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CHALLENGES OF PRIVATIZATION IN THE POLISH HOSPITAL SECTOR

Abstract

The structure of the Polish hospital sector calls for changes due to exploding health care costs, legal situation of the involved institutions, and demographic development. The paper explores the actual situation in the hospital sector in Poland and highlights the possible options of privatization. The author focuses on the would-to-be effects for each privatization alternative in terms of management, human resources and service quality. The paper also presents the debate over privatization of public hospitals, which seems to be among the most difficult political decisions.

Key words:

health care, hospital sector, Poland, privatization, public sector.

Introduction

In the last decade, Poland has re-examined the structure of governance in its health-care system. A number of challenges in the health sector were highly conducive to the current wave of reform. In addition to demographic, political and social factors, the key contextual pressure is the increased expectations of citizens and patients. The Poles, similar to the citizens in all parts of Europe demand a more patient-oriented approach to the delivery of health care services.

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Patients have strong views on the need for choice and quality in health services, often backing up these demands with out-of-pocket payments to providers.

In order to meet the increasing patients' demands, as wells as to keep costs under strict control, public health care units, especially hospitals, turn to privatization. This paper attempts to discuss the possible lines of action to adopt for privatization and to demonstrate their advantages and drawbacks.

1. The Reform of the Polish Health Care System

In Poland, a number of the market-style mechanisms have been introduced within different fields of the health system: in health care funding, in many sub-sets of the production of health services (e.g. hospitals, primary health care), in the allocation mechanisms. The Government's reform of health care provision in 1999 was designed to give patients a choice in the service available to them by introducing a competitive structure in the health care sector. This type of publicly planned market, which was termed as internal market, public competition or quasi-market [3; p. 159], involves the separation of the purchaser from the provider by means of negotiated contracts. An accompanying trend reflecting the changing role of the state was the development of the new methods and forms of funding and reducing the share of budgetary funds in health care financing [8; p. 281–293]. Another accompanying trend was the decentralization of responsibility to lower levels within the public sector. Finally, the growing focus on the micro-level institutional activities generated an increased concern about the quality of the relations established with patients. The rationale behind this reform and the reforms introduced in other countries is the supposition that health care providers would have a greater incentive to satisfy their patients if a larger proportion of their income was linked to the total number of patients on their lists [5; p. 57–64].

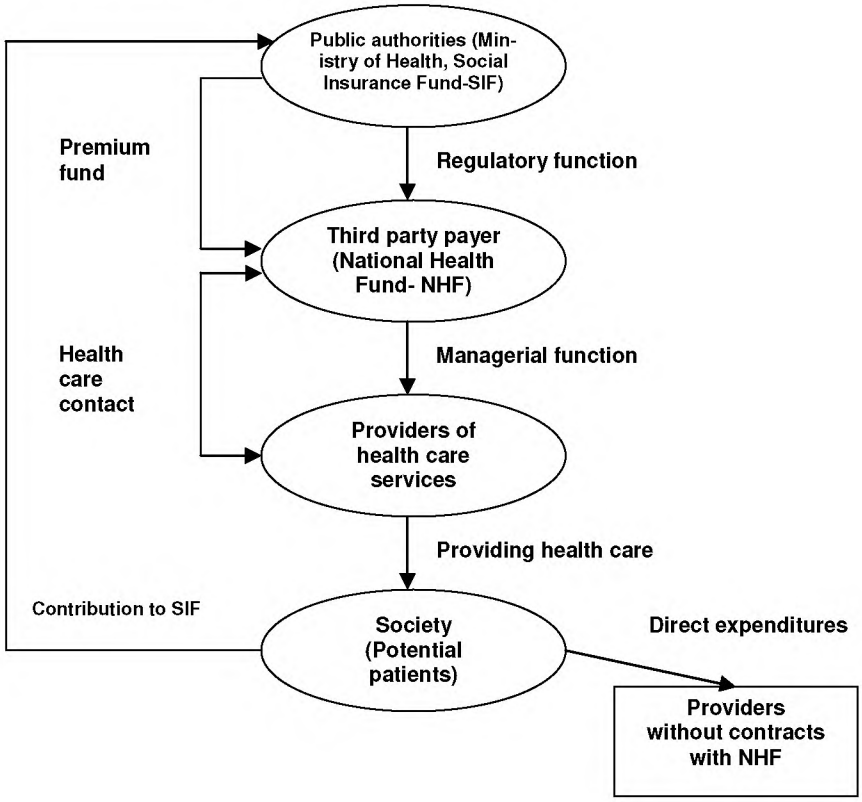
As a consequence of the above mentioned trends, health care providers were found to be under a growing pressure to increase access, lower costs, and raise quality. Among the many tactics they employed to cope with it, was the privatization.

