



Quality in and Equality of Access to Healthcare Services

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Country Report for Poland

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CONTENTS

Abbreviations	6
1 Introduction	7
1.1 Country profile	7
1.2 Promoting social inclusion through policy action at the system level	12
2 Major barriers of access to health services	19
2.1 Introduction	19
2.2 Population coverage for health care under public health insurance	20
2.2.1 Ways of staying uninsured	22
2.2.2 Mental health protection system	24
2.2.3 Access to health care of foreigners	30
2.2.4 Health protection for immigrants – legal basis	34
2.2.5 General comments on issues of health protection for migrants in Poland	38
2.3 The scope of the health basket	39
2.4 Cost-sharing requirements of health services	41
2.4.1 Legally demanded co- payments	42
2.4.2 Access limitation evidence due to individual payments	43
2.4.3 Direct expenditures of households	45
2.5 Geographical barriers of access to health services	47
2.5.1 Rural – Urban differences	53
2.6 Organisational barriers	56
2.6.1 Practical nuisances in getting access	59
2.7 Supply side responsiveness	66
2.8 Health literacy, voice and health beliefs	66
3 Improving quality of and access to health care for people at risk of poverty or social exclusion: elderly people with functional limitations	70
3.1 The scope of the elderly population with functional limitation	70
3.1.1 Social insurance for the elderly and disabled people	71
3.1.2 Epidemiological profile of the elderly	73
3.1.3 Expenditure on the provision of healthcare to the elderly from health insurance funds	74
3.1.4 Use of healthcare services by the elderly	75
3.1.5 Access to health care for older people with functional limitation	76

3.1.6	Interface problems between health and other social services for older persons _	80
3.1.7	Conclusions concerning the healthcare policy in relation to the elderly with functional limitations. _____	82
4	General conclusions _____	84
5	References _____	87

Abbreviations

CBOS	Centrum Badania Opinii Społecznej – Center for Public Opinion Studies
CSI OZ	Centrum Systemów Informacyjnych Ochrony Zdrowia - Centre for Health Information Systems
FUS	Fundusz Ubezpieczeń Społecznych – Social Insurance Fund
GUS	Główny Urząd Statystyczny – Central Statistical Office
IFiS PAN	Instytut Filozofii i Socjologii Polskiej Akademii Nauk – Institute of Philosophy and Sociology of the Polish Academy of Sciences
IPiSS	Instytut Pracy i Spraw Socjalnych – Institute of Labour and Social Studies
KRUS	Kasa Rolniczego Ubezpieczenia Społecznego - Pension Fund of the Agricultural Social Insurance Fund
KUP	Krajowy Urząd Pracy – National Labour Office
MPiPS	Ministerstwo Pracy i Polityki Społecznej – Ministry of Labour and Social Policy
MONAR	Foundation for Drug Dependent Persons
NFZ	Narodowy Fundusz Zdrowia – National Health Fund
NSIS	Narodowa Strategia Integracji Społecznej – National Strategy of Social Integration (Inclusion)
NSP	Narodowy Spis Powszechny – National Population Census
PARPA	Państwowa Agencja Rozwiązywania Problemów Alkoholowych – State Agency for Prevention of Alcohol-Related Problems
URiC	Urząd ds. Repatriacji i Cudzoziemców - Office for Repatriations and Foreigners Affairs
ZAZ	Zakład Aktywności Zawodowej – Professional Activation Centers
ZOZ	Zakład Opieki Zdrowotnej – Healthcare Centre
ZUS	Zakład Ubezpieczeń Społecznych – Employee Social Insurance System

1 Introduction

1.1 Country profile

After the Second World War, in Poland the solutions of the health care system organization was discontinued in comparison to the status from before the war. Prior to 1989 the Polish health care sector was a part of centrally planned state economic system organized as a public integrated, funded from general taxation system, sometimes called as the Soviet Siemaszko's¹ model. The concept of Siemaszko was founded on the following premises:

- central authorities are responsible for health;
- access to health care services is universal and free-of-charge;
- there is prevention against the so-called 'social diseases';
- provision of health care is based on high quality medical professionals;
- there is a very close link between medical scientific research and practice;
- preventive, curative and rehabilitation services are integrated.

That model appeared to be effective at the early stage, in the epidemiological context, which was dominated by infectious diseases. At the next stages of development, with civilization diseases, diseases connected with ageing, it became unadopted and chronic under financed. Despite similar conceptual frames, its shape in particular communist countries was diversified; depended on a level of economical development of the country, to some extent on institutional tradition and cultural factors, but also a way of development of the socialist system in the particular country, which was also not identical. As for Poland, where always significant part of the economy remained private (mainly in agriculture), there was developed a model of private and, so called, cooperative medical practice.

¹ Mikolaj Siemaszko (Semashko) was a Russian physician and politician (1874 – 1949), the first health commissioner in the USSR, who designed a vision of health care operations within the framework of centrally planned system.

Private and cooperative practices of specialist physicians in Poland were established as an offer for the peasant population, which was operating in the private sector and, as such, had no access to state health care. From the end of 1960's, peasants were gradually acquiring the title to social insurance and health care after the farm was transferred to the state treasury. Total equality of rights to health care services was introduced in 1990. In the course of time, cooperatives of specialist physicians have evolved into a channel of access for inpatient care unit of choice (which employed the specialist who was providing health care services in the cooperative as well) for everybody who could afford to pay for this (Golinowska, Tymowska 1994).

Those times, despite declared full and equal access to health provision, in reality it was limited by establishing, so called, catchment areas, or significantly enlarged for some privileged groups of people. Those sub-systems were better developed and better equipped than generally available sector of health care. In the course of time, industrial health care (selected branches of industry) has also developed its own hospital care, as well as rehabilitation centres and sanatoria. Furthermore, such closed sub-systems (parallel systems) of health care were established not only by particular industries, but also by some branches of services, e.g. the railways, the military, the police and central administration. While the presence of the 'islands' of industrial health care was justified by the ideological dogma of the leading role of the working class and its extraordinary merits in country development, in the case of central administration and the so-called 'military' services their privileged access to health care was kept hidden behind the 'yellow curtains'. Other feature of the Polish healthcare system was, as a so-called non-productive sector (in Marxist terminology), its permanent under financing, resulting in low infrastructure standard of the premises and low wages of personnel. Medical professionals used to compensate their low incomes with work in many different places, including private sector practices, and also accepting informal, so-called gratitude payments from patients, called in Poland *proofs of appreciation or expression of gratitude*.

The disintegration of the socialist order in the end of 70. significantly affected the health care system. The creation of the independent workers union

Solidarity, with strong group of healthcare workers, caused that growing discontent of the public with the level and quality of care created not only a necessity, but also an opportunity for discussion. Various ideas were offered for curing the "sick" system, either through limited reforms or through a radical modification (Włodarczyk 1998).

The key factor in the forthcoming evolution of the health care system was the Health Care Institutions Act of August 1991, which introduced a formal separation into service providers and fundholders, emphasizing the right of different, not only public, institutions and organisations, to create health care units and increased the range of independence of integrated health care units, even those that formally remained under the control of public authorities.

Over the years of economic transition, the health care system has twice been subjected to radical changes: in 1999 and in 2003. In 1999 health insurance was introduced in place of budget (general taxation) financing, complemented by a system of 16 regional and 1 occupational health funds and so-called internal market principles (with competition possibilities between providers based on contracts from the health funds) . According to the Law of Universal Health Insurance, Health Funds had to sign contracts with health care units . Regional Health Funds covered particular voivodships (administrative regions) populated by 1 to 6 million people. Since the year 2000, there were no legal barriers for the Health Funds to extend their activities to other regions. Citizens were free to choose the Health Fund irrespective of their place of living.

For four years (1999-2002), the health care system was functioning according to those principles. The health care reform met with mass-scale criticism of medical communities, patients and opposition politicians who had declared already back in 2000, that the system would be changed and this they have done after assuming power. Although problems were being gradually overcome and the new organisational system was slowly "falling into place," in 2003 health funds were abolished and payer functions centralised, with the creation of a central fund – the National Health Fund (NFZ) and its 16 regional branches in respective voivodships (regions).

The process of recentralization of the system lasted 2 years and was burdened with a lot of technical problems and shortcomings. It would be enough to say that in the period from 2001 until 2005 there were 6 (six) Ministers of Health appointed in row, and the Health Insurance Act was completely re-written twice, one being after the intervention of the Constitutional Tribunal. One of the reasons declared by the Tribunal as a legal failure of the law was the lack of defining “*conditions and scope of services ...*” to which an insured person is entitled under the health insurance law.

The recent developments of the system, only partially realized, in most part yet planned and prepared, involve definition of explicit benefit package, which main goal is to create legal certainty for patients and professionals what is included in the scope of benefits of the public system, and what not. This work is associated with reassessment of the waiting lists system, which introduced in 2003, did not fulfill expectations, among others did not provide a feeling of security and trust in accessing health care. Still, physicians are being accused for misusing their power to determine time of service provision to achieve personal benefits. Additionally there is a plan to come back to build a nationwide network of public hospitals with two aims: to ensure equitable access to health services from geographical point of view and at the same time to limit the number of acute hospital beds and introduce rigorous planning in hospital development process.

From health services access perspective it is important to indicate a new law on National Medical Rescue Service (2006)². Aim of the new law was to guarantee proficient and effective realization of state’s assignments related to medical rescue operations towards every person in a state of emergency, i.e., when any postponement of medical assistance could cause loss of health or loss of life. In confines of medical rescue operations taken by unit of medical rescue service, the so-called health pre-hospital services are provided. According to the Law, the system of first-aid services includes executed of various assignments depending in particular on:

² Law of 8.09. 2006 on National Medical Rescue Service (Letter of Issue 06.191.1410)

- the possibility of making an immediate call for help using means of communications
- the immediate arrival of medical rescue service unit on location
- the immediate taking of proper medical rescue operations on location
- organizing of transportation which is suitable to needs
- organizing immediate admission to the closest hospital or emergency or hospital ward proper to the kind of emergency

Health pre-hospital services are funded from the state budget from the part under disposition of the regional governor (regional representative of central government), on the basis of contracts concluded with units' administrators (units of medical rescue services). Every person is entitled to receive the service free of charge.

In-Hospital rescue operations are funded from the National Health Fund and are regulated similarly to whole insurance regulations. Among others, services have to be covered by the insurance fund. In case of immigrants not having any insurance, there are claims issued by the hospital hoping to receive reimbursement of funds, which however often is not covered.

Total spending on health care according to some experts estimates (MZ 2004 and GUS 2006c) constitutes over 6.6% of GDP and public expenditure - around 4.15% of GDP.

If we evaluate the real growth of public expenditure based on an index of prices in health care, which in the last 10 years was higher than the consumer price index, we will see that there was no increase in real terms. Therefore public expenditure has not increased in real terms since 1996. Meanwhile, if we look at the structure of expenditure, there is a clear upward trend in spending on medicines, which began in 1998. Spending on out-patient care was also rising faster than the overall expenditure .

In the 1990s the share of private expenditures increased. The reasons of this increase are complex. Firstly, expenditures increased due to growth of access to expensive pharmaceuticals that dynamically entered the Polish market.

Secondly, private sector medical institutions offered to higher income strata more luxurious and expensive treatment. Finally, private payments for services provided in the public sector were continued. Out of pocket payments include not only direct payments to medical staff, but mainly payments for medical institutions (via foundations and gifts). Also employers co-finance medical treatment for their employees by assuring basic basket of services provided by public or private institution. Scale of this phenomenon increases in the last years. Based on data from a so-called modular household survey, GUS estimates that households are already financing 35% of the health care system in Poland (GUS 2006). This is a substantial figure, ranking Poland high among EU countries in this regard.

1.2 Promoting social inclusion through policy action at the system level

Poland and other new member states entered the OMC when the social inclusion and pension strands were already implemented by the old member states. First National Action Plans on Social Inclusion were to be submitted by EU-10 member states already in August 2004, only a few months after the accession to the EU.

In order to prepare Poland for the full participation in the OMC, the Commission launched the process of preparation of Joint Inclusion Memoranda (JIMs) that were mutually agreed documents between acceding country and the European Commission. However, the role of the JIM was to present the current policy of the country in the light of the Nice and Leaken objectives, rather than formulating policy priorities in the future.

First National Action Plan for Social Inclusion for Poland was submitted in July 2004 and covered the period between 2004 and 2006. From 2006 both new and old member states prepare their NAPs/Inclusion in the framework of integrated reports, covering the same period.

Preparation of all three documents for Poland is also embedded in the national context. Namely, in 2004 a National Strategy for Social Inclusion (NSIS) was prepared. The strategy was prepared by the broad Taskforce, encompassing the representatives of government, local governments, social partners, non-governmental organisations and international institutions. The strategy formulates long-term recommendations for social integration policy in Poland. As the strategy covers the period until 2010, it points out the strategic directions that are followed in the National Action Plans.

Chart 1. Interactions between NSIS and OMC reports in Poland



In the framework of the strategic goals formulated in the NSIS, the National Action Plan for Social Inclusion for 2004-2006 formulated four main priorities:

- educational, social and health activities protecting against exclusion and supporting equal start of children and youth;
- further development of social safety net, fighting poverty and exclusion;

- activation and integration of groups threatened with social exclusion;
- development of public social service and institutional development of social services and their co-ordination.

The first NAP/Inclusion followed the objectives and targets formulated in the NSIS.

As a part of the OMC process, the European Commission prepared an assessment and recommendations for Poland, based on the submitted National Action Plan. The challenges formulated by the Commission in 2005 Joint Inclusion Report were as follows:

- to reverse the very negative employment and poverty trends by defining a policy framework encompassing social inclusion priorities and employment creation measures;
- to improve access to the labour market of people with low qualifications, young unemployed persons and people with disabilities;
- to step up administrative capacity, strengthen social policy institutions and improve policy coordination at local level;
- to provide adequate support to large families, families with disabled children and promote affordable housing for low/moderate income households;
- to consolidate the reform of the pension system, notably by organising the conversion of funded pension savings into safe annuities, addressing the issue of raising employment rate of older workers and equalising retirement age conditions for women and men.

After the assessment performed in 2006 it should be noticed that not all of the actions were implemented as planned. It is difficult to assess the implementation of the NAP, as the evaluation table prepared for monitoring could not be followed. The main difficulties were as follows (Chlon – Dominczak 2006):

- lack of ranking of the indicators;
- lack of target values for the indicators;
- not always adequate matching of activities with priorities and indicators with activities;
- inadequate choice of activities.

The National Action Plan for Social Inclusion for 2006-2008, prepared within the framework of the new strategic document: National Strategy Report for Social Protection and Social Inclusion (NSR) builds on the experiences from the implementation and assessment of the first NAP. It also pursues to continue actions initiated in the period 2004-2006. Following the common guidelines for the preparation of the NSR, there are three main priorities formulated in the NAP/Inclusion that are sub-divided into specific actions.

The first priority is the support for families with children. Within this priority, three actions are planned:

- Development of the integrated family support system, including:
 - family support programme before and after childbirth;
 - development of actions supporting families helpless in respect to care and education issues;
 - development of social housing;
 - development of civic and family counselling.
- Development of the income support system, including the revision and further development of the following:
 - Family benefits system;
 - Scholarship system;
 - System of housing benefits;
 - Food support;
 - Changes in the tax system.

- Supporting reconciling work and family life, through:
 - improvement of the social security of employees after childbirth;
 - development of care services;
 - promotion of flexible forms of employment for parents and guardians.

The second priority is the inclusion by activation. This priority focuses on activating social policy measures that lead to the social inclusion through activation of individuals at risk of social exclusion and their integration with the labour market. This priority includes the following actions:

- Reform of tools and instruments for active inclusion:
 - Activating formula of social welfare benefits;
 - New application of social tools;
 - Instruments for active inclusion;
 - Activation and inclusion of the disabled.
- Development of the public-social partnership:
 - defining the term of public utility social services;
 - unifying the procedure for contracting public utility social service tasks;
 - improving the effectiveness of co-operation between public entities and non-governmental organisations in the performance of tasks.
- Development of the social economy institution.

