive and negative dimensions of the key choices are known.

The other areas of reform: a) provider payment, b) structure and function of health care provision and c) consumer expectations and behavior, are not sufficiently addressed in either the original law or the current legislative proposals for revision, despite the fact that they may be more critical to the cost-effectiveness of the health system than financing. Payment methods are left up to the discretion of the individual regional funds. The design of the new health system is simply described as one in which independent and sometimes private providers contract with the regional funds. Consumer issues are hardly mentioned; they are addressed largely through possible co-payments and consumer representation in the governance bodies of the health funds.

National Health Insurance (NHI) as an Engine of Reform:

NHI provides a means to raise funds for health care through mandating earmarked contributions from the eligible population or from the state for those unable to make such contributions. Since collections will continue to be done through the same state apparatus that now collects taxes, and since direct state subsidies to insurance funds are still envisaged, it is unlikely that this system will raise less money for health care, than the current state financing system. Revenue sources will be more clearly identified and the state will still be available to assure at least historically comparable levels of financing.

Indeed, analysis of health expenditure trends through the mid-1990's in other eastern European countries which have adopted NHI shows that total health expenditures have increased even when resource mobilization via insurance alone has faltered, since governments remain major

contributors (Goldstein et al, 1996). Of course, this may present a significant cost to the state and the economy and there will be limits to how far the state can go to support health insurance. Ultimately, secular growth in health expenditure should depend significantly on economic growth, as it probably would under any system during this period of economic recovery.

Financing reform, including the separation of payer and providers, as well as the creation of new performance-based payment methodologies (to be used with increasingly independent providers), are currently perceived as the hallmarks of the new system. The new payment incentives are expected to drive far-reaching changes in health care provision, including: a) improving productivity through changes in organization, staffing, and resource use; b) reducing excess use of higher cost services; and c) increasing service orientation to patients; which together will be sufficient to produce gains in efficiency and quality of care and ultimately health impact. This expectation rests on substantial assumptions, which are not borne out by international experience.

Consider the experience of the Czech Republic. Many health system reformers in that country, as in Poland, expected that gains in efficiency and effectiveness would lead naturally from three major structural changes: a) pluralism in financing, b) increasing "independence" or privatization of provision, and c) incentive-based payment methods linking the newly separated payers and providers. Social health insurance was established in January, 1992, and this step was immediately followed by moves to privatize health care provision. By the end of 1993, 85% of all health care facilities in the Republic were under private ownership. Privatization moved rapidly in primary care, with "90% of general practitioners and 70% of pediatricians and adolescent care physicians" in private practice by that time (Filer et. al, 1995). Hospital ownership took on diverse forms with local governments and individuals, as well as other entities holding title.

Privatization of financing in the Republic began simultaneously in 1994. By the end of 1994, in addition to the state-owned General Health Insurance Office (GHIO), there were 18 separate private insurance companies. A largely fee-for-service payment system was established combining a relative value scale or "point" system for labor and overhead costs but allowing for direct cost reimbursement for material costs, such as drugs. The GHIO established the scale and a standard point value, but private insurers have been allowed to pay more or less than the GHIO point scale.

The results of this system should be enlightening for those planning similar reforms. The newly privatized providers faced strong incentives to increase output and even stronger motivation to be generous in their use of directly reimbursed material inputs. There were no substantial regulatory checks on this process, since providers were independent and insurance contracts promised benefits. Cost escalation was rapid, bringing the Czech Republic's health spending from 6.5% of GDP in 1991 to 9.5% of GDP in 1995 (Goldstein et al, 1995 and World Bank, 1997). The state was forced to subsidize rising expenditures and several private insurers went bankrupt.

In one sense the Czech Republic's rapid shift to NHI was successful. It created a viable and productive health care provision sector almost entirely outside of government administration. It also rapidly created the capacity to satisfy the population's demands for access and quality, which had been repressed in the previous public system. However, without sufficient checks on demand and utilization the inevitable result was steep cost escalation. Retrenchment at this later date is increasingly difficult, since both providers and patients are now expressing new levels of entitlement. Lack of action now to reduce costs, however, carries large risks for a country seeking to thrive in an increasingly international market.