Under the current health care system (Figure 1), the function of the main payer was entrusted with the National Health Fund established on April 1, 2003. The Fund replaced the health care units (kasy chorych) which had been functioning since 1999 pursuant to the Act of February 6, 1997. The goal of the project entailed institutional separation of the payer, as an entity responsible for purchasing health care services, from the service provider that would satisfy the reported health care demand. The purchase of services is, however, one of the final stages of realization of the functions entrusted with the payer [4; p. 3]. In order to make a decision as to allocation of funds coming from insurance contributions, the National Health Fund und previous health care units should, at the

same time, fulfill the tasks related to identification of health care demand of the insurers and inhabitants in the sixteen Polish regions. They should plan the ways of securing the demand, contract the services for realization of the identified demand, finance service providers, and control contract execution. While executing their tasks, the management of the National Health Fund and its sixteen territorial units should find out which services, in which quantity, with which service providers, and at which price they should purchase. The realization of contract monitoring can, on the one hand, provide the basic information needed for, at least, a partial assessment of the decisions made, and, on the other hand, ensure the supervision over the quality of services provided.

Figure 1.

The Model of Health Care System in Poland



Source: compiled by the author.

At the early stage of functioning of the common health insurance, the hopes for institutional change were raised by the Act on Common Health Insurance [1], which stipulated that starting from January 1, 2002, people subjected to common health insurance would be able to fulfill their duty not only with public health care units (at present National Health Fund), but also with other institutions for health insurance, which would operate based on separate regulations as to insurance activities. However, the ammendment of the Act in November 2000 [2] jeopardized these hopes or at least deferred them far into the future.

2. The Overview of the Actual Situation in the Polish Hospital Sector

For hospitals, with the exception of large regional and teaching ones, the organizational change meant transformation form state ownership to municipal ownership. To date, none of the 736 existing public hospitals have changed their ownership form to private companies (i.e. to the for-profit or non-profit sector). The situation in the hospital sector can be explained with the help of figures presented in Table 1.

Table 1

The Data Reflecting the Situation with Polish Hospitals

Total number of hospitals	736 (including 45 non-public ones)
Beds ratio (per 10,000 persons)	48.7
Physicians ratio (per 10,000 persons)	22.4
Average length of stay in days	8.4
Average occupancy rate	74.6%

Source: Rocznik Statystyczny Rzeczypospolitej Polskiej, GUS, Warszawa 2002.

It is a commonly shared opinion that public hospitals are too old and ill-equipped, and capital expenditures are insufficient to support the existing facilities or introduce modern technology. High-cost equipment, specialized surgical facilities and advanced pharmacology are not as widely available as in Western Europe. The access to a limited number of centers with high-cost, state-of-the-art technology is limited either legally by long waiting-lists of patients or informally by connections and income. At the same time, the emergency hospitals account for the largest share of health expenses. Some indication of inefficiency

is given by relatively high lengths of stay, but only moderate occupancy rates. Occupancy rates average 74.6 per cent, with higher rates in central tertiary hospitals and district secondary hospitals and considerably lower rates in rural hospitals. The average length of stay in 2001 was 8.4 days. Further, there is a high rate of use of in-patient care.

On the other hand, a closer look at private hospitals reveals that their averages for beds, cases and days of stay are much below the respective averages for public hospitals. This fact shows that the majority of private hospitals are small and specialized hospitals with a few departments. As a result, it turns out that the majority of private hospitals are practicing a profitable medical case-picking [11].

Under these circumstances, as well as due to exploding health care costs and demographic development, the need for effective management is the top priority of the public hospital's policy. Privatization is one of the possible ways of achieving this goal.