The final priority is related to the governance structure and is called mobilisation and partnership. This was a common goal for all strategies and plans, including as well health care sector issues.

The European Strategy on health care in the framework of Open Method of Coordination was established relatively late in comparison to the inclusion and pension strategy (not till than 2004). It was decided that the Open Method of

Coordination would in 2005 also be applied to health and long-term care. The Member States presented preliminary reports covering *the challenges facing their* healthcare systems, current reforms and medium term policy and long term care issues by March 2005."

Polish National Action Plan on health and long-term care as part of the NAP mentioned above (adopted by the Council of Ministers on the 9th October 2006) based on common principles in this area: availability, quality and financial stability, includes 4 strategic and 16 operational objectives, as well as the description of actions aimed at their achievement: These are:

- Enhancing health safety of the society:
 - development of the medical rescue system;
 - preventing adverse health effects of exposure to hazardous physical, chemical and
 - biological factors in the environment;
 - preventing food safety risks through the implementation of biological indicators of
 - risk assessment, including the monitoring of chemical contaminants;
 - preventing adverse health effects of exposure to hazardous environmental factors in water intended for human consumption.

- Increasing the effectiveness of the health care system:
 - maximising health benefits through improved effectiveness and quality of medical treatment,
 - reducing information shortage in the area of health policy development (creating data bases on health services and their costs, collecting epidemiological information, e.t.c.)
 - introducing market elements to rationalise the demand for healthcare services,
 - optimising the use and costs of medicinal products,

- investing in health care infrastructure.
- Adapting health care to the dynamics of long-term demographic trends:
 - improving health of women of childbearing age, newborns and infants,
 - improving health of children and young people,
 - providing adequate care to people of working environment,
 - providing adequate care to elderly people, and extending the period of their
 - psychological and physical efficiency and capacity for fulfilling appropriate social roles.
- Improving the health of the Polish society to the extent that reduces the distance between Poland and the average health condition in the European Union:
 - implementing the updated National Health Programme, 2006-2015,
 - strengthening the participation of the society in activities which enable the
 - achievement of the objectives included in the National Health Programme, 2006-2015,
 - reducing the incidence of, and mortality from chronic non-communicable diseases.

The two first objectives of the Polish National Action Plan on health and long – term care address general and fundamental problems of the Polish healthcare system, which faces significant difficulties in provision of adequate access to health services, as a result of budget constrains and low efficiency in management. .Two other objectives are linked to other parts of the NAP for the years 2006-2008, connected mainly with inclusion strategy. They involve aims related to youth health, where some access barriers also occur, aims related to healthy ageing and decreasing geographical differences in access to care. The last of the “inclusive” aims is a consequence of implementing National Health

Programme for years 2006 – 2015, where decreasing geographical differences in access to care is a priority. Implementing inclusive aims of NAP for 2006-2008 does not have however, high priority in governmental and other stakeholders actions in Poland, what is a result of dramatic needs to improve functioning of health sector in Poland, in general. The inefficiency of the system at this stage may hamper health security.

2 Major barriers of access to health services

2.1 Introduction

According to declarations establishing the right to health care are part of Article 68 of the Constitution of the Polish Republic (1997) every individual has the right to health protection. All citizens, regardless of their material status, are guaranteed by the government equitable access to health care financed from public funds. The conditions and range of services provided are determined by relevant legislation.

Potentially, lack of insurance may create a barrier of access. In some moment of time, Polish legal regulations omitted some categories of people in coverage, but gradually this barrier was eliminated. In practice, a problem occurred of limitation in access for those who did not pay their premiums, because of lack of incomes and unemployment. Gradually also this problem is regulated, although still some individual problems happens.

Polish Constitution, declaring equal access for all citizens, does not guarantee access to ALL services and goods, but only to those financed from public sources. This creates a necessity of defining scope of services and goods, guaranteed by the State and financed from public sources. A scope of exclusions (negative benefits package) from public financing was defined in 1999, and currently the government works on a *positive package*.

A practical access problem is caused by limited financing from public sources, governed by National Health Fund (NFZ), which determines, so called, limits of

admissions/encounters. Patients facing this problem, either use private sector, or get to the waiting lists system. Organization of the waiting lists system, practical use of it, methods, scope and value of informal payments for passing the queues, are not properly recognized, yet. This is due to the fact that official waiting lists system was introduced in 2004 and only recently some systematic assessment was performed³. Nevertheless, it is commonly perceived as one of the most serious access problems in the country.

Some barriers are created by differences in geographical distribution of the system resources, worsened during transformation period, as a result of regional and local differences in economical development. Some barriers caused by regionalisation of responsibility for service provision, which persisted in the past, was overcome by introduction of legal changes.

Enlisted barriers, potential and practical, are presented in details further on.

2.2 Population coverage for health care under public health insurance

Universal Health insurance covers⁴ almost all Polish citizens resident in Poland as well as foreign persons resident in Poland who have a working visa, permanent or temporary residence permits if they have to be insured or insure themselves optionally. No health insurance contributions are payable for family members of insured persons (e.g. children and spouses) if there is no obligation for them to be insured separately. After many modifications, the list of persons who have to be insured includes several dozen social groups, starting with hired labour, farmers, private entrepreneurs, the unemployed, pensioners and recipients of various social benefits (like beneficiaries of “withdrawing from homelessness” program), ending with officials of various state services and

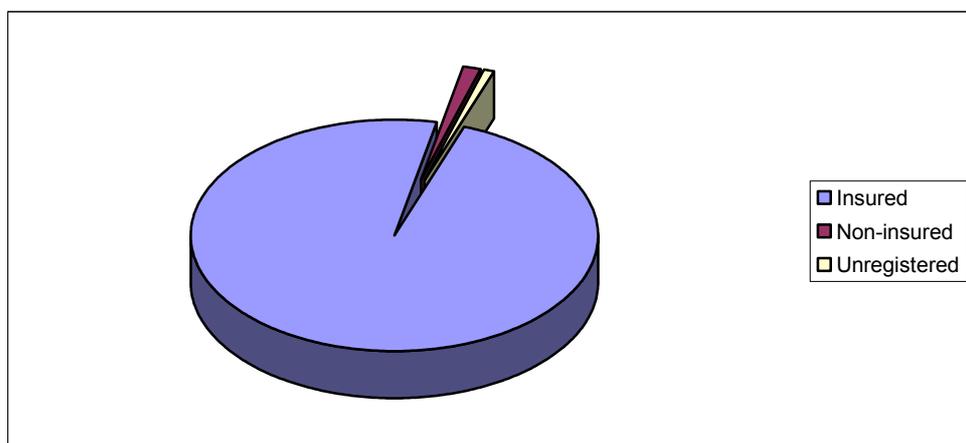
³ The assessment was done by a team formed by the Institute of Public Health, on request of the Ministry of Health,

⁴ In this subchapter there were materials from Mapping Health Services Access: National and Cross-Border Issues (HealthACCESS), under EC Public Health Programme 2004 (Kozierkiewicz A ed.) used

forces. Although persons exempted from universal health insurance can insure themselves on their own accord, frequently they choose not to do so. This regards mainly relatively young people, working as free-lancers or in other non-systematic way, leaving Poland or just returning, who do not care much for proper health insurance status.

According to the information, delivered by the National Health Fund⁵ in 2005, there were 37 376 734 persons (97,9%) registered in the NFZ data bases, as active insured (population: 38 180249). There were 512 087 people who were registered as “non-insured”. Taking into account public register data, from the middle of 2004, there was a difference of 291 428 persons, who theoretically could be non-registered. This figure however, may be lower, since population is decreasing recently, among other due to migration to other UE countries, and the overall population of Poland in may 2005 might be a little lower then a year earlier.

Chart 2. Population, insured and uninsured in Poland, 2005



Source: own calculations based on data of GUS 2005 and NFZ 2005

⁵ Information on request of the researcher, provided by J. Miller, a President of the National Health Fund, in letter nr NFZ/CF/BI/05/05/0047 dated 27 of May 2005.

Under the term “insured” the NFZ understands overall population of people registered for insurance by employers (premium payers) and family members, for whom there is an active registration in the National Health Fund (NFZ), made by ZUS or KRUS⁶, or there is a premium registered for the recent 3 month (excluding current month).

Under the term “uninsured” the NFZ understands overall population of people, for whom there an active registration in the National Health Fund, made by ZUS or KRUS, is lacking and there is not registered premium for the recent 3 month (excluding current), and the persons are elder the 18 y.o. (since the younger persons are insured automatically).

2.2.1 Ways of staying uninsured

From the interviews carried out with the employees of the National Health Fund (NFZ)⁷ it appears that only a small number of people possibly does not have covered by the health insurance. People belonging to the groups obliged to take out the insurance, are insured by the particular institutions to which they are affiliated or on they do it themselves (as self-employed). People without this obligation may join the insurance on their own, if they wish. In case they can not afford it, they can turn to the appropriate health care service and on the specified conditions be categorized as ‘beneficiary’, what means they *benefit* from the system, although they are not insured. Costs of their treatment are covered by public funds in one of a number of ways.

The basic step to take out the health insurance is an application for insurance – filling in the appropriate administrative forms from Social Insurance Institution (ZUS) and Agriculture Social Insurance Fund (KRUS). The application is noted down in the Central Data Base of Insurees that is the NFZ information system built on the basis of data collected from ZUS and KRUS. The system stores the patients’ personal data and their identification number (PESEL). Next to the application the prompt payments of insurance premium are necessary.

⁶ ZUS (Social Insurance Fund for employees), KRUS (Farmers Social Insurance Fund).

⁷ Interviews with Adam Miłkowski, Anna Ferenc and Anna Krowicka, NFZ Headquarters on 19 May 2005

However, the people's behavior does not directly comply with the existing legal rules, probably due to complex administrative procedures and burdening paperwork. The most common cases where people don't have the health insurance coverage concern the situations in which the insuree does not include his/her family or household members despite he/she is entitled to do so. According to the procedure of insuring the family/household members, the insuree should register other persons who he/she wants to be covered by the insurance. This takes place at the level of the institution to which they are affiliated (most often the employer) and on the voluntary basis; even a person who has children is not obliged to register them; the children should be registered by one of the parents. The data and identification numbers of the children/charges who were not registered won't be entered into the Central Data Base of Insurers. According to the law the insurance procedure is completed under the condition of a filled-in application for insurance and prompt payment of insurance premiums, which is in fact a prerequisite for insurance to be certified. The technical problem of the health and social insurance system, still not fully solved, is prompt registration of received individual insurance premiums. In practice, it causes a great deal of troubles, mainly because the period of insurance coverage expires in 30 days after the insuree ceased to pay the insurance premiums. Namely, if a person changes place of work or is employed temporarily, the short period of time when he/she is insured, combined with a delay in data flow: from employee, to social insurance fund (regional and central level), and further to health insurance fund, makes that his/her rights for care are not recognized on time. This makes that the person sometime is required to prove his/her insurance status by presenting documents of insurance premium coverage.

The insurance premiums are collected from various incomes e.g. salary (for the employees according to Labour Law) or compensation for diverse commissioning contracts, when a private person performs a short-time work. Because of employer's delays in payment of the insurance premiums, technical shortcomings of transferred data (incompleteness, distortions and mistakes) and other circumstances, the information about the insurance premiums made for the registrants doesn't appear next to their personal data in the data bases

of collecting institution - ZUS and NFZ. In this situation the obligation of verification if the insurance coverage is valid was partially passed to the health service providers. Before service delivery they are requested to check the document which confirms, directly or indirectly, the payment of insurance premiums. This means that the healthcare provider requests patient the certification of employment, a copy of transferring the premium coverage, or other documents which may prove that the person is insured. The above way is not 'tight' and efficient way of verification the insurance status. On the one hand, it creates troubles for the people who pay the insurance premiums regularly, since they are demanded to prove they did it. Since vast majority of patients are insured, and have problems in proving this, providers often omit whole the procedure. This, on the other hand, makes that those not paying the premiums, make use of the services, in spite of invalidity of their rights at that moment.

Besides, the situation is getting more complex on account of absolute obligation to treat any person in condition threatening life or health, regardless his/ her insurance status. This rather wide formula, being a subject to current interpretation of health service providers, gives the possibility to make use of significant number of services independently from the insurance status.

2.2.2 Mental health protection system

In Poland still exists a separate system of the psychiatric health care, which can be accessed freely, without any special limits or conditions. In that parallel sub-system mentally ill people receive also services connected with their somatic illness. Effectiveness problems of that health care sub-system for mentally ill people were described in the special part (IV) of the report.

Public attitudes, main activities and substance abuse therapy towards mental health protection in Poland were anew regulated in the 1990.⁸ The main Act – from 1994 - defines mental illnesses and psychical disorders, proposes a list of

⁸ (1) of 19/08/1994 on mental health's safety (Letter of Issue No 111, pos. 535, with lower changes 11, (2) of 24/04/1997 on counteracting drug addiction (Letter of Issue of 2003 No 24, pos. 198 and No 122, pos. 1143, (3) - of 26/10/1982 on education in sobriety and alcoholism counteracting (Letter of Issue of 2002 No 147, pos. 1231, with later changes).

activities that should be implemented in order to prevent psychical disorders, promote mental health and main principle of therapy towards mentally ill people. It also points institutions responsible for taking appropriate actions with respect to psychical disorders.

According to this anew defined and main Polish Act on mental health, health services provided to mentally sick or handicapped people by health care public institutions are without charge. Medicines, sanitary supplies, accommodation and catering which are appropriate to the health status are free of charge for patients staying in public hospitals for mentally sic people.

According to par.5 of this Act, health care for people with mental disorders includes both basic and specialist care, in particular psychiatric health care – in the form of instant, ambulatory, daily, hospital, and environmental help and in social homes. According to par. 12, in selecting the type and method of health care, not only health objectives are taken into consideration but also other personal benefits to the patient, the goal being to achieve improvement of the health status in the least onerous way. The utilization of the treatment is voluntary, subject to the patient's consent although in special cases the so-called "direct compulsion" can be used.

According to par. 18 of this Act, direct compulsion towards people with mental disorders can be applied only in case of actions threatening the person's own life or health, the life or health of other people, public safety or violent destruction of objects or in other specific cases defined in the act. Direct compulsion is decided by a physician who determines the method to be used and personally supervises the process.. For patients residing in mental hospital or in social homes, when the doctor's decision is impossible, the decision may also be taken by a nurse, who is obligated to notify the doctor immediately. Every instance of direct compulsion is reported in medical documentation. Direct compulsion includes holding, enforced application of medicines, immobilization or isolation. Persons whose behaviour indicates it can be harmful to their own life or the life's and health of others, or who are not able to fulfill basic life needs due because of mental disorder, can be referred to psychiatric examination without their consent or of their legal representative (in case of a

juvenile or a totally incapacitated person). Then, par. 18 on direct compulsion takes effect.

The regulation of 1994 became a basis for future mental health protection programmes. In 2003, the Ministry of Health prepared a proposal for a national programme and in 2004 it presented a project of the *National Programme on Mental Health Protection* (Narodowy Program Ochrony Zdrowia Psychicznego) together with amendment to legal regulation of 1994. Until now, the National Programme on Mental Health Protection has not been accepted and work on it continues. Programmes' objectives include mental health promotion and prevention of psychological disorders, assurance of access to integrated health care and community care (in the community, family, workplace), investment in research and development of information systems in health care with respect to psychological disorders. Activities proposed are complex, covering information on mental health disorders and counselling, organizing network of psychiatric centres providing integrated care (including hospital care), promoting community and non-governmental organizations' actions in mental health protection and lowering dependence on institutional care. The Programme also promotes multisectoral approach to mental health protection.