The message from the Czech experience is to pay close attention to the details in health care delivery which can provide incentives for cost control throughout the multi-layered health system. Poland has been experimenting with a variety of approaches to address both cost and quality issues over the last five years. But these efforts have been at the local (gmina or voivod) level,

modest in scope, rarely evaluated, and have been largely ignored in developing the new NHI legislation. Indeed, the local units of government which have led the way in these experiments are being sidelined to make way for the new insurance institutions. This is ironic just as legislation is introduced re-establishing poviats local government entities. The poviats promise to extend to rural areas the advantages in health service delivery that large cities have offered up until this point in time.

Creating The Conditions for Successful Health Financing Reform

For health insurance to successfully promote efficiency and equity in the health care system, it must provide adequate resources in an environment which enables the health care providers and consumers to respond in the desired way, that is in ways which increase quality of care, consumer satisfaction, and health outcomes, as well as efficiency. Health insurance is a powerful force for behavior change, through the financial incentives embodied in the payment system. But it must be complemented by certain essential conditions which enable its efficient operation. We would include in these conditions the following:

- **Authority:** whether the actors, mainly the provider organizations, have the legal and organizational basis for responding to the new finance environment;
- **Accountability:** whether managers and providers are held responsible for their performance;
- **Capacity:** whether there exists the necessary factor inputs, such as staff, buildings, equipment, supplies, to respond adequately;
- **Capability:** whether the regulators, managers, service providers, and patients have the knowledge and skills to respond appropriately; and,
- **Information:** whether there exists the necessary information to enable regulators, payers, providers, and consumers to respond rationally.

For many of these conditions, there still exists great uncertainty in Poland. Our thesis is that insurance by itself will not address these sufficiently to achieve the goals many have for health sector reform.

Poland has already invested considerable, although insufficient effort in developing new legislation, institutions, and practices to address the gaps in these essential conditions. We would cite the following as examples:

- Independent Unit legislation and the initial steps to create and operate independent units as hospitals and ZOZs in late 1996 and 1997;
- Decentralization of ownership, financial, and management authority to Gminas (for primary care (and in some cases) hospital care) and Voivods for many other services;
- Development of extensive, but poorly documented and regulated, private ambulatory medical practices for both general and specialist services;
- Development of "family doctors", a new model of general practitioner for primary care delivery;
- Payment, contracting, management and public health innovations at the local level, in areas including Koszalin, Krakow, Suwalki, Szczecin and Posnan; and
- New patient-level information bases, such as "RUM".

In nearly all of the above listed cases there has been little evaluation, and little linkage to ensuing policy formulation. Consider two examples from the Harvard-Jagiellonian project: First, in Krakow Voivod, four hospitals were transitioned into "independent" units in the first wave of such transformations during 1996. The hospitals selected were not large general hospitals, but

rather smaller specialized facilities with little range in output. Initial contracts were written largely to preserve current practices, not to change them. This conservative approach is understandable, perhaps even wise in the current environment, but it offers little promise of the significant cost containment or improved productivity, quality, and satisfaction expected to result from a system-wide shift to independence and contracting in 1999. Second, Suwalki Voivod is perhaps the most advanced in Poland in terms of contracts for primary care providers and dentists, with a large number of providers now under contract. Yet there has not yet been a careful assessment of this large experiment; at this time we do not know the impact of these contracts upon the financial solvency of payer and providers, the volume of services provided, clinical quality, or patient satisfaction. Our studies suggest, however, that such experiments benefit from substantial cost-shifting and demonstration effects that will not be available when the application is general.

In other cases, not only have local experiments in health provision not been adequately evaluated, but they have also not reflected painful lessons learned from international experience. As indicated above, most experimentation with providers has focused upon the nurturing of autonomy, i.e. the development of "independent" units and private physician practices; an initiative, which when added to an earlier decision to shift outpatient primary care from voivodships to large cities, has led in effect to the breakup of previously integrated systems of care.