3. The Debate over Privatization of Public Hospitals

Since 1991, the privatization of public hospitals has been one of the major concerns for health care policy-makers. The starting point of the discussion is the distinction made between privatization of property and privatization of activity. The arguments for privatization mentioned are the following [15]:

- the introduction of professional management;
- the escape from bureaucratization of public supervision and realization of non-effective goals, e.g. protection of employment in redundant hospitals;
- the development of the conditions for building service ties among healthcare institutions;
- the need for capital investment and top managers that are not available within public sources;
- the reduction of physicians' moral hazard related to the transfer of the part of the treatment costs of a private patient on to the budget of the public institution;
- the prevention of distribution coalitions developed by politicians, public institution managers and holders of public resources with the aim of realizing particular interests.

On the other hand, the opponents of privatization believe that it can result in or contribute to negative effects, such as [9]:

- changes in the range of hospital activities (withdrawing from the production of certain services which can deprive patients of the possibility to use them),
- the new profit-oriented owner's commitment to gain maximum benefit in the short run, which can result in devastating exploitation of resources without consideration for future activity,
- the management's treatment of the purchased health care facilities, in particular land, as a subject of speculation.

The position of the Ministry of Health towards privatization can be described as favourable. A proof to that is the draft of the act on the health system, where privatization intensions are strongly emphasized: hospitals should be transformed into foundations or joint companies operating under commercial law. However, a more in-depth analysis demonstrates that the concept of the mechanism of allocating the initiative and accountability for the development of the hospital infrastructure among the government administration, local authorities and private investors is not clear [16]. This fundamental lack of clarity influences the interpretation of the whole programme of privatization and results in uncertainty as to the manner of privatization suggested by the Ministry. Still, the ministry upholds the position adopted and supports the initiatives not only by voicing general declarations, but also through publicity, such as informative publications on possible activities.

According to the 1999 reform, local governments became the owners of hospitals, yet they did not receive any money to run them. In this situation, the privatization allows governments not only to get rid of the responsibility connected with managing the institutions, but also to improve the infrastructure at the time of crisis in local public finances. It guarantees a continuous provision of healthcare services as well.

As far as public opinion is concerned, it should be evaluated from the perspective of the Siemaszko Model under which the Polish healthcare system has been organized for several years. Dissatisfaction with the performance of public hospitals has brought about the idealization of the private sector. When in 1993, at the beginning of transformations, this issue was surveyed, the public showed a very strong support for private provision of healthcare. Several years later, the majority of respondents (56%) favoured, fully or partially, the idea of privatization of hospitals, while 32% of respondents objected to it, as showed the conducted studies [8]. However, when respondents were asked whether privatization should take place in the near future, the ratio of figures differed to the advantage of opponents (48%). Thus, the hypothesis that privatization of hospitals remains an idealized issue and not a real prospect for the majority of the society seems to be justified. A decrease in the number of supporters of privatization may be connected with the disappointment with in healthcare reform in general. Recent

studies show that 60% of the Poles express the fear that privatization of hospitals will generate additional costs [14].

Finally, the representatives of managerial groups clearly notice a good point in hospital privatization. These groups seem to be mostly in favour of the accelerated hospital privatization, stressing in particular freedom from political influence, which also includes admission, evaluation and dismissal of the manager [13].

4. Privatization Options for Public Hospitals

The health care reform in Poland did not define the demarcation line between the public and the private sectors [6]. Consequently, there is a great discrepancy in the constitutional entries on the right to common health care and the possibilities of its realization. It consists not only in the limited volume of funds, but in operation mechanisms as well.

Let us have a more systematic look at privatization (Table 2).

Table 2

Possible Combinations of Privatization Forms

Owner	Management	Operation	Description
public	public	Private	Outsourcing of the hospital's clinical and auxiliary services to private sector.
public	private	Public	Outsourcing of management services
public	private	private	Outsourcing of clinical and support operations, such as management of the hospital
private	public	public	Private sector provides a hospital and/or equipment to the public sector
private	private	private	Divesture of public assets

Source: Adopted from: G. Greenshields, Cele i strategie prywatyzacji opieki szpitalnej w Polsce, Raport koncowy, listopad 2000.