Despite the national programme has not been accepted and implemented, at regional level, in Malopolskie voivodship, similar benchmark programme was prepared and operates. The *Malopolski Programme on Mental Health Protection* (Małopolski Program Ochrony Zdrowia Psychicznego) for the period of 2004-2008 is guided by the motto: „no health without mental health”. The Programme concentrates on two objectives: (i) creating regional model of psychiatric care, what well responds to decentralization of health care system implemented in 1999, (ii) preparing and implementing model of community care in psychiatric disorders in place of highly institutionalized hospital care.

Implementation of the regional Programme is coordinated by the voivodship's consultant⁹ on mental health and consultant on psychiatry of children and

⁹ Institution of national and regional consultant in medicine, nursery and pharmacy is based on legal regulation on health care units (from 1991, with later amendments). In March 2001, the Minister of

youths. They are supported by regional – governmental and self-governmental - public administration together with a committee working on mental health by the regional Public Health Council. This team works as regional Mental Health Council and its members are nominated by the marshal of Malopolskie voivodship. Regional consultant on psychiatry fulfills the function of the Council's President. Legal basis for the Council's actions are set by the regional Programme and article 12 point 3 of legal regulations on regional self-government.

Other actions undertaken in Poland in order to prevent psychological disorders concern consequences of alcohol and drug abuse. In these two areas national strategies and regulation are prepared.

Alcohol abuse is a subject of relatively extended actions. The basis for that is the Act on education in sobriety and counteracting alcoholism from 1982. Addicted persons, their family members affected by the consequences of alcohol abuse receive therapy and rehabilitation in public health care institutions. These services are free of charge. Children receive psychological and psychotherapeutic help in public health care institutions, public specialist clinics or in protective educational and reclaiming facilities. They may receive such assistance in spite of the disagreement of their addictive parents or trustees.

The disaccustoming treatment for alcohol abuse is offered by inpatient and outpatient facilities designated for this purpose or by health care institutions. Submission to disaccustoming treatment is voluntary. However, there are exceptions from this rule. According to par. 24 of the referred Act, alcohol abuser causing decomposition of family life , corruption of minors, evade professional duties or systematically disturb peace or public order should be referred to an examination for issuing a statement and prescribing therapy in an appropriate institution. If found addicted to alcohol, such persons can be

Health (regulation from March 19th 2001) regulated system of appointing consultants, defined their responsibilities and activities. National consultants are appointed by the Minister of Health, while regional by voivodship, who represents governmental public administration.

coerced to submit to disaccustoming treatment in inpatient or outpatient facility. Compliance to such obligation is ruled by the regional court by place of residence or stay.

Excessive drinking of alcohol always constituted a serious social problem of the Polish society. Numerous actions have been undertaken in order to combat drinking, and mainly to reduce the consequences of alcoholism and to help the families of alcoholics. It was the task of social organizations, the church and the government. The activity of a specially created state agency - The State Agency for Prevention of Alcohol Related Problems (PARPA) with its own budget (coming from the excise tax) was recognized as an example of good practice in the NSIS document (NSIS 2004). The goals of its activities are defined by PARPA as follows:

Goals of PARPA:

- Preparation of a draft of The National Program of Prevention and Resolving Alcohol-Related Problems for following years and a plan for the division of funds for its implementation,
- Giving its expert opinions and preparing the drafts of legislative acts and agendas on the policy concerning alcohol and alcohol-related problems,
- Providing information and education and preparing expert opinions,
- Preparing and executing the new methods of preventing and resolving alcohol-related problems,
- Providing professional support to local governments, institutions, associations, and individuals that perform the tasks connected with the prevention and resolution of alcohol-related problems,
- Initiation and coordination of activities that make the substance abuse therapy more efficient and more available.

In 2005 the Minister of Health appointed a special committee to prepare strategy for preventing alcohol abuse. In result, in 2006 *National Programme to Prevent and Solve Alcohol Problems for the period of 2006-2010* was accepted. Coordination of the Programme is a responsibility of the PARPA. The Programme refers to *European Alcohol Action Plan* of 1992-1999 and 2000-2005 in implementation of which Poland was actively involved.

The new edition of *National Programme to Prevent and Solve Alcoholism Problems* (Narodowy Program Profilaktyki i Rozwiązywania Problemów Alkoholowych) is more concentrated on prevention and promotion. These include prevention of alcohol consumption by youngsters, protection of family against abuse (specific project in family abuse prevention is currently discussed). Next to it, actions against drinking and driving as well as alcohol abuse in public facilities are undertaken. The Programme also foresees educational activities in communities and actions against alcohol marketing.

With respect to drug abuse in 1997 was accepted a special (totally new) Act on this problem. In pursuance of the Act on counteracting drug addiction, people addicted to narcotics or psychotropic agents can receive free treatment, rehabilitation or participate in a program of reintegration run by centers for social integration (par. 14 of act 6). The above services are provided by health care institutions regardless of the addicted person's permanent place of residence. Treatment and rehabilitation provided by a health care institution or by doctor running an individual practice. Rehabilitation of addicted persons can also be provided by specialists with high non-medical education; people who have at least secondary education can participate in the rehabilitation process, if they have completed a specialist courses in the area of addictions, according to a program approved and certified by the minister of health.

Addicted persons can be treated by means of a substitutional (e.g. metadon) therapy (par. 15) which can be offered only by public health care institutions, after receiving permission from the governor acting in cooperation with the minister proper to health cases.

Addicted person may receive treatment or rehabilitation on a voluntarily or forceful basis. According to par. 17. on proposal of legal representative, straight line relatives, siblings or actual care-giver or from office, familial court can direct addicted person, younger than 18 years old, onto enforced treatment and rehabilitation.

Based on the regulation on drug abuse counteractions, a *National Programme of Drug Abuse Counteractions* (Krajowy Program Przeciwdziałania Narkomanii) for the period of 2006-2010 was prepared (Szrogosz 2006). Objectives of the Programme include not only drug abuse prevention, medical assistance and curative care to drug abusers but social reintegration of drug addicted as well.

2.2.3 Access to health care of foreigners

Ethnic minorities

Compared to other European countries, Poland is a very homogenous country in terms of nationality, however historically the Polish state used to be multinational. Before the II World War various national minorities constituted about 25% of Poland's population. Nowadays it is estimated that no more than 2 % of the total number of the country's residents represent national minorities including Ukrainians Byelorussians, Lithuanians, Slovaks, Germans and Gipsies (GUS NSP 2003). The biggest national minority groups are Germans, Byelorussian and Ukrainian. The information of the size of those groups results from National Population Census from 2002 (GUS 2003) collected on the basis on individual declarations about nationality.

Table 11. Number of the members of ethnic groups in Poland

Minority population group	Number of the other nationality than Polish	Members of national and ethnical associations in Poland
Byelorussian	48 700	5 221
Kashubian	5 100	4 700
Lithuanian	5 800	2 390
German	152 900	311 570
Slovakian	2 000	3 260
Ukrainian	31 000	880
Gypsies	12 900	13 756
Jewish	1 100	4 870

Source GUS 2003 – NSP and GUS 2007 – Statistical Yearbook 2007, p. 218

So, the ethnic groups in Poland are rather small but relatively well organised (with exception of Ukrainian probably due to displacement (action Vistula) to the north part of Poland after the WWII).

Labour immigrants

Temporary labour migration from the East (neighbouring countries, but also Vietnam and China) is a new phenomenon in contemporary Poland. It is difficult to estimate the number of that kind of migrants because of their diversified status. Officially about 20 000 work permits for foreigners are issued every year. In the same time it is estimated that four times more people work without any permits. Since 2004 citizens of some countries can be employed without a work permit (southern neighbors of Poland, Sweden, UK and others) however the biggest group of working foreigners is employed illegally. There are various estimates for the illegally working: from 80 000 (Labour Inspection) to 150 000 (MPiPS - Ministry for Labour and Social Policy)) and 450 000 (URiC - Office for Repatriations and Foreigners Affairs) .

Legally employed foreigners have to be reported by the Polish employer to the system of social insurance and health insurance. Their access to the health services is formally equal to the access of Polish citizens.

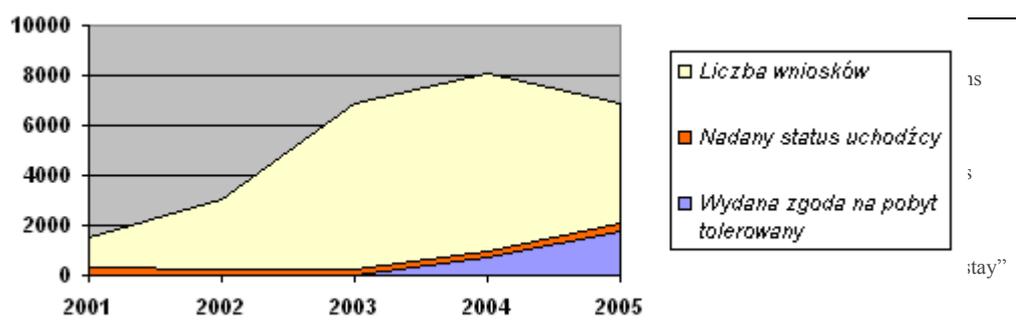
Illegally working foreigners can use (and are using) private health care facilities. The network of private doctor practices and ambulatory specialists (mostly in a form of doctors cooperatives) has developed in Poland in the 60. and 70. in order to create access for peasants working in the private agriculture sector, which (what was mentioned in the p.1.) was not covered by the state health care system. In the recent years network of private hospitals was also developed.

In reality foreigners working in Poland without job permits use Polish private health services only in cases of urgent needs. They rather use medical treatment in their countries. It is possible because a working period abroad is short: 2-3 months and they use a tourist visa in order to come to Poland. After this short period they return to their home countries while other foreigners (from their families or from a friends' group or from local community at home) perform their job in Poland for the time of their absence. It means that the work of illegally foreign workers in Poland is usually based on a working period of rotation scheme. Quality studies on that issues (Domaradzka, in: Golinowska 2004) indicated that employers accept this form of job performance. Those employers are not only Polish firms, but very often households as well (Gmaj 2005), which need care for chronically ill or disabled family members, care for small children (usually made by Ukrainian women), help in cleaning, helping in the garden (rarely in the farm). If the foreign worker has to use medical treatment, he usually receives help from his employer, who pays for this treatment. The employer can of course deduct the cost of medical service from the workers earning. There are various behaviors of employers in cases of illness of their employees.. However often the employers are very helpful. It is because the demand for care in families is in Poland huge due to underdevelopment of the institutional care for children and at the same time for elderly and chronically ill people (Golinowska, Balcerzak – Paradowska, Kruszynski 2007) . The existence of such demand favors decent employers behavior and a relatively good gratification for caregivers; not only in cash.

Refugees

There is also in Poland a group of refugees and asylum seekers from other countries, mainly coming from Kosowo, Armenia, Tchetchenia, Afganistan and most recently from some African countries. The number of asylum applicants is in the present decade bigger than in previous one. In the early 1990s. it was about 500 – 600 persons (Hryniewicz 2005) and nowadays it is ten times more. In 2005 there were 7 000 persons.

Chart 3: Number of asylum applicants, immigrants with established status refugees and immigrants with ‘tolerated stay’



As one can see from the chart above, since 2003 (a year before accession to the EU) a number of immigrants with established status refugees, has increased. Polish law distinguishes persons who are asylum seekers and those who wish to stay in Poland, without seeking asylum. The second category applies for a refugee status, and a right of “tolerated stay”.

The prevailing majority of people applying for the refugee status in Poland, in the course of the on-going proceedings, stay in so-called reception centres, in isolation from the Polish society and normal life. They receive small funds, so-called pocket money and a lump sum for basic hygiene expenses. The refugee centres provide full board and learning aids for children. Moreover, their expenses incurred for transportation and medical examinations ordered by physicians are refunded. They have full access to the health care. The doctor of

first contact is available on-site, and they are entitled to further treatment, specialist or hospital, upon obtaining a referral. Non-government organisations provide assistance in providing care services for refugees, and these are in particular: Helsinki Foundation, Polish Red Cross, Polish Humanitarian Organisation, and Caritas Polska.

Until the moment of obtaining a refugee status or a tolerated stay, the asylum seekers have no right to enter legal employment. The forced inactivity and passiveness in the course of the proceedings on the granting of the refugee status result in the attitude of acquired helplessness and expectation of full external support, and in relation to the future – as a consequence of the above described circumstances – developing a dependence on aid. The lack of a developed perspective for the further stay in Poland breeds depressive attitudes, thus creating additional limitations of the beneficiaries activeness and self-reliance. The situation of refugees with families is slightly better. Children attend Polish schools, and through the acquisition[“learning”?] of Polish, they constitute the main link with the outside World

Social exclusion situation of refugees responded a special initiative “Education for Integration — Partnership for Refugees” (EDI). Project was worked out by Jagiellonian University Human Rights Centre and accepted for funding under EQUAL Community Initiative Programme in Poland under European Social Fund. The main objective of the innovate project is based on a pre-integration model and it aims at providing asylum seekers with information and skills (Polish language and vocational training) necessary to start an independent existence and facilitate their integration into Polish society.

2.2.4 Health protection for immigrants – legal basis

General rules

The general rule, established by the **Health care units Act** and **Physicians profession Act** is that any person who requires care which necessary, what is understood as life-rescuing, should be granted the care, regardless of the person insurance status. This obligation is put on health care providers, and

professionals, and they may be accused at a basis of Penal Code, if do not comply. Another issue is financial coverage of the services. There is a number of regulations clarifying who pays for services for, among other, foreigners or uninsured persons. There are however, frequent cases, when a care is provided and health care unit does not receive reimbursement, since the potential payer is not identified. According to some opinion of hospital directors, the most commonly the situation occurs in case of treatment of citizens of Ukraine, Belorussia and Russia, who illegally live in Poland, but sometimes also in case of homeless persons or those whose identification is impossible.

People who suffer from infectious diseases are treated under specific rules. The **Act on infectious diseases and infections**¹⁰ is a legislative document that introduces actions aiming at safety of life and health not only of individuals but of the community as well. This Act contains regulations and provisions regarding the mode of conduct in terms of preventing and overcoming infectious diseases and infections in people and, in particular, of recognition and surveillance of the epidemiological situation and taking anti-epidemic and preventing actions for removing the source of infection and eliminate spreading, including those that affect immunity. All persons staying in the territory of Poland are subjected to the provisions and they are obligated to:

- submit to examinations that intend to detect infections and infectious diseases, including also submitting to treatment that intends to take or deliver material to these examinations
- submit to mandatory preventive vaccinations
- submit to mandatory treatment, mandatory hospitalization, isolation, quarantine and epidemiologic supervision
- provide information that is essential to infectious disease prevention.

The obligation for vaccination does not concern people staying in the territory of Poland for a period of time shorter than three months, except for vaccinations

¹⁰ Law on infectious diseases and infections from 6.09. 2001 (Letter of issues 01.126.1384)

against rabies and tetanus of people suspected for being infected. Mandatory vaccinations and appropriate testing of uninsured people, among others immigrant ones, are funded from the state budget, from the part under disposition of the minister of health.

A separate group of services comprise the care provided to people coming from abroad sick or that are suspected of being contagious. These people can be submitted (have the obligation to submit) to examinations intended to detecting infections and infectious diseases as well as to mandatory treatment or hospitalization, isolation, quarantine or epidemiologic supervision, that is, by administrative decision issued by the proper sanitary inspector. The same happens in the case of diagnosed tuberculosis. Fulfilling duty to treat TB involves submission to a medical check-up and other diagnostic tests as well as to the treatment prescribed. Health care services in this case include administration of drugs as well.

The Regulation of the Minister of Health of 2002 on the mode of funding from state budget the expenditures of health care services provided in connection with infectious diseases and infections is applicable to all health care services associated with infectious diseases provided to uninsured people are funded from the state budget, from the part under disposition of the Minister of Health¹¹.