First, it is not clear to what degree managers in many of the newly "independent" units have had real autonomy in the critical areas of financial and human resources, as the example described above from Krakow indicates. Second, two elements of this strategy are striking to students of international health system reform. First, a *more* atomized delivery system is likely to result in health facilities competing with each other to maximize volume; an incentive structure which conflicts with the payer's need to reduce unnecessary use of specialists and hospital stays. Second, experience internationally has increasingly led other industrialized nations, including the U.S., to emphasize integrated (primary, specialized, and inpatient resources) systems of care delivery as a means to improved quality and efficiency. This thrust has paralleled an increasing shift from inpatient to outpatient care as the preferred (less costly) locus of delivery, and the development of new medical technology further enabling this transition. Consider the development of "fund-holders" in Great Britain as one well known example of physician "gate-keepers;" their function is to rationalize care decisions at the fundamental doctor-patient level. Gate-keepers cannot operate in an atomized system of care.

Another issue deserving much more attention is the development of private medical practice. It has been estimated that about 30% of Polish physicians already engage in at least part-time private practice. In addition, a recent Consortium study reported a much higher level of informal payments in hospitals and clinics than was previously estimated. These findings suggest that Polish health care may already be more privatized than currently thought. There is much more money flowing into the system than is suggested by public expenditure figures alone. Providers in public facilities already face complex incentives between their public and private roles.

These conditions will alter the impact of insurance financing, especially if the new model includes payments for private providers. Physicians in multiple practice roles currently face incentives to reduce their public provision activities (because they are most commonly paid on a straight salary basis) and to enhance volume in their (fee-for-service) private practices. Increasing money flows to private practice, especially in ways that provide incentives for increased utilization, will only exacerbate this phenomenon. Public services can be expected to experience further declines in quality. Overall, poorly managed health insurance could drive rapid privatization of primary and specialized physician services in Poland. If payments and regulation do not keep pace, this could have extremely negative effects in efficiency and equity.

Looking Beyond Health Insurance: Strategies for Transition:

The Harvard-Jagiellonian team recommends that the government of Poland take a multi-phase approach to health sector reform, and that the four key elements (financing, organization, regulation and management of health care delivery, provider payment, and consumer behavior) be addressed in a comprehensive manner in each phase. Our proposal reflects the perception expressed throughout this paper that the structure of health care financing is not the only, and perhaps not the most important, determinant of the performance of health care in Poland over the next 5-10 years. Rather, we would argue that the largest and most immediate gains in efficiency, quality, and health will result from reforms addressing the other elements. To achieve rapid improvements in health and health care in Poland, these issues must receive higher priority than they have to date. In addition, they are essential preconditions for successful reforms in financing, without which Poland faces significant risks of cost inflation, decreasing equity, and popular dissatisfaction.

Financing: In (at least) the first phase we support the notion of unitary regional funds. Whether these should initially be financed out of tax revenues or earmarked wage-based contributions we view as a largely political decision initially, since in any case government will be called on to assure at least historically comparable levels of financing. The proper functioning of an equalization fund, operating across regions, will be important. More critical, however, is the recommendation that regional funds be utilized as the main vehicle for promoting and supporting reforms in payment and provision, as well as in health care delivery through a locally-determined mix of existing and new organizations and structures.

Structure and function of health care delivery: Our proposed flexible approach would promote gminas, poviats, voivodships and potentially other administrative units to play a variety of roles under the governance of the regional fund. Health sector reform, after all should reflect the country's new emphasis and initiatives on local self-government. For example, local government could act as a financing intermediary, receiving a capitated payment for a defined population, and acting as a payer to independent public and private providers on behalf of that population. This proposal is directly aimed at the serious problems referred to earlier inherent in systems that separate in financial and organizational terms the multiple levels of health care services. To some extent this integration is already taking place in certain voivodships and municipalities. Local governments could also determine the mix of public and private ownership of provision that would be feasible and effective in their respective areas. Alternatively, local government could act as the manager of an integrated provider organization, receiving funds and using internal market mechanisms to provide incentives to its own providers for care of the population. In both cases, our proposals are designed to increase the potential for integrating public health, primary, and higher level care for a defined population.