Option 1.
Outsourcing of Hospital Sub-Services

Contracting for support services, such as catering, laundry, cleaning, is very common in Polish hospitals. Positive experiences with such a strategy are voiced both on the supply and the demand side of the in-patient services market. For clients (patients), the results are quickly visible simply by improved quality of non-clinical services. From the supply-side standpoint, the potential for cost curtailment is maximized through equal competition for contracts among private providers. Contractors use fewer staff, and their wages are likely to be higher than in the public sector. However, under this option, hospital managers run the risk of having problems with the staff being paid different rates within the same institution due to work for different employers (i.e. contractor's employee *versus* hospital's employee). This option is also politically sensitive due to evident reduction in staffing levels.

Option 2.
Outsourcing of Clinical Support Services

Recently, in Poland attention has been given to contracting out of clinical services for provision of preventive and curative care services. This strategy aims at improving the productivity of public resources by taking advantage of efficiency gains that exist in the private sector. However, the requirements for the public sector to monitor and manage these contracts may in some cases reduce these efficiency gains. Often this process needs to be developed prior to conclusion of the contracts, and therefore, it requires investment from the public sector well before the savings are achieved.

The most frequently practiced outsourcing in this context refers to laboratories, imaging services or radiology. These types of services require high equipment content, so the result in improvement of medical equipment provision is very likely. Hospitals enter into contract with service suppliers for the service based on output measurement (e. g. provision of laboratory services to an agreed standard) rather than inputs (e. g. staff). The cooperation between public hospitals and a private Swedish company proves to be the positive evidence of such an operation. *Nova Medical Poland* has introduced organizational changes in hospital central laboratories to adjust labour standards so that it would soon be possible to implement a quality system compliant with the international norm PN-EN ISO/IEC 17025.

Despite of the similar positive impact on service quality, this strategy fails to address the basic issue of under-funding. Given the present state of the buildings, it is unlikely that there would be much feedback to contracting out clinical services without some major investments being undertaken by public hospitals [7].

Option 3.
Outsourcing of Management Services

Contracting out management services, such as payroll or computer services is not very common in Polish public hospitals. They are more likely to buy professional software and implement it using their own, frequently scarce work force. Most often hospital management associates the outsourced provision of computer systems with a cost and forgets that it could be sustained by efficiency measures.

Option 4.
Privatization of Complete Clinical Services

Under this option, private sector has contracts for providing specific clinical services directly with the Sickness Funds. The type of services suited to this approach is those with high equipment content and high levels of expertise such as renal dialysis or endoscopies. The main advantage would be there, where required are high equipment set-up costs and where the type of services could be easily separated from the hospital.

Similarly to Option 2, this strategy will not solve the basic issue of underfunding. However, better facilities usually bring more private income that should be used to subsidize prices and allow more provision. The outsourced services are under contractor management, while the present hospital management is still in charge. It may result in some cross-fertilization of ideas and attitudes over time, which can improve management skills in the public sector. There is little chance to improve financial and clinical information systems on the whole, but it may be the case in a particular outsourced area. The crucial point of this concept is the attitude of medical staff, especially doctors. Some of them may oppose the idea because it may reduce their informal income («grey zone»), which is often maximized in the situations when there is limited access to in-patient healthcare.

Option 5.
Divesture of Public Assets

The privatization of hospitals is currently not very intensive on the whole. The main reason for such a situation, apart from the unsolved questions of the so- called social resistance and moral correctness of the adopted path, seems to be its rather unclear legal status. Since there are no mandatory regulations, the only recognized and widely used privatization path for public hospitals is the liquidation followed by the sale or contribution of assets to a company. This particular path proves to be suitable for small outpatient clinics, whereas in the case of large hospitals occur numerous problems and difficulties, including such issues as high costs (severance pays), long and complicated legal procedure, or a risk regarding the obligation to satisfy liabilities of the liquidated hospital by the

owner. Consequently, a number of methods have been developed on the basis of two major procedures [12]:

- contribution of the part of assets or the whole entity by a public hospital to a company established by an investor or staff instead of shares in a new company, the final goal being the liquidation of the hospital and decision on the liquidated assets to be made by the established body. These methods provide a wide scope of privatization, less complicated legal procedure, lower costs, and taking over of the hospital by a new private entity by virtue of the law;
- lease or sale of a part or the whole of the entity's assets either by the hospital (running its activities by means of the remaining assets or being a subject that serves the lease system) or local government body (after the liquidation of the hospital). In certain cases this procedure may be beneficial and advantageous, especially when the assets are held by the local government.