Special rules

Different kinds of immigrants enjoy different level of health and social care coverage.

The best health protection is offered to citizens of the European Union countries, who benefit from a system of coordination of social protection schemes, regulated by provisions of Regulation 1408/71 and 574/72.

¹¹ The Regulation of the Minister of Health of 18/04/2002 (Letter of Issues No 63 of 2002, pos. 577

Health protection rights of asylum seekers, refugees and illegal immigrants are clearly defined in a special Polish Law from 2003 – the Act on foreigners¹². This act contains provisions that grant foreigners placed in guarded centers or in detention for the purpose of expelling authorization to receive free health care. Foreigners have the right to health care services, including admission to hospitals, in case of medical indications. Foreigners accommodated in guarded centers or in detention for the purpose of expelling must have a medical examination or sanitary treatment, if needed. Physicians providing health care services to foreigners in guarded centers or in detention for the purpose of expelling must maintain documentation according to certain rules. The above costs are reimbursed from the state budget, from the part under disposal of the minister of the interior.

Foreigners placed in guarded centers or in detention for the purpose of expelling receive health care services, medicines, sanitary articles and meals, according to rules applied in relation to people placed in penal institutions and in custody, on the basis of the Executive Penal Code.

Foreigners who are not EU residents and are not covered by above described scheme for foreigners use health services on private basis in Poland or go to the own countries for treatment. A scope of problems which the people face is not known, and only superficial observation lead to a conclusion that probably the number of unregistered and consequently uninsured foreigners rises. The nationalities mainly suffering from illegal status are: Vietnamese, Ukrainians and citizens of other countries of former Soviet Union. Although regulations for legal employment looses, still it is estimated that more citizens from the ex-Soviet Union countries tend to employ illegally, because of fiscal obligations they are burdened if employed officially.

¹² Law on foreigners of 13/06/2003 (Letter of Issue No 128, pos. 1175 and of 2004 No 96, pos. 959 and No 179, pos 1842)

2.2.5 General comments on issues of health protection for migrants in Poland

Poland, as a relatively ethnically homogeneous country, and as a traditional emigration country as yet has not experienced the problem of difficult integration of foreigners. Admittedly, in the 1990's economic immigrants and refugees turned up, but the scale of the problem is insignificant, although even at this insignificant scale certain integration issues have become visible (e.g. related to the integration of refugees). This in particular pertains to people who come from different cultural backgrounds and have basic communication difficulties due to the lack of command of foreign languages.

Whereas, from some time the social system in Poland has been experiencing difficulties related to the necessity to provide social and health care for people returning home after years of hard labour abroad for foreign employers. Poles have been emigrating to work abroad periodically, in a significant part engaging in illegal employment or on the bases of bilateral agreements between countries (e.g. with Germany), which either did not guarantee the performance of any health services or guaranteed such services only during the working period. The research into the labour provided by Polish migrant workers reveals that they have mostly worked physically in those sectors of economy where native labourers were hard to find: in agriculture, construction, mining industry, catering services, and hotel industry (Golinowska 2004). They often do overtime and do not integrate with the society of the receiving country (Jordan and Duevell (2002). They come back to their country of origin „overworked” after many years of work, normally performed in the rotation system (some time abroad and sometime in Poland), unstable, in the relatively hardest conditions and they immediately become clients of numerous social and health care institutions in Poland. From the research conducted in the regions of the highest intensity of periodic economic emigration (Śląsk Opolski, Małopolskie and Podkarpackie voivodeships), it follows that the number of disability pension applications and applications for admissions to care and therapeutic centres is over-representative. POZ doctors and psychiatrists also signalise their apparent mental problems in terms of re-adaptation and with the background of „loosened” family relations.

Due to the serious scale of economic emigration from Poland and insufficient social provisions of this group of migrants (not only in the past), Poland is experiencing its share of more and more prominent costs for health and social care for its population who devoted its professional life to foreign employers. There is lacking strong evidence in this matter, and only some anecdotal evidences say that citizens working abroad, in case of health problems, return home to seek care in the Polish healthcare system, although they are (usually) covered by foreign insurance system. This may lead to conclusion that they face access barriers in their employment countries, most probably due to language and cultural barriers rather than legal ones.

2.3 The scope of the health basket

Health protection in Poland is a multisectoral issue, however it's the most important part belongs to the social protection system. Its legal basis was founded in 1997 in the Constitution where there is reference to entitlement to health services financed from public funds. Article 68 of the Constitution states that, among others, everybody has a right to health protection, and that citizens shall be provided with equal access to health care services financed from the public funds. For obvious reasons the Constitution provisions are general and more specific are the laws adopted by Parliament, which regulate certain areas of social protection, which include among others, provision establishing scope of health benefits and rights to care. The most important regulation is a health insurance law which is establishing an universal and obligatory insurance scheme, covering practically 99% of Polish citizens and a large part of non-citizens residents, both short and long term ones. This law defines benefit basket¹³ in rough terms, but in contrary defines very exactly the list of benefits which are excluded, which however, are of marginal importance for the population, since they are rare and of minor importance (as transsexual operations, for example).

¹³ In this subchapter there were materials from benefit package and costs of services – Health Basket, Report I - POLAND, under 6th SP21-CT-2004-501588 (Kozierkiewicz A. ed.) used

Besides, there is a number of laws targeted to specific problematic health areas, e.g., infectious diseases, mental health, drugs and alcohol abuse problems which regulate obligation of public authorities and individuals regarding the protection against and coping with those specific problems. In result those regulations grant some specific benefits to people endangered by those conditions (as alcohol abuse therapy, for example), regardless if they are insured or not. Also rescue system and services laws regulate the functioning and financing of the national rescue system, which by definition serves for all, regardless their insurance status.

A specific laws define also right for health care for people who remain under strict control of the state: prisoners and foreigners, living in closed centers for immigrants, waiting for decision on deportation or, so called, “approved stay”. Those people have rights for care which is limited to this which is “necessary”, and have far smaller choice of providers, what is a very important privileged of regularly insured persons.

Many of those laws contain the so called delegations to regulations/decrees regulating on a technical level both the scope and conditions of services available to individuals in Poland. The underlying logic of the legislative process in Poland provides that laws establish the fundamental principles and mechanisms while regulations/decrees govern their practical application. Therefore, regulations/decrees cannot exceed the legal delegation set in specific law and they are issued by Ministers of Government. The three levels described above are legal acts in understanding the Polish legislative system. They are obligatory by nature and there are legal and administrative sanctions for non-compliance.

Besides legal acts, there are some additional documents referring to benefit package which are not of legal nature. The most important among them and the only one discussed herein is a catalogue of services (so-called “products”) which are purchased by the National Health Fund (NFZ), the sole insurance institution that executes universal mandatory health insurance in Poland. The catalogs are appendices to procurement documentation in procedures of purchasing health services and goods within the universal health insurance

system. The “products” included in catalogues are then the subject of contracts between the NHF and the services providers, to be provided to “beneficiaries”.

From the legal point of view, patients in Poland should not face with many barriers. The most recent studies on access barriers reveal following (CSIOZ 2007):

- many of the barriers have a organisational character, like long waiting before a person is admitted to the physicians office (this is a situation when a patient waits for admission in the waiting room), or lacking an option to reserve an admission by phone,
- other barriers are caused by limitation in number of services provided, which result with long waiting lists (what means that a patient is enlisted at a distant place in the queue and finally decides to use private *out-of-pocket* provider),
- more rare cases regards geographical barriers, what means tha a specific specialty physician in not available in a village or small town, and receiving care requires to move to the bigger town, what may cause both physical and financial difficulties for some persons,
- in some cases, like dental care, the number of (item of) services provided is so small, and consequently the waiting time would be so long, that patients choose privately paid care, especially since their costs usually is not very high. Some of the patients may face however a financial barrier preventing them from using private care.

2.4 Cost-sharing requirements of health services

Considering cost-sharing requirements one should take into co-payments explicitly required in the public health care system, and individual spendings of insurees, being a result of inadequate access, quality or misbehavior of some of the health care professionals.

2.4.1 Legally demanded co- payments

According to legal regulations there is a set of cost-sharing arrangements, which regard a selection of services and goods:

- medicines,
- diagnostic tests excluded from insurance
- medical appliances,
- rehabilitation and sanatorium (spas)
- nursing facilities

Out of ab. 14000 pharmaceutical products, including all their forms and dosages, which have been registered in Poland, about 2,700 have been placed on the basic and supplemental lists for reimbursement. Insured persons admitted to hospitals and other stationary health care centers are provided with drugs without charge. In fact there is common practice, however, that patients admitted to hospitals and other stationary health care centers are “asked” to bring their own drugs sometimes, especially when the drugs are expensive and are used also in ambulatory care, which means they are available in regular pharmacies. Overall expenditures for this category were estimated at 20% of all private expenditures related to hospital care (GUS 2004b). Drugs for ambulatory patients on a physician’s prescription, which should be administered at home, are reimbursed according to a defined list determined by the Minister. Drugs on the list are divided into two categories:

- basic medicines and magisterial preparations;
- complementary medicines.

Basic medicines are reimbursed to a fixed cost determined by the Minister. Patients pay only PLN 2.5, regardless of the actual price of the drug while the rest is covered by their insurer. Complementary drugs are reimbursed at 70% or 50% of the drug price, depending on which list it has been placed on.

Rehabilitation stays in sanatoriums (spas) are partly financed by the Fund; patients bear costs of transportation and catering in the sanatoriums, and also single room, and other accommodation conditions on request.

Minister of Health declares also medical appliances which are available for patients. Prosthetic devices, hygienically materials are fully or partly financed by the Fund, according to list published as attachment of an appropriate regulation.

Officially there is NO COPAYMENT in the system, understood as cost –sharing from the patient side. Nursing homes, rehabilitation in spas are regarded as those of minor importance in functioning healthcare system, what makes they tend to be omitted in access to care assessment. According to the law it is meant that health services are fully covered by the Fund. On the other hand there is a permanent deficit of services, in comparison to public expectations, what causes informal payments, discussed later.

2.4.2 Access limitation evidence due to individual payments

Despite health services officially being almost free of charge, in practice patients and their families pay for them in various forms, a phenomenon which is hard to fully assess.

Firstly, patients in Poland often present doctors with gifts as expressions of gratitude for the received care. At the end of their therapy, patients give flowers, sweets, alcohol, books or small craft gifts when saying goodbye to the medical personnel. Under the planning economy -of shortages (term of Hungarian economist J. Kornai), peasants would offer a rooster, a piece of meat, fruit from their orchard or vegetables from their garden. Today, gifts are becoming increasingly symbolic although as recently as in 2003, it was estimated that they constituted 1/3 of all individual costs related to hospital stay (Central Statistical Office - GUS 2004b). Later research (Tymowska in *Diagnoza Społeczna* [Social Diagnosis] 2005 and 2007) suggests that the value of these gifts is decreasing however the custom of gift-giving continues to persist.

Secondly, patients and their families support hospitals which are underfinanced and burdened by debts, in the form of donations previously made in cash (so-

called hospital donations) and now rather as payments for services, most frequently in the area of nursing care and accommodation, mostly given in kind. Patients purchase sanitary materials and medicines necessary during hospital care. It is estimated that the value of medicines and medical materials plus nursing services rendered for a fee constitute approx. 25% - 30% of all individual payments incurred in relation to hospital stay (GUS 2004b,). This kind of support is welcomed by hospital management, despite the fact that officially all costs of hospital care should be covered by public finances, since it allows them to continue core functions (such as new admissions and continuity of care), in a situation of budget limitations and use of inadequate contracting prices by the National Health Fund.

Thirdly, it happens that patients give doctors bribes, which used to be the case in order to be admitted to a specific hospital and nowadays, it is done to skip waiting lines. It appears that bribery is becoming increasingly less common. Currently, in a situation when most medical specialists have their private offices and continue to work at public hospitals, patients don't have to give bribes. In order to receive the necessary medical care, patients first seek treatment at the private office of a given specialist, thanks to whom they are then admitted to the hospital at which the specialist is additionally employed.

Finally, corruption incidents also take place. Corruption is considered to be payment for health services 'under the table'. These services have specific prices, which are an open secret on hospital markets. Patients give money in an envelope. There have been rumors circulating about some doctors who absolutely demand payment according to the 'known' price. When these types of practices became the target of the Central Anticorruption Bureau¹⁴ actions, doctors began demanding fair salaries, putting up banners reading "I don't take unofficial fees (bribes) but I want a decent salary". In the opinion of the medical community, the reason for corruption in health care are low salaries of doctors and nurses, which do not reflect their qualifications or efforts inherent in the job (Kubiak, 2001). However, the greatest beneficiaries of informal payments are

¹⁴ In Spring 2007, the Central Anticorruption Bureau organised a media show by arresting a known surgeon and transplantology specialist for collecting payments from patients for surgeries.

the higher-qualified groups of medical professionals – heads of wards, which raises serious doubts as to the low salaries being the only cause of corruption.

The above classification of various forms of payments made by patients is not reflected in government statistics (i.e.: in module surveys on health service supplementing household budget surveys GUS), in which all additional payments are treated alike; the value of expressions of gratitude is added to the costs of travel to sanatoriums or additional laboratory tests. At the same time, these surveys do not include questions on informal payments for specific medical services. However, surveys (i.e.: Górecki in CSIOZ 2004, or Tymowska in: *Diagnoza Społeczna [Social Diagnosis] 2005*) reveal that differentiation of informal forms of payment in the society is of fundamental significance for the evaluation of this phenomenon. If expression of gratitude is treated as an element of good practice then indirect payment for medical services is a reprehensible phenomenon although some patients, as sociological research shows, feel more secure after making payment.

The phenomenon of informal payments more frequently concerns large cities and wealthier people (Górecki op.cit.) while older and poorer people most often do not take part in it, believing that the Polish healthcare system provides treatment free of charge.

2.4.3 Direct expenditures of households

The representative method used in surveys of household budgets constitutes a basis for the generalisation from the households under survey to the entire group of households in Poland, which, in turn, offers a possibility to estimate how much the general populace spends nationwide on health care. Unfortunately, the reliability of survey results of household budgets is reduced by a high percentage of households that refuse to participate in such surveys.

Table 3. Estimated direct health care expenses of Poland's population based on the results of household budgets surveys in 1999–2005

Year	Total nominal expenses of households PLN	Dynamics of increase in real terms* 1999 = 100	Proportion to public expenditure %	% of GDP
1999	10 988 453	100.0	41,2	1,8
2000	12 165 391	101.1		1,6
2001	12 659 481	97.7		1,7
2002	12 992 865	98.1		1,7
2003	13 860 266	104.5	40,0	1,8
2004	15 895 570	112.7	43,5	1,9
2005	15 797 040	96.9		1,6**

Source: MZ (Ministry of Health) 2004, GUS 2005 and 2006d

* consumer price and services index for health was used

**according to OECD Health Data this value is rather 1.9% and not 1.6%, as presented by the MZ

In 2004, direct expenses sustained by the population totalled at least PLN 15.9 billion (household budget surveys) and constituted around 31% of the total and 43% of the public health care spending. Adopting the maximum estimate of health care spending by the population in 2003, which totalled PLN 17,783.7 million, we have to conclude that it constituted 35.7% of all health care spending. Such a high increase in individual health care spending was not observed in any OECD country, even over a relatively long period (1970–2001)¹⁵.

This amount of individual expenditures is universally considered a threat to the rule of the 'equal access to health care services', which is in Poland in force as constitutional principle. With this amount of individual expenditures, it is no evidence that the less wealthy social groups experience some restrictions on access to the services, because of economic reasons. Rather more wealthy

¹⁵ For example, in the Czech Republic in 2003, the share of public expenses in overall health care spending was 90% , as compared with 94.7% in 1990. See: OECD 2004.

people use often private services because of waiting lists to specialists and poor quality of some providers.