We are suggesting that the new Polish health system should be designed concurrently from both horizontal and vertical perspectives, and with proper scale in mind. On the financing side the new regional funds will slice the system horizontally, and the population covered by each fund will have to be large enough in order for its insurance or risk-sharing function to work properly. On the provision side of the system, however, vertically-organized (from primary through hospital care) structures appear to lead to the greatest cost-effectiveness. These latter structures, however, function best when operating with relatively smaller populations and in competition with other similar vertically-integrated organizations or networks. These integrated systems can be operated by the local governments as mentioned above, or could be employer or government agency (railroad, military)-based.

The more flexible approach outlined in this paper could be viewed as a cornerstone strategy for Poland's health care transition. It is a transition from an integrated, but bureaucratically regimented system of state provision and a widespread and relatively unregulated private sector. It is a transition to a system that responds to local initiative, but allows different patterns of ownership and management to emerge, in response to finely tuned incentives. The ability of

health funds and government to monitor and regulate this transition will of course be essential, and far from simple. Over time, authority will be clarified, capacities and capabilities will improve, and increased information and regulatory capacity will allow the development of appropriate standards for certification, payment, and quality. The transition will blend the current state and private sector into a new mixed sector, without prejudging the balance or the mix.

Provider payment. As we propose a flexible approach to regional fund arrangements with local governments organizing local delivery of care we also think it highly beneficial to encourage concurrent experimentation with different payment methodologies. Equally important will be a significant effort to monitor and evaluate the effects of different payment regimes. We favor the development of capitation-based payments, possibly blended with bonuses for productivity and quality, for primary care providers. We also would like to see integrated providers operating under capitation, including both primary and specialist care and acute hospital care. For hospitals, we hope to see development of a simplified DRG-type payment system, perhaps of the type utilized today in Hungary. The high-end hospitals might be financed through a global budget. We also favor more experimentation with quasi-market incentives, which might operate within independent integrated ZOZs or gmina/municipal health care departments, who in turn may be paid by capitation. All of the above proposals stem from a core concept, that money should follow patients. The facilitation of patient, (or consumer) choice, should be another cornerstone of payment reform.

In combination properly designed systems of health provision and incentive-based payment mechanisms lay the foundation for the sort of wide-scale improvements in management that are needed to avoid a continuation, even steady worsening, of cost control problems. Pharmaceutical management will always be a special concern. Only the proper incentives and decision-making structures can effect the required changes in thinking from the level of patient-provider interactions to decision-making at the highest levels of management. Economic rationality must be very carefully injected into the system without adversely affecting the quality of or access to care.

Consumer behavior. This topic, perhaps the most critical to containing costs, has received the least attention. In the first phase we concur with proposed legislation that permits the use of co-payments. Co-payments are important mechanisms for limiting inappropriate over-utilization of scarce and expensive resources. If designed and implemented appropriately they can have a large impact upon cost-containment, while at the same time avoid adverse effects upon equity. Consumer behavior will be heavily affected by the nature of the relationship with primary care providers. We strongly support initiatives which strengthen this relationship.

Conclusion

This brief note is intended to introduce some new perspectives into Poland's national health reform debate, not to lay out a comprehensive and detailed strategy for change. The Harvard-Jagiellonian perspective is driven by our focus, these last three years, on the payment-provision-consumption side of the health care system. Our experience tells us that the current debate on national health insurance has given insufficient attention to the essential means needed to make insurance work. We propose an approach which will open the door to much more rapid development of those means.

We are most anxious that Poland gain from international experience and not repeat the mistakes of others, including its neighbor, the Czech Republic which was referred to earlier. Poland can certainly rapidly create an insurance-based financing system with largely privatized health care provision. There are some who feel that this is the optimal strategy for change. It would quickly incentivize providers, it would be a clear break with the past, and it would resemble some of key features of systems that are admired in western Europe. But there is also a high risk that this strategy would impose dramatic new cost burdens on the country and increase inequity and inefficiency in health care provision. We believe that a more flexible approach, and one which responds to the leadership of local government to have a better chance of capturing some of the very positive elements of Poland's current health care system while avoiding some serious dangers.