Conclusion

All of what has been said above indicates that there are no formal or legal barriers to privatization of hospitals. Why don't we witness a mass-scale privatization of hospitals in Poland then? Three main reasons may be put forward, i. e.:

- lack of clear formal and legal procedure (e.g. act on privatization of public hospitals); although there are possibilities of transformations, the privatization process is complicated from the legal point of view, and it is not commonly accepted by the society. Moreover, in many cases it is impossible due to the entangled legal status (mainly in the field of real estate ownership);
- fear of the local government to lose control and influence over future operations of health care units, and very difficult and generally negative social response to privatization of hospitals as such, also among health care personnel;
- rather limited interest of investors in participation in the privatization of public hospitals due to high investment risk connected with the uncertain system of financing health care in Poland and poor progress in the development of private health insurance system.

Some outpatient health departments and bodies have already been privatized in Poland, and the in-patient health service system will soon undergo the process. The privatization tendencies that occur within the local government and the actions taken by politicians (regarding advanced work on privatization of the health care system), as well as advantages of privatization, seem to be a right

trend that might result in opportunities for the development of hospitals and improvement in the quality and availability of services provided by the hospitals.

In order to make the operation of the hospital sector clear, it is necessary to define the line between the public and the private sector in the context of rights to services financed from the public funds, as well as from the private ones. One of the solutions could be the introduction of private insurance. Then, the question about whether the common and the private insurance are the substitutes, or whether they are to function in parallel should be answered.

Bibliography

1. Act of 6th February 1997 on Common Health Insurance (Journal of Laws No. 28, Item 153, Article 4a).
2. Art. 1 Item 2 of the Act of 30th November 2000 on Amending of the Act on Common Health Insurance (Journal of Laws No. 122, Item 1311).
3. Critical challenges for health care reform in Europe, Saltman R.B., Figueras J., Sakellariedes C., Open University Press, Buckingham – Philadelphia 1998.
4. Czepulis-Rutkowska Z., Function and Behavior of the Payer, in: The Diagnosis of Health Care System after Three Years Health Reform Functioning. Improve – Where and How?, ed. S. Golinowska, Conference Materials, Krakow 2002.
5. Gabbott M., Hogg G., Choice of GP: facts or fiction?, «Journal of Management in Medicine» 1993, Volume 7, Number 1.
6. Golinowska S., Health Care Reform in Poland after 3 Years; Challenges for New Authorities, Operation of Health Care Institutions after the Reform. Promises for Changes, CASE Foundation 2001.
7. Greenshields G., Cele i strategie prywatyzacji opieki szpitalnej w Polsce, Raport koncowy, listopad 2000.
8. Kozlowski A., Szpitale kliniczne wobec prywatyzacji, «Szpital Polski» 2000, No. 3.
9. Marciniak J., Prywatyzacja ochrony zdrowia. Rozwiazania optymistyczne, «Słuzba Zdrowia» 2000. No. 1–2.
10. Piotrowska-Marczak K., Kietlinska, K., Reforming health and social services in Poland, «Public Management Review» 2001, Volume 3, Number 2.
11. Prause G., Rudawska I., Privatization Strategies for European Hospitals – an International Case Study between Germany and Poland, in: Challenging

the Frontiers in Global Business and Technology, ed. N. Delener, C. Chao, Global Business and Technology Association, USA 2003.

12. Przybyla W., Prywatyzacja w sluzbie zdrowia, «Przewodnik Menedzera Zdrowia» 2001, No 2.
13. Slawatyniec T., Polityka kontra zdrowy rozsadek, «Służba Zdrowia» 2000, No. 75–77.
14. Sondaz «Rzeczpospolitej»: Na zdrowiu lepiej nie zarabiac, «Rzeczpospolita», 24.03.2001, No. 71.
15. Tymowska K., Prywatyzacja opieki zdrowotnej w teorii i praktyce, «Prawo i Medycyna» 2000, No. 5.
16. Ustawa o ochronie zdrowia: Kontrowersje i watpliwosci, «Służba Zdrowia» 2000, No. 18–19.

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