2.5 Geographical barriers of access to health services

There are two groups of legal entities providing licensed health services in Poland; health care units (zakłady opieki zdrowotnej – ZOZ) and individual (and group) practices. Health care units (ZOZ) operate on a basis of a dedicated law, and before they start their functioning they have to be registered in, so called, *register of health care units*. The same mechanism functions in respect to individual practices, both of physicians and nurses, but registration agency are Chamber of Physicians and Chamber of Nurses, respectively.

There was a common belief, that generally there is a need to lower the amount of inpatient beds, except for of long-term care and psychiatric beds in some regions.

Table 6. Number of acute hospital beds in Poland generally and in voivodship per 10000 inhabitants

Hospital beds per 10000 inhabitants	1998	1999	2003	2005
Poland average	53,1	51,4	49,1	46,5
Dolnośląskie		57,6	50,6	47,6
Kujawsko-pomorskie		44,8	45,1	42,9
Lubelskie		56,4	52,8	49,7
Lubuskie		47,9	52,5	42,3
Łódzkie		55,7	58,1	52,1
Małopolskie		48,7	44	42,9
Mazowieckie		50	46,5	46,3
Opolskie		48,4	43,2	38,5
Podkarpackie		41,5	41,3	41,6
Podlaskie		55	53,5	50,1
Pomorskie		47,4	42	38,8
Śląskie		62	58,3	55,4
Świętokrzyskie		46,5	47,6	43,8
Warmińsko-mazurskie		43,3	45,1	41,1
Wielkopolskie		48,1	47,9	46,6
Zachodniopomorskie		50,5	48,7	45,2

Source: GUS (1999, 2000, 2004, 2006b)

Presented data¹⁶ suggest that total number of hospital beds indeed diminishes, although it still is quite distant from the target established by the Ministry of Health. Moreover, there are important differences in numbers of beds in each of voivodship. The highest numbers are observed in Śląskie voivodship where it reaches almost 60 beds per 10 000 inhabitants, when on the opposite side there is Podkarpackie voivodship with as little as 40 beds per 10000.

Changes in utilization of hospital care look to be unrelated to the present changes in supply of hospital beds. In all regions, but Śląskie, number of hospital beds was decreasing during recent years and utilisation was increasing. Apparently different mechanism played a role in this rise than change in capacity. Most probably there were financing methods which driven utilization, and in smaller extend, ageing of the population which rises fast.

Table 7. Number of hospital admissions per 1000 population by voivodships 1998 - 2005.

Voivodships	1998	1999	2001	2005
Poland, average	138	147	164	173
Dolnośląskie	154	188	225	176
Kujawsko-pomorskie	135	142	165	156
Lubelskie	156	164	173	185
Lubuskie	135	152	154	156
Łódzkie	152	160	173	190
Małopolskie	125	129	142	155
Mazowieckie	134	141	153	184
Opolskie	122	131	154	150
Podkarpackie	110	129	140	170
Podlaskie	155	161	174	181
Pomorskie	125	131	155	153
Śląskie	153	148	154	173
Świętokrzyskie	130	139	158	178
Warmińsko-mazurskie	128	138	162	176
Wielkopolskie	138	145	169	178
Zachodniopomorskie	130	146	175	174

Source: GUS (1999,2000,2002,2006b)

¹⁶ Authors used data from Mapping Health Services Access: National and Cross-Border Issues (HealthACCESS), under EC Public Health Programme 2004 (Kozierkiewicz A ed.)

Differences in utilization of hospital care among regions reach 20% (the highest in Mazowieckie, and the lowest Lubuskie or Podkarpackie, for example) and generally they coincide with the overall capacity of hospital beds. One may conclude that patients in regions with higher density of hospital infrastructure tend to use hospital care more frequently, than those in regions with fewer beds. This may suggest, although it has to be verified, that in some regions of Poland there are barriers of access to hospital care, caused by unequal distribution of infrastructure. Until recently, an access was officially measured by infrastructure and utilization. Only during last 2-3 years, experts are looking for different measures of access, like waiting time and subjective limitations, as they are perceived by citizens. There is however lacking systematic assessment of both mentioned measures in regards to hospital care.

Number of health professionals working in each of the voivodship differs significantly, too. In a category of physicians, the ratio of physicians working in the health care units per 100000 population ranges from 0,28 in Mazowieckie, down to 0,16 in Warmińsko-Mazurskie voivod. Even wider difference occurs in category of dentists; in Malopolskie there is almost three times more dentists practicing in the health care units than in Warmińsko-Mazurskie. More balanced is the situation in nursing; here the differences do not exceed 20% among voivods.

Table 7. Indicators of personnel employed in health care units, according to regions, in the year 2003.

Voivodships	Physicians	Dentists	Biochemists	Nurses	Midwives	Physiotherapists
Dolnośląskie	0,23	0,28	0,09	0,50	0,50	0,11
Kujawsko-pomorskie	0,18	0,20	0,07	0,45	0,60	0,09
Lubelskie	0,24	0,33	0,03	0,53	0,64	0,05
Lubuskie	0,17	0,20	0,06	0,45	0,58	0,09
Łódzkie	0,26	0,36	0,08	0,46	0,56	0,06
Małopolskie	0,23	0,39	0,09	0,49	0,56	0,15
Mazowieckie	0,28	0,37	0,08	0,49	0,51	0,12
Opolskie	0,17	0,13	0,07	0,41	0,39	0,09
Podkarpackie	0,18	0,18	0,06	0,46	0,68	0,11
Podlaskie	0,25	0,24	0,16	0,48	0,65	0,03
Pomorskie	0,25	0,29	0,04	0,43	0,51	0,06
Śląskie	0,26	0,31	0,11	0,52	0,53	0,10
Świętokrzyskie	0,20	0,17	0,06	0,48	0,56	0,07
Warmińsko-mazurskie	0,16	0,14	0,05	0,41	0,55	0,05
Wielkopolskie	0,20	0,15	0,08	0,40	0,52	0,10
Zachodniopomorskie	0,21	0,33	0,06	0,41	0,53	0,07
Poland average	0,23	0,28	0,08	0,47	0,55	0,09

Notice: As one may observe, there are significant differences in number of personnel employed in any kind of category.

Source: MZ (2004)

Ambulatory care is divided in Poland into primary care and ambulatory specialist care, the second one is provided both in ambulatory and hospital settings. Before the reform of 1999, it was a common opinion that primary care plays too little role and the reform should have increased it. In opposite, ambulatory specialist care, providing a bulk of ambulatory services, should have been limited to counseling rather, and not taking responsibility for whole treatment process.

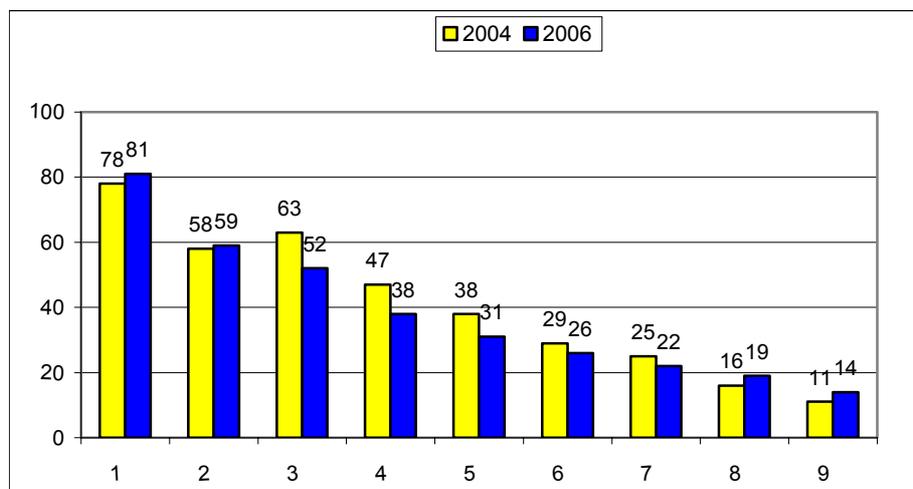
Table 8. Number of visits in ambulatory care, per person per year, year 1998-2005

Voivodships	1998	1999	2001	2005
Dolnośląskie	6,6	6,2	5,9	6,1
Kujawsko-pomorskie	5,7	6,2	6,4	6,9
Lubelskie	6,2	6	6,2	5,9
Lubuskie	5,5	4,9	5,7	5,8
Łódzkie	6,7	6,4	6,2	6,7
Małopolskie	6,9	6,7	6,5	6,5
Mazowieckie	5,8	5,4	5,6	5,7
Opolskie	5,5	5,3	5,6	5,7
Podkarpackie	5,9	5,8	5,7	5,6
Podlaskie	7,5	7	6,5	6,7
Pomorskie	6,6	6	5,9	5,9
Śląskie	7,4	7,1	6,9	6,8
Świętokrzyskie	6,2	6	6,3	6,0
Warmińsko-mazurskie	5,6	5	6	5,7
Wielkopolskie	5,7	5,2	5,4	6,0
Zachodniopomorskie	6,1	5,9	5,9	5,7

Sources: GUS (1999, 2000, 2002, 2006b)

Watching data for particular regions we do not see many striking differences or trends. Regions with higher ambulatory care consumption, like: małopolskie, podlaskie śląskie present a consumption pattern on a level of 7 visits per year per inhabitant, while voivods with lower figures, like; lubuskie, opolskie, warmińsko-mazurskie, consume 5,5 visits per year per inhabitant. During the years there were some changes in presented figures, but one cannot be sure how much the differences depend on structural changes (privatization) of ambulatory care and how much on consumption patterns.

Figure 4. Major difficulties in accessing specialty consultation (ambulatory) (% if persons indicated following)



- 1 Long waiting time
- 2 Too few patients admitted during working hours.
- 3 Long waiting in a waiting room
- 4 Long waiting for registration
- 5 Lacking possibility to register by phone
- 6 Inconvenient working hours of ambulatories
- 7 Difficulty in receiving referral from the GP
- 8 Long distance and/or transportation difficulty
- 9 Lacking consumer information

Source: CSIOZ, 2006

As presented at the chart above (Figure 4) geographical barriers (or transportation difficulties) are reported by less than 20% of the respondents and it seems as one of the minor problems, comparing to the ones connected with waiting time and improper organization of admissions.

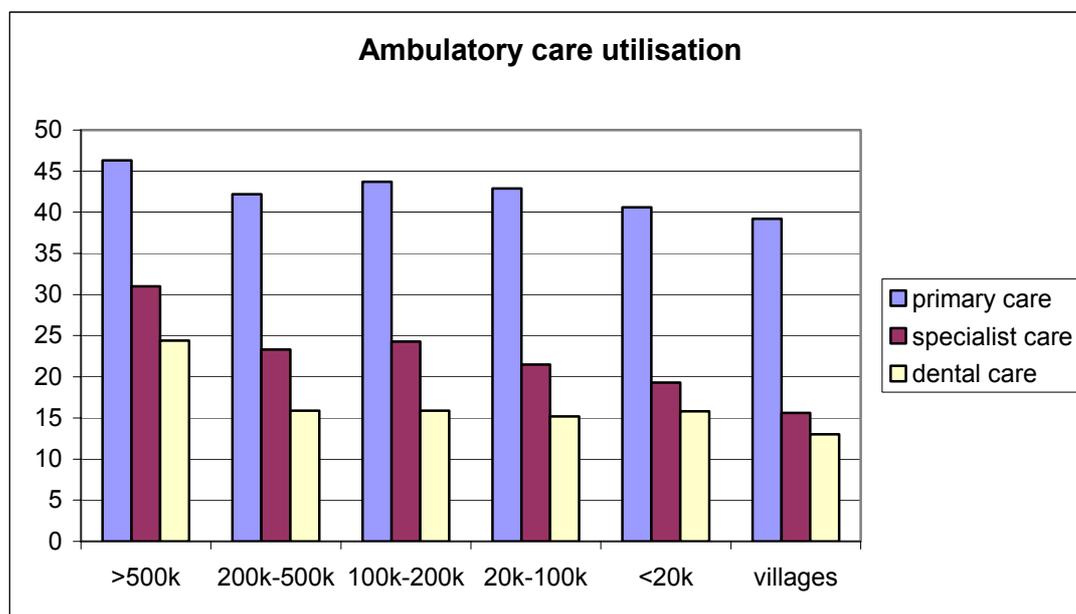
Geographical barriers might also be overcome, to some extent, by making available transportation for persons who are unable to use public transportation and do not have access to private transportation, too. According to art. 41 transportation is financed in case of emergency and when patient requires transportation to other health care unit, and does not have own transportation and use of public transportation is not recommended, because of health status. It is common that dialyzed patients are transported for hemodialysis sessions, and this is an integral part of a service provided to this category of patients. In

other cases, transportation is an own responsibility of patient. There are no evidence known to what extend transportation is an important barrier in getting access to care, and no significant actions were taken to make this potential barrier smaller

2.5.1 Rural – Urban differences

There is a difference observed as regards consumption of health services among urban and rural population. According to *Diagnoza Społeczna* study (2003 and 2005) overall, 73% of adults had used services of general practitioners, family doctors or specialists in the period of three months. Among people aged 60 – 64, this percentage amounted to 82%, and in the group of people of 65 and over the percentage is 87% (among the retired this is 89% and for farmers only 60%). Inhabitants of big cities utilize medical assistance more often than people from rural areas and small towns. Similar results were observed in the year 2003 and 2000. Another criterion that significantly differentiated people with regard to the use of medical services was income - the higher the income, the higher the use - while education factors showed that only people with primary and no education use them slightly **more often**. Thus views on the unequal access of health services cannot be supported by the results of this work.

Figure 5. Percent of households members utilising different kinds of ambulatory care, 2003

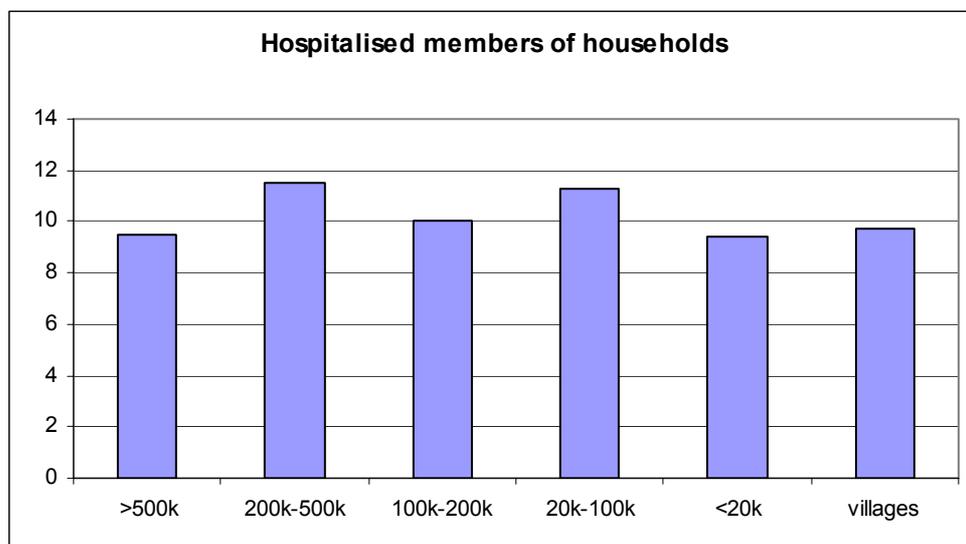


Source: GUS (2004b)

The same observations are confirmed by surveys of household budgets from 2003 provided by GUS (National Statistical Office). The difference in favor of big cities inhabitants is bigger in dental care, and smaller in primary care. In case of dental care, 15% of people living in villages used services during previous year, and 24 % of inhabitants of cities.

Hospital care was used by 22% of adult respondents, but in the group over 65, it was up to 38%. In 2000, people from rural areas used hospital care more often than urban dwellers; this difference has subsequently disappeared. People with higher education used hospital services less often than people with primary or lower education, what can be partly explained by the differences in the education of the elderly and the young population. Older people have generally lower education, but more often suffer from chronic illnesses and sudden deterioration in their health is an indication for hospitalization. The highest percentage among those using hospitals is among the retired (38%, similar to the case of the elderly).

Figure 6. Number of hospitalised members of households, per 100 per year, 2003



Source: GUS (2004b)

Slightly different picture comes from GUS households surveys, which reveal that consumption of hospital services (hospitalisation) among rural population is slightly lower than in urban population. However, the differences are not significant and the conclusion may be that the method of study made the difference, but also the utilisation of hospital services, and supposedly access to hospital services is not hindered by place of living in Poland.

Other study (CSIOZ 2007) reveals that access problems which inhabitants of rural area face are of different nature from those which inhabitants of big cities do. Perceived barriers in access to specialty ambulatory care is a long distance to healthcare facilities in rural areas (44% respondents indicate it) and, what is understandable, only 5% of big cities inhabitants. Waiting time is an important problem for 88% of big cities inhabitants and 77% of inhabitants of rural areas. Similar differences occur among persons living in wealthy and poor households.

Table 10. Major types of barriers in accessing ambulatory specialist care, differences between marginal of respondents.

Type of difficulty	Village	Big cities	Income below 80 Euro per HH member	Income over 300 Euro per HH member
Long distance to healthcare facility	44	5	45	12
Long waiting time	77	88	66	86

Source: CSIOZ 2007

Data on utilisation and famous sociological studies (Diagnoza Społeczna [Social Diagnosis] 2001, 2003, 2005, 2007) suggests then, the more wealthy and educated population, the more critical towards publicly financed services are. The more wealthy and inhabitants of cities use more often the privately paid health services. Those, who live in rural area and are less wealthy select publicly paid services, and use them generally slightly less frequently. The biggest differences occur in specialty physicians care and dental care, while in hospital care or primary care the differences are smaller, or even reversed.

2.6 Organisational barriers

Access barriers caused by poor organization were rarely a subject of specific research in Poland, because of general opinion that dominating problem are the budget constrains. The financial limitations are also sometimes reason of organizational shortages. The few studies which present difficulties in receiving care (they are called like this rather, then access hurdles), reveal that many of the problems announced by survey respondents are of organizational nature. The selection of the major problems in accessing specialty ambulatory care was presented at chart 4. The enlisted problems, in hierarchy of importance, were following:

- 1 Long waiting time (far place at the waiting list)
- 2 Too few patients admitted during working hours
- 3 Long waiting in a waiting room
- 4 Long waiting for registration
- 5 Lacking possibility to register by phone
- 6 Inconvenient working hours of ambulatories
- 7 Difficulty in receiving referral from the GP
- 8 Long distance and/or transportation difficulty
- 9 Lacking consumer information

Out of the listed above, reason mentioned in points 2,3,4,5,6,7, and 9 one may qualify to organizational ones. Anecdotal evidence suggest in the same time, that the problems are better solved in private health care units, contracted by the National Health Fund, then in the public ones.

We may also take as given that prolonged waiting for care (long waiting lists) is an indicator of both budget constrains and organisational shortages. Waiting lists were present in the Polish health care system financed from the public sources for many years. In the recent three years they became however a part of organisation of the system. The first regulation regarding waiting lists was established in the year 1998; regulation on medical documentation in the health care units obliged every hospital to keep a “waiting book” and places in the book every patient who qualified for therapy and could not be admitted immediately. The regulation did not establish rules of queuing but only the form of the inscription to the waiting book. In the year 2002 Stefan Batory Foundation started a media campaign, which resulted following:

- requirements for developing register of waiting patients set for providers by the National Health Fund – in the year 2003,
- regulation on general conditions of providing health services, establishing by law the above mentioned requirement,

- a change in the insurance law, and subsequently the law on health services financed from the public funds, demanding transparent queuing of patients waiting for services financed from public funds.

The practical results until present time are not completely satisfactory, since there is a lot of technical problems which are not solved to run waiting lists smoothly. The table below contains data on patients' waiting lists in various specialties. Until recently, the National Health Fund also published data about the waiting times for individual kinds of services. At present, this kind of data is provided by regional branches of NFZ.

Table 11. Number of patients awaiting health services by selected specialties in 2005 (in thousands)

Specialty	Outpatient care	Inpatient care
Ophthalmology	157	48
Cardiology	71	15
Traumatic-orthopaedic surgery	63	53
Gynaecology and obstetrics	72	-
Endocrinology	50	-
Rheumatology	-	17

Source: Rada Ministrów (Council of Ministers) 2006.

The Ministry of Health has issued regulations, based on the law on health services financed from the public sources, as below:

- the regulation on medical criteria for placing patients on the waiting lists
- the regulation on setting the acceptable waiting time,
- the regulation on information collected by providers and delivered to the Fund.

A common opinion is that the reason for waiting in the system is not the lack of infrastructure, but rather lack of financial resources to purchase health services. The National Health Fund signs capped contracts with providers and does not increase the volume of funds regardless of “production”, with exception of emergency cases sometimes. So, the elective admissions are limited in numbers and in the most famous clinics there are temporal or permanent waiting lists. Hospital managers declare they might increase production by another 20-30% if there were funds available to pay for the additional volume of services.

2.6.1 Practical nuisances in getting access

Rules and conditions of access theoretically established both by the legislator, in the legal system, and the payer, in the contracting arrangements, are not the only which are in force. There is a set of practical problems which patients face and which create barriers in access to care, which either come from financial and organizational restrictions of providers, and sometimes even are a result of intentional action taken by them [please provide examples: what is meant here?]. A knowledge on the barriers of this kind are rather limited and often anecdotal, but sometimes supported by more systematical research, like this which was performed by the Centre for Health Information Systems (called Centre).

As mentioned before, in theory access to care is not limited by official co-payments, and also geographical barriers are not the main problem, but the practical functioning of the system, the “friendliness” of the system, specially at the lowest level, between care provider and the patient, make that people perceive the system as ineffective, in a sense of poor performance, and not oriented at client, like in other sectors of economy.

The Centre for Health Information Systems studies of access issues focused at the opinion of patients on the most commonly utilized services, like primary care, ambulatory specialist care, diagnostic services, and hospital care. The study using identical methodology has been performed four times, in years 1998, 1999, 2000 and 2003, what was summarized in a publication

(Borkowska- Kalwas, Pączkowska (2004)). This may be supported by a series of cases, which were known to the Report authors, which tend to be characteristic for the system how it works.

The most commonly used services are primary care visits, performed by family physicians, which became a fundamental of the reform of 1999. It was supposed, by the designers of the reform, that family physicians would become the first row of care providers which take most the encounters with patients in their arms. The practical functioning of the group of providers differ however, and among good examples of performance there are also such which make access and *friendliness* of care difficult and uncomfortable.

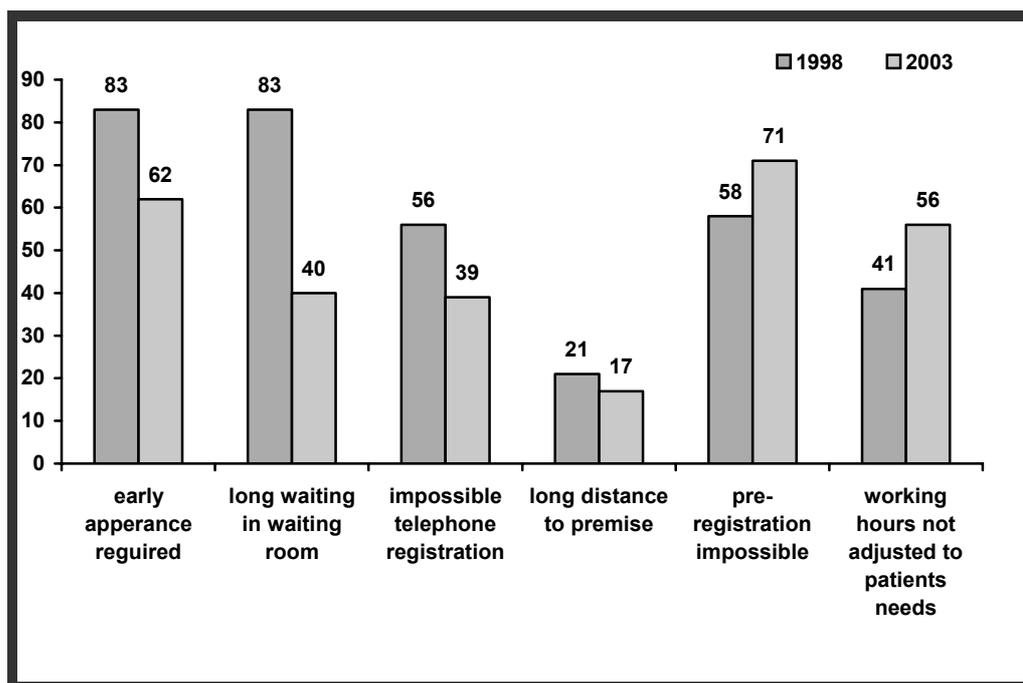
Case I. Availability of primary care in day of appearance

For many years, mainly in public health care providers, there was a routine developed, which demanded from patient to appear in the morning to get a “number”, allowing to encounter with physician this day. So, patients, often elderly and by definition sick people, used to be forced to come early in the morning to be registered for visit the day. In some cases, lines of people formed as early as 5 or 6 a.m. to get to a doctor at 8 or 9, or later. If the number of patients was big, some were refused to be registered and forced to come another day. This routine, theoretically easy to reformed by telephone registration, for example, persist until today. Among possible causes of this routine there are mentioned, too big number of patients at a list of given physician (official limit is 3000 people per one family physician), to short working hours but mainly it is supposed to be bad organization in the given provider. Certainly, at the end, one may say that financial limitations make the all above problems.

According to the Centre study (CSIOZ 2004b), the overall accessibility to family care physician was assessed as “good” or “rather good” by 91 percent of patients in 1998 and 89 percent in 2003, what taking statistical error into account, means that this was not changed during the reform years, although it

is also not bad at all. Worse results were revealed as regards accessibility to home visit access (between 84 and 82 percent respectively).

Figure 7. Reason of difficulties in access to primary care physician in 1998 and 2003



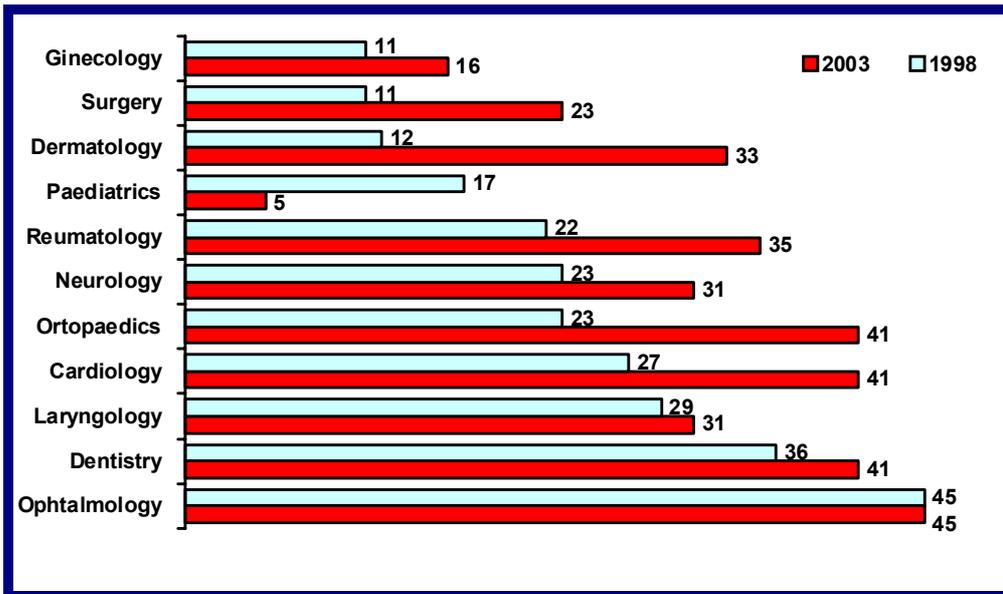
Source: CSI OZ 2004

Among the most common hurdles, patients mentioned requirement to get a “number” (“early appearance required”), lack of phone registration or other earlier registration possibility. Many patients mentioned also “long waiting in waiting room”, what is closely related to the above, and speaks of poor organization of work in the providers, whatever causes make it.

Even worse results, as regards accessibility to care, are observed in an area of specialty ambulatory care. In fact, one of the aims during the early years of reform was to limit ambulatory specialty services, instead offering competent and quality access to primary care. The results of the Centre study reveal that the aim was generally achieved, however, patients perceive it as painful

limitation and opinion on quality and competence of primary care are also questioned.

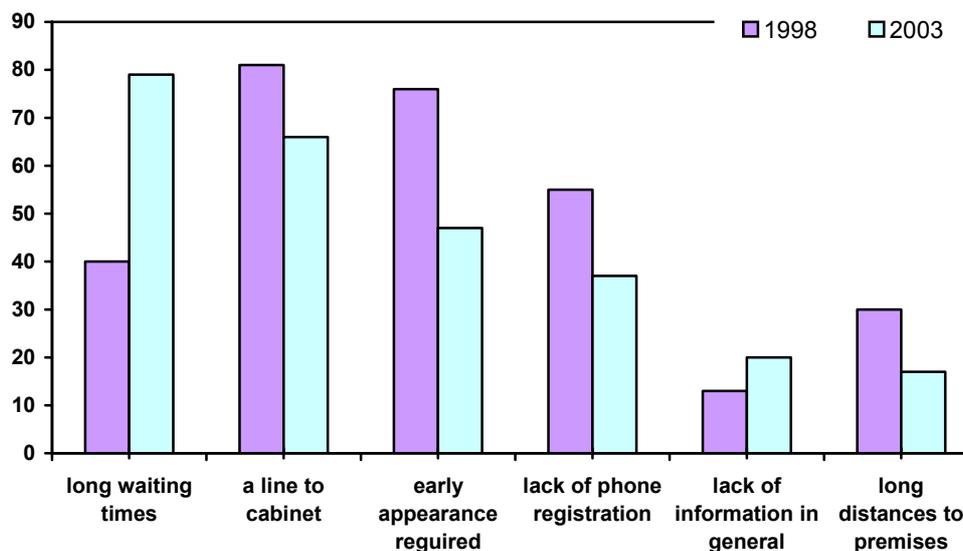
Figure 8. Accessibility to ambulatory specialist care physicians in 1998 and 2003



Source: CSI OZ 2004b

Patients declare that in most cases difficulties (poor accessibility) in getting to specialist rose during the time of reforms, with an exception of paediatrics only. In case of ophthalmology no difference was revealed, although difficulty level here is the highest, and reaches 45%.

Figure 9. Reason of difficulties in access to hospital care physician in 1998 and 2003



Source: CSIOZ 2004b

Among the most common hurdles, patients were mentioning long waiting times before the visit is possible. This was and remains the most worrying issue as regards specialist care and is related to the waiting lists system, discussed before in the Report. Nevertheless, this is the most widely discussed issue, causing that patients feel insecure, not having guarantee to get care on time, making also that many, mainly wealthy and educated patients move to private sector (in sense of method of financing), what was shown in the *Social diagnosis* study, discussed earlier. Another problems of access mentioned here were requirement to get a “number” (“early appearance required”), similarly to family physicians services, “lines to cabinet” (similar to “long waiting in waiting room”), and lack of phone registration, but those obstacles tend to decline, in opposite to the “long waiting time” problem. What is interesting, the most painful problems more frequently occur in urban area than rural area; respectively “early appearance” problem declines in cities from 89% to 71% of cases, while in rural areas from 68% to 38%. Similarly waiting time problem rose in cities from 29% to 93%, while in rural area from 47% to 75%.

Another category of commonly used services are diagnostic tests, both laboratory and imaging. In comparison to the year 1998, in the year of 2003 there is a dramatic decline declared by patients, when asked if they used/received this kind of service. Probable reason of this situation is the contracting arrangement of the payer with the providers, who are motivated to limit access to those services. This is practically done in many different way, often patients hear that the diagnostic test is necessary but is unpaid by the payer, and patient has to pay for it him/herself.

Figure 10. Use of selected diagnostic services in 1998 and 2003



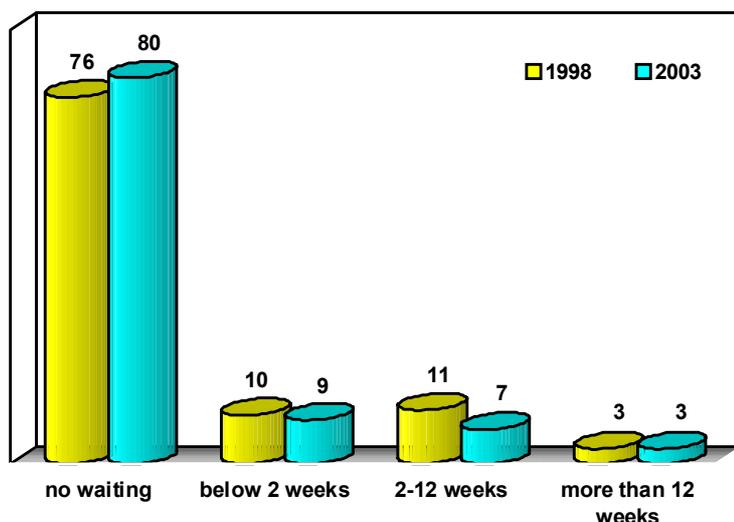
Source: CSI OZ 2004b

Case II. Accessibility to diagnostic tests

Family physicians are contracted according to capitation method, getting certain amount of money per patient per year, which includes also amounts for diagnostic testing. There is a list of diagnostic tests which family physician is required to perform at his/her expense. Obviously, family physicians try to spare funds, and although they are obliged now to spend some amount for tests, they try to avoid this expenditure. Their practice is therefore various; they try to pass (refer) patient farther, to the specialist care or to hospital, if possible, without making test, and hoping that the test will be done there. Other times they inform patient that he/she should pay for the test himself, and surely, if a given test is not in the list of test which physician is required to finance, the test is not provided for free. Patients, usually not aware of the regulations, perceive it as a form of abuse, and get frustrated and worried.

Another side of the same coin is a rapid increase of hospital admission which was observed during those years, and which was discussed earlier in the Report. Because of difficulties in access to specialist care and diagnostic tests in ambulatory settings, if patient is not able or willing to pay for it himself, and the care is necessary or at least justifiable, her/she is referred to hospital and care is provided there. Estimated 30-40% increase of hospital care is not explainable in any other way, than replacing care which was provided in ambulatory settings before; no epidemic reasons, and even ageing can explain such a fast increase, so economic and organizational causes should be explored. This, certainly, create financial burden to the system, but also difficulties and nuisance for patients, especially that admissions to the hospital are not easy, too.

Figure 11. Waiting for hospital admission in 1998 and 2003



Source: CSI OZ 2004b

Waiting time creates big social concern in Poland in the recent years, as discussed above. The chart above present however, that taking the average, this does not look bad, especially comparing with other, often much more wealthy countries, like the UK or some Nordic countries. There is a supposition that not the waiting is a problem, in fact, but uncertainty, however this thesis was not confirmed by any study, yet.

2.7 Supply side responsiveness

No evidence [have discussions with stakeholders revealed any new information here?]

2.8 Health literacy, voice and health beliefs

Systematic research on health literacy, as far as today, in Poland was hardly performed. There are beliefs that health awareness among Polish citizens is

inadequate, what makes that patients often appear to doctor with serious diseases too late. One of studies covering patients appealing for sick-health benefits revealed that some groups of patients, mainly those living in villages, approach to a doctor in late and advanced phases of their diseases, what makes that treatment process in ineffective, and finally those patients were granted a status of disabled person (Golinowska 2004 with a collaboration with Koziarkiewicz).

Late appearance in doctors office in case of serious diseases is mainly concerning in case of neoplasms. Early detection and its effects on further therapy were a subject of loud public campaigns, which the most spectacular recently were enlisted in a table below.

Comparison - Social campaigns on cancer prevention

Subject	Name of campaign	Target group and scope	Provider and sponsor of campaign
Prevention of breast cancer	It is good to have breast (Dobrze mieć piersi)	Women; national wide	Cosmetic firm Avon
	Pink ribbon (Różowa wstążka)	Women; national wide	Cosmetic firm Avon and women magazine 'Twoj styl'
	Pink Lunch (Różowy Lunch). Możesz zdążyć przed rakiem - i co dalej	Women Local	Jolanta Kwaśniewska (Presidents Wife) Foundation
Prevention of prostate cancer	What every big boy should know (Co każdy duży chłopiec wiedzieć powinien)	Men Local	Jolanta Kwaśniewska (Presidents Wife) Foundation
Prevention of skin cancer	Malignant melanoma - stop (Czerniak-stop. Skóra pod kontrolą)	Population National wide	Cosmetic firm La Roche Posay and Dermatology Clinic of Ministry of Internal Affairs Hospital

Other loud campaigns took as subject the mental diseases and were focused at creating tolerant attitudes towards people suffering from them, and at their social integration, as for example a campaign entitled Schizophrenia - Open the door (Schizofrenia – otwórzcie drzwi), organized by Polish Psychiatric Society together with WHO and Polish Ministry of Health. During the campaign negligence of psychical disorders in Polish society was emphasized. Negligence of mental illnesses is also related to overemphasized concentration on curative care and other than psychical disorders types of diseases. Simultaneously, social polls show that insecurity and worries about mental health are increasing. 45% of respondents declares being worried of their mental health. This trend more often concerns men than women, active age population than young and elderly and people in less advantaged socio-economic positions: unemployed, poor, low qualified (CBOS 2005). Importance of the last factor is emphasized by the fact that 77% of respondents indicates lack of employment as a significant risk factor for psychical disorders. The second cause of psychical disorders – as viewed by the respondents – are family disorders (47%).

Another campaign on mental health was focused at detection and treatment of depression; “To fight depression (Pokonać depresję), initiated by ‘Gazeta Wyborcza’ newspaper.

Presenting relations between life style, nutrition, consumption of alcohol and tobacco are rarely in a form of big social campaigns, with one exception: smoking. A campaign in this field was initiated at the beginning of 1990-ties. Personal engagement of famous epidemiologist, professor Witold Zatoński was very important here, and thank to his determination many actions were undertaken. Currently he engages in another epidemiological problem; consumption of fats and its relation with cardiovascular diseases (Zatonski, Willert 2005), promoting consumption of plant fast instead of animal ones.

Health literacy is increasing also by improvement of knowledge on diseases, awareness of their symptoms and results. In this area media play important role, themselves. In the TV (TVP2), there is a daily morning program on health and diseases, with attendance of physicians, who inform watchers calling to the

studio. Major magazines and daily papers in recent years addend to their issues brochure encyclopedia, providing information on diseases, their etiology and symptoms, and also on therapies and medicines. The brochures, provided information in very communicative and easy way, were usually sponsored by pharmaceutical industry. Weekly magazines were engaged in creating quality rankings of health care providers, rehabilitation centers and pharmacies.

Thanks to the Office for Consumer Protection, food products and drugs, nearly all, are equipped with data on chemical content and potential side effects, in case of drugs certainly. Achievement of this effect was not when importation of products rapidly increased at the beginning of the 1990-ties.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion: elderly people with functional limitations

3.1 The scope of the elderly population with functional limitation

On the basis of NSP data collected by the Central Statistical Office (GUS) in 2002, it has been established that the number of disabled people with an officially determined disability (defined as the inability to work) amounts to 14% of the entire population in Poland (GUS 2004). Almost 60% of people with disabilities are people aged over 60/65¹⁷. The percentage of disabled people in the subsequent age brackets as well as the level of disability increases and at the age of 75 or older, almost half of the population has an officially determined disability done by the administrative assessment process defined in the so called invalidity assessment regulation. This rate is higher for elderly women than for elderly men (48.8% and 47.4% respectively) but difference is not statistically significant.

During the conduct in 2002 of the NSP, GUS also gathered information on the self-perception of fitness and disability. This data reveals that the feeling of being disabled is stronger in older age than it appears from the statistics of official records on occupational disability. As much as about 20% of the elderly feel to have functional limitation without possessing legal determination of disability, whereas this is only 4% for the total population. Moreover, elderly women feel to be disabled more strongly and more frequently than men (over 25percentage points) (GUS 2006).

The number of people with a significant degree of disability increases with age, which is a not surprising,. However, the growth rate of this most profound type of disability was very high in Poland during the 1990s. This growth became

¹⁷ Polish statistics also provide information on people of the so-called non-productive age, namely above 60 years of age for women and above 65 years of age for men.

parallel to health status improvement measured by the average life expectancy, after years of stagnation, of these indicators.

3.1.1 Social insurance for the elderly and disabled people

Both the elderly as well as disabled people possess relatively good social insurance in Poland in terms of income. Old-age pension and disability pension provide a safety net against poverty even to a greater extent than income derived from employment by the economically active population. This results from the fact that the system of social insurance in Poland constitutes the most important and the most politically sensitive aspect of social policy. For this reason, the disability pension and old-age pension formula includes a significant redistributive common element, independent from employment record: 25% of the average wage¹⁸. Additionally old-age and disability pensions are systematic indexed according to the increase of the inflation index and partly – to the increase also of wages. In contrast, the economically active population is marked by a high unemployment rate, one of the highest in Europe in terms of long-term unemployment and only about 15% of this group receives an unemployment allowances .

The relative poverty rate, which is estimated on the basis of household budget surveys for people above 65 years of age is significantly lower than the poverty rate for people at an economically active age (25-64) for each relative rate differentiated by the level of the poverty line; 40%, 50%, 60% and 70% of the median household expenditure with the application of the old OECD equivalency scales.

¹⁸ In the futures according to the reformed pension rules pensions will be determined on the ‘defined contribution’ principle

Table 13. Relative poverty rate according to age and disability

Age of household head	Poverty rate according to poverty lines			
	40%	50%	60%	70%
Average	4.5	10.1	17.6	26.0
65+	1.4	4.0	8.0	13.4
65-74	1.3	3.8	7.5	12.5
75+	1.6	4.3	9.1	15.3
<= 64	4.9	10.9	18.8	27.6
25-64	3.8	8.7	15.4	23.3
25-54	4.2	9.4	16.7	25.1
55-64	2.3	5.2	9.5	15.3
0-24	6.5	14.0	23.7	33.7
60+ with determined disability				
	1.6	4.4	8.6	15.0
1st group – disabled but partly able to perform work	1.3	3.0	6.6	11.9
II group - unable to perform work	1.6	4.4	8.6	14.4
III group – unable to lead an independent life	1.9	6.1	11.5	19.9

Source: individual data of Polish BGD (HBS) 2003

The data from the table above shows that the highest poverty rate amongst the elderly is present in the group of severely disabled people, unable to lead an independent life. This is the outcome of a weak record of employing these people (taken into consideration in the formula setting the disability pension) as well as the limited opportunities to earn additional money.

Persons aged 75 or more receive a permanent allowance of the same amount each month in addition to their old-age or disability pension to cover attendance care costs. This is a universal allowance, regardless of the degree of dependency and also in case they have no functional limitations at all. The amount of this allowance (120 PLN) is symbolic in comparison to the actual costs of care (20 times higher according to commercial prices of LTC institutions) and at the same time, contrary to the name, this is an unjustified expenditure in the case of fit persons.

3.1.2 Epidemiological profile of the elderly

The available information on illnesses and causes of disability amongst the elderly does not enable for the full epidemiological picture of this population to be presented. By using GUS sources derived from self-assessed health status surveys, it is possible to indicate the illnesses that the elderly complain of. In turn, by using information collected by the National Insurance Institution (ZUS), it is possible to identify illnesses which led to the official determination of inability to work. Causes of death amongst the elderly can be established from mortality statistics. Each of these pieces of information provides a limited view but an overview of the full picture is still possible to derive. It emerges from it that the elderly most often suffer from cardiovascular diseases. These illnesses most often constitute the basis for determination of disability (about 25% ZUS 2007) and they most often are the cause of death.

In the second place are tumours. Out of the total population applying for disability pension, 18-19% are people suffering from cancer. Cancer is the most common cause (50%) for determination of the inability to lead an independent life in the total population however it constitutes only 4.2% in the population of persons aged above 65. It is the second leading cause of death in mortality statistics.

Mental illnesses constitute the next, the third leading cause of disability (16% of determined disabilities). In recent years, the growth dynamics of people suffering from this type of illnesses has been very high, higher than in the case of other illnesses. Amongst people above 65 years of age, over 12% of determinations of inability to lead an independent life are due to mental disorders (ZUS, op.cit.).

50% of persons above 65 years of age with a determined disability unable to lead an independent life suffer from bone, joint and muscle disorders that limit movement. Respiratory illnesses are the second most common cause of disability, affecting 37% of the population in this age group (ZUS, op. cit.). The rate of serious sight and hearing impairment increases with age and paresis caused by strokes significantly increases.

It is obvious that elderly people die more frequently than younger categories. More interesting is what is the mortality pattern of the elderly. Mortality data from 2005 reveal that elderly people more often die from cardiovascular disorders, especially atherosclerosis (despite some doubts regarding validity of this diagnosis), cerebral vessels disorders (excl. stroke), and imprecisely diagnosed conditions of heart, heart failure and hypertension. Chronic bronchitis is also more frequent condition, than in general population, as well as, diabetes. Much less frequently, elderly people die from any external causes, starting from car accidents, to poisonings (GUS 2006d, p. 381 – 397).

3.1.3 Expenditure on the provision of healthcare to the elderly from health insurance funds

The share of the National Health Fund (NFZ) expenditure on the healthcare needs of the elderly in Poland amounts to 30%, which equates to around 6 bn PLN. This average share indicator is higher in the case of primary healthcare, first aid, expenditure on rehabilitation equipment and medical material, sanatorium as well as – of course - long term care.

Table 14. Expenditure on health care of the elderly

Category of spending	Population - total	Elderly - 65+
Total	100.0	30.0
Primary care	100.0	37.4
Specialists – first aid	100.0	20.5
Inpatient care	100.0	31.7
Mental disorders with therapy of addiction	100.0	12.2
Rehabilitation	100.0	27.2
LTC	100.0	72.1
Dentists	100.0	13.7
Sanatorium	100.0	32.1
Emergency	100.0	47.9
Health promotion and preventive care	100.0	7.5
Medical and rehabilitation equipment and materials	100.0	50.5

Source: NFZ database 2004 - 2005

As the above table data shows, visibly less financial assistance is provided for elderly people with mental disorders than for specialist care and slightly less for rehabilitation.

3.1.4 Use of healthcare services by the elderly

Information about the use of healthcare services comes from so-called module surveys that supplement household budget surveys in 1998, 1999 and 2004, published as *Health Care in Household surveys (Ochrona zdrowia w gospodarstwach domowych)*¹⁹. The survey results show that old age in Poland influences predominantly greater frequency of primary care use. Hospitalization also increases with age but to a significantly lesser extent when compared with primary care.

Information about self-assessed health status as well as accessibility to healthcare comes from the same source (GUS module surveys) as well as the CSIOZ report (2004b - Healthcare Services Accessibility by Polish Citizens 1998-2003) that analyses data from the mentioned GUS surveys. They give rise to the following conclusions:

- Elderly people usually better evaluate access to specific type of services. They more often declare satisfaction with access to healthcare services and the service provided itself.
- Elderly people less often declare that patient order on waiting lists depends on money and connections. 44% of people aged 65+ indicated *connections* as a means of speeding up treatment and 86% of people aged 18-24. 34% of the elderly stated that individual payments increased accessibility in comparison to 70% of young people.

¹⁹ These are repetitive representative surveys supervised by GUS. Their objectives are to describe health service utilization in Poland and to provide basic information on self assessed health status. In 1998 the survey covered a sample of 3,916 households and 11,983 individuals; in 1999 a sample of 5,796 households and 17,816 individuals; and in 2003 sample of 4,073 households including 12,337 individuals.

- Elderly people with low income significantly more often than young people stated that they could not purchase their medicine; 40% of people aged 65+ and 20% of people aged 18-24, respectively. Similarly in the case of health services, 31% of elderly people and 15% of young people did not consult a doctor due to lack of money. It should be assumed that the health services concerned those of selected private health practitioners.
- Access to hospital services is better in the opinion of the elderly; only 8% of people aged 65+ incurred any related costs. However persons aged 35-44 stated (22%) the necessity to incur costs related to hospital stay.
- A common problem of people with healthcare needs was the exhaustion of quotas for admission to publicly funded healthcare centres. It is interesting that people in their *prime age* (45-64) came across such situations twice as often as elderly people (65+); 17% and 8% of the respondents declared such situations, respectively.

Overall, elderly people are by far less critical in terms of limitations and barriers in accessing the public healthcare system. Only 25% of elderly people notice signs of inequality in the healthcare system whereas such inequalities are observed by 42% of people aged 35-44.

It is difficult to interpret these results in the context of the study because older people usually have lower expectations but at the same time actually experience less of the barriers of health care access.

3.1.5 Access to health care for older people with functional limitation

The issue of access of elderly people with functional limitation to healthcare services is not the subject of any systematic observation. It is assumed that legal provisions as well as the lack of discriminatory behaviours toward the elderly ensure they have the same level of access as other population groups in the case of typical diseases. In the case of people with strong functional limitations have been found first of all that they have to experience severely problems with adequate nursing care services.

There is a few strong evidence confirming or denying this thesis. One possible measure of access and potential barriers is a utilisation of health care by different age categories. For obvious reasons utilisation of health care by elderly is much (7-8 times) more frequent than this by younger population (age below 50). This fact however does not prove the lack of barriers, yet. Some other measurements are based on opinion. Inequality of access to health care is perceived **much more** frequent by better-off people; inhabitants of big cities, better educated people, more wealthy etc. This observation, here cited after the Centre for Health Information Systems (CSIOZ 2007), is present in studies, too (Tymowska 2007 in: *Diagnoza Społeczna [Social Diagnosis]* and (GUS (2006a),). Besides lower expectations of those categories of population, it may also suggest that generally the health care system is oriented at provision of basic care, at the level which is satisfactory for less demanding groups of population, and disappoints more demanding younger and more wealthy population.

Table 15. Categories of respondents who are most and least frequently confident of inequalities in access to care.

Most frequent	%	Least frequent	%
People in age 25-35 and 45 – 54 years old	27	People in age of 65+	12
Big cities inhabitants	27	Inhabitants of villages	16
High (university) educated people	29	Low (primary) educated people	13
Self-employed	36	Manual workers	15
White-collars	38	Farmers	23
	36	Retired	14

Source: CSIOZ 2007

In the area of healthcare, press articles tend to focus more on the fact of high (over-representative and outright excessive) use of primary doctor services and hospitals by the elderly. It is only through contact with families of elderly persons with functional limitation or NGOs which support these people and their families that it is possible to see the problems and barriers faced by these people in the healthcare sector. Below are outlined results of a quality

survey²⁰, which was conducted amongst healthcare staff and carers of elderly people suffering from dementia (and Alzheimer's disease). It is estimated that approx. 400,000 people show signs of dementia and approx. 200,000 suffer from Alzheimer's disease in Poland (<http://www.portalmed.pl>).

The first conclusion that ensues from this survey concerns the limited role of doctors of first contact (family doctors). The elderly and their families who consult doctors with symptoms of dementia do not receive sufficient medical care or information on the available socio-medical aid. Most often, doctors do not recognize the illness in its initial phase or ignore it, suggesting senile sclerosis or atherosclerotic changes. They do not want to refer patients for diagnostic tests or neurological or geriatric consultations. They do so only under very strong pressure exerted by the families. Carers admit to exerting such pressure as consultations and tests are very expensive. Nonetheless, at times it is necessary to use private healthcare services as it takes several months to see public medical specialists. In particular, this concerns several specializations, including – neurology (NFZ: information about waiting lists provided by regional NFZ offices, www.nfz.gov.pl).

When family doctors suspect or even diagnose the dementia syndrome, their knowledge about means of providing care to patients or potential institutions and means of help is poor. Doctors admit that they do not possess sufficient information material. Most often, they use material supplied by pharmaceutical companies together with medication for dementia illnesses. This probably means that they have not received adequate training to deal with these health and social problems of elderly during their medical education. Families also admit that help from pharmaceutical companies is professional and constructive.

Families complain about the way doctors communicate with them as well as the patients in their care. Distance as well as avoidance of encroachment into

²⁰ The survey was conducted by a public healthcare student at Collegium Medicum UJ in Krakow – Violetta Kijowska as part of her Masters thesis. The survey was based on the focus group method with the participants consisting of healthcare staff and family carers of people suffering from dementia syndromes.

nursing and care issues which are treated as non-medical matters, constitute typical behaviour of health clinic doctors.

Patients and their families from the surveyed focus group stated that they do not take into account nursing homes in social assistance sector as they are convinced that these institutions are focused exclusively on lonely or very poor patients. They also list cultural reasons. It is still frowned upon in Poland to send elderly or ill persons to institutions at the family's initiative (without the doctor's suggestion), especially in villages and small towns.

Another conclusion resultant from the cited survey concerns easier resolution of nursing and treatment problems in hospitalization cases. When patients are admitted to hospital for reasons of co-existence of other serious illnesses, i.e.: strokes or heart attacks, then together with the families they automatically receive rehabilitation and information help concerning nursing and social care. Patients may be referred to LTC institutions and nursing homes managed by the health department. Their stay at the hospital exposes other difficulties of general nature: insufficient nursing care (particularly troublesome in 2007 due to several-month long strikes of healthcare personnel), lack of medication, poor diets or problems with feeding patients.²¹

Proposals were also put forward concerning non-medical institutions and free of charge access to materials on chronic illnesses amongst the elderly, especially the dementia syndrome. Complaints were made about the actions of electronic media, women's magazines and newspapers, which omit counselling in such difficult situations as dementia diseases, and focus instead on ads for common ailment medications and cosmetics. Internet was named as the most helpful tool however access to this source of information is very limited amongst ill people and their carers.

A review of NGOs oriented toward helping patients and their families in cases of dementia illnesses leads foremost to the conclusion that there are not many of

²¹ Hospitals have en mass adopted a system of outsourcing of food services, which do not adjust to the ongoing patients' dietary needs and employees of catering companies, as external staff, do not help with feeding patients.

these types of organisations. The handful that does operate has to cope with an enormous amount of information work. The most known organisation is the Polish Association of Help for People with Alzheimer's disease [*Polskie Stowarzyszenie Pomocy Osobom z Chorobą Alzheimera*] founded in the early 90s. The Association's chairperson - psychologist Alicja Sadowska - initiated and personally wrote most of the elementary pamphlets on this illness as well as advice for carers on how to care for people suffering from Alzheimer's. Currently, more people have become active in this field, which is reflected in the creation of the website: www.alzheimer.pl managed by a team of editors. At the beginning of the present decade, an educational campaign was launched on Alzheimer's disease together with the opening of an infoline.

Carers of people suffering from dementia diseases organise themselves into self-help groups. The Church as well as basic care institutions, community nurses, local journalists writing on social issues plus local government employees and social workers act as mediators in this respect. Membership in such groups is a source of emotional support while carers continue to emphasise the lack of knowledge and need for significantly greater expert information from the part of the health service.

3.1.6 Interface problems between health and other social services for older persons

The biggest problem of the Polish healthcare system for the elderly with functional limitations is underdevelopment of infrastructure of services that at the same time ensure health, rehabilitation and nursing care. Although a special network of LTC institutions for people with functional limitations started to develop in the 1990s, this development is still insufficient in relation to the dynamic growth of needs. About 11,000 beds (for determined period of stay and rehabilitation) are available at LTC institutions, which accounts for 6% of all beds in stationary care (<http://www.mz.gov.pl>).

The intention behind the creation of a network of LTC institutions which followed the government programme (part of the health care reform 1999) was to take some workload off hospitals in terms of healthcare provided to non-independent

persons who no longer require medical care but continued monitoring of pharmacological treatment previously administered in hospital, a certain scope of medical rehabilitation as well as constant nursing care. LTC institutions admit patients whose condition is defined in the range of 0-40 points on the ADL scale of independence. The period of stay at an LTC institution has been defined by regulation in principle as “up to 6 months” but it can be extended and even defined as permanent stay (such a possibility was introduced by provisions in 2005) upon doctor’s orders and if the payer expresses consent for this.

There are usually waiting lists for LTC institutions. Although there is no data on waiting lists for LTC institutions, procedural practices are known for cases when patients are referred to such institutions (information available on websites on conditions of admission to specific institutions). Patients usually spend their waiting period in a hospital. However, hospital practices have become more restrictive recently and families are requested to place the patient in other stationary care institutions or take the patient home whereby a basic healthcare doctor assumes responsibility for the patient’s care.

All patients staying in nursing homes have to cover the costs of food and accommodation. Maximum monthly payment cannot be higher than 250% of the lowest pension, but in a certain case a fee cannot exceed 70% of a patient’s pension. The same rule applies to children under 18 residing in nursing homes, however, in this case a monthly payment cannot be higher than 200% of the lowest pension and not exceeding 70% of income per capita in a particular family.

When NFZ funds healthcare at long-term institutions at a scale lower than the number of patients, the institutions in that case offer places at commercial prices with a promise to lower the price following acquisition of funds from NFZ. The commercial price is usually 2 – 2.5 times higher than the fee that takes into account NFZ’s financial contribution. The poorest patients may rely on subsidies from social assistance institutions sources.

The limited funding of LTC institutions from NFZ funds means that the elderly and non-independent people in terms of healthcare, rehabilitation and nursing

care encounter not only infrastructural obstacles but also a financial barrier. This barrier does not concern the poorest patients (entitled to social assistance) or the richest patients (that can afford to pay commercial rates or use entirely private centres of this nature) but average patients with average incomes.

The elderly and non-independent people in need of healthcare at the place of their residence use basic healthcare services provided by family doctors or community nurses. It emerges from research that the basic problem in the scope of provision of healthcare services to these people is the lack of systematic geriatric evaluation encompassing somatic and mental health conditions as well as the family situation and living conditions of the elderly (Szczerbińska 2004) and their careers. In consequence, these people are subject to rehabilitation actions to an insufficient extent. Healthcare often reduces to pharmacological treatment and care.

3.1.7 Conclusions concerning the healthcare policy in relation to the elderly with functional limitations.

Older people with functional limitations do not constitute as yet a group of sufficient healthcare policy interest in Poland although this group is becoming increasingly numerous. Its number is currently estimated at about 2 m with an expected increase by 30% in the next 20 years (Szuklaski 2004). A change of the healthcare policy in relation to the discussed group requires several simultaneous actions:

- Increased education of doctors (particularly GPs) oriented toward treatment of old-age illnesses and geriatricians,
- Increased education and motivation of nurses to work with older people with functional limitations,
- Increase of skills of basic healthcare doctors (through appropriate training) in the scope of healthcare, nursing care and social care within local community,
- Introduction of tests of independence evaluations for the elderly through methods such as ADL tests in order to estimate rehabilitation as well as

nursing needs of these people, both for care in institutions and for home care

- further development of the network of LTC institutions,
- Complete reorganisation of funding of care over non-independent elderly people at home. The little universal care allowance functioning so far for elderly people over 75 should only be granted in cases of real need for care and in adequate scale to the prices (or rate) of such care. At the same time employment of social workers and nurses connected to the institution of a family doctor should be developed.

4 General conclusions

The Polish health system is subject to a number of limitations, which concern all of its users and not just socially excluded persons. These limitations are related to the low funding of the sector as well as inconsistent reforms that on the one hand allow the functioning of market mechanisms (autonomy and privatization of healthcare centres) and on the other, apply administrative budget controls on the basis of not entirely clear criteria (CASE 2005). Moreover, the system is ridden with conflicts against the backdrop of low salaries of young doctors and nurses (the medical strike lasted several months in 2007) and also the weak governance of and within the sector.

The consequences of the poor functioning of healthcare institutions affect mainly persons who are forced to use its services in these conditions and limitations of access concern predominantly persons with lesser formal access, i.e.: the long-term unemployed or not economically active who do not possess insurance due to lack of employment or do not entitle to social benefits and as consequence - do not pay social insurance contributions. Access to health services of this group of people requires government subsidy to cover their contributions.

It is people with the biggest healthcare needs, including chronically and terminally ill patients, who are forced to use the system and as such they bear the brunt of the poor functioning of Polish healthcare institutions. These weaknesses can be bypassed by using the private sector, which is fast becoming the practice amongst more affluent groups. People belonging to these groups pay their public healthcare contributions and at the same time pay doctors directly for consultations at private doctor's offices and clinics. Companies are increasingly signing agreements with clinics for the provision of private healthcare services to their employees. Poorer and seriously ill patients use exclusively the public healthcare sector.

Under-funding of the public sector, above-all of the hospitals and medical rehabilitation centres is leading to a situation whereby patients and their families are supporting these centres through the provision of medications and medical materials. This happens through spontaneous and joint reactions of families of the patients upon realization of the lack of a specific product. It is not officially demanded by the medical personnel. Customarily, patients present medical staff with flowers, books and sweets in appreciation of their care. Findings of the *2005 Social Diagnosis* (Tymowska 2006) reveal that this custom continues to persist although the value of such gifts is gradually becoming lower.

A significant issue concerning use of the public healthcare system by people with more complex health problems (the chronically ill or patients suffering from mental disorders or dementia) is the fact of inadequate skills of family doctors as well as limitations of access to diagnostic tests and specialists. At the level of primary health care the Polish healthcare system in the educational and information scope is not adjusted to the new phase of epidemiological development (connected with aging). Additionally - primary care physicians, due to improper economic incentives (financing based on capitation method), tend to shift patients with more serious and chronic diseases to upper levels of care, what results with wrong allocation efficiency.

Access difficulties also arise from the lack of coordination in a situation of joining of healthcare, nursing care and social care so far overseen by different government departments. Not only does this make life more difficult for those in need of coordinated care but it also substantially increases the costs of the system. For example, a social assistance home patient can most easily receive specialist medical care by being hospitalized, meaning through more costly means.

The existence of such grave difficulties in the functioning of the healthcare system, such as those present in Poland, gives rise to numerous initiatives of doctors and social workers who fill educational, informational as well as interventionist gaps within the NGO sector. Initially, they prepare and lead social campaign programs which increase awareness of the society as well as policy makers about the health problems faced by vulnerable groups. The internet

serves as a useful tool that supports national prevention programs, programs of combating various illnesses and also promotes social integration of the ill. Some of the good practices in this area include initiatives on open treatment as well as social integration of persons with mental disorders.

In order to stimulate greater awareness of the society as well as policy makers about health problems of vulnerable groups, research identifying specific access difficulties as well as inequalities in the health system would be most beneficial. However, the high costs of creation of a database for such type of research have to date always lost out against the costs of medical research in a situation of profound under-funding of the health service. Inequality of access to health care rarely is analysed at a technical level, too, although very often used in political debates. This inconsistency persists for years and no progress is noticed, so far. One may only hope, that European level policy and tools will make national health administration to cope with the problem at a practical dimension and not only the rhetoric.

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