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FROM DECENTRALIZATION TO PRIVATIZATION. THE CASE OF THE POLISH HOSPITAL SYSTEM[1]

1. INTRODUCTION

Debate on governance of health systems – from the institutional perspective – is focused on two major tensions: between private and public (state and market), and between central and local management[2]. Both dilemmas gained more interest and relevance with the expansion of New Public Management (NPM) that put strong emphasis on the dissemination of market-oriented schemes for health services delivery and decentralization of health systems governance. While discourse on effects of marketization of health systems has already attracted attention in the literature[3], studies on the outcomes of decentralization are less advanced. This article focuses on the effects of the partial decentralization of hospital management in Poland. Particularly, it explores to what extent assigning responsibility for hospital management to local self-government units enhances the process of commercialization (corporatization) and privatization of hospitals. This study is based on literature review and information provided by the Ministry of Health of the Republic of Poland.

2. DECENTRALIZATION AS A PILLAR OF THE NEW PUBLIC MANAGEMENT AGENDA

The New Public Management agenda and other market-oriented reform patterns introduced a number of tools that gradually transformed the modus operandi

[1] This article was prepared within the framework of the research project "The promises of decentralization in health care" funded by the National Centre of Science under contract No. UMO-2013/11/B/HS5/03896.

[2] R. H. Blank, V. Burau, *Comparative Health Policy*, London 2013, p. 102.

[3] M. Gaynor, R. Moreno-Serra, C. Proper, *Can competition improve outcomes in UK health care? Lessons from the past two decades*, "Journal of Health Services Research & Policy" 2012, 17(suppl 1), pp. 49–54.

of post-war welfare states. The catalogue of NPM instruments applied in various areas of welfare provision includes the purchaser-provider split, extensive outsourcing of welfare service provision to private operators, providing citizens (customers) with more choice and better exit options, implementation of targets and performance measures and, last but not least, decentralization[4]. NPM does not "invent" decentralization, yet it fostered the already strong trend towards it[5].

As New Public Management is not a homogenous and comprehensive framework, but rather an umbrella term for wide array of reform arrangements, understanding of the scope of and forms of the necessary decentralization differs amongst scholars dealing with NPM. Rondinelli et al. developed the most extensive catalogue of forms of decentralization, including deconcentration, delegation, devolution and even privatization[6]. While deconcentration and delegation are limited to dispersing execution of some powers amongst lower tiers of central government (deconcentration) or local governments without ensuring policy and managerial autonomy (delegation), devolution requires transfer of powers and responsibilities to an independent external body[7]. Devolution might be considered as the strongest form of decentralization, as it leads to the creation of territorial administrative entities autonomous from central government.

Arguments in favour of decentralization are mainly of a political and managerial nature. Decentralization is expected to enhance local democracy by bringing power and authority closer to the citizens[8]. From a more technical, efficiency-oriented perspective, decentralization should guarantee more flexible, innovative and effective management, as decentralized institutions are able to generate deeper commitment and greater productivity among their staff members[9]. NPM advocates noticed that "one size does not fit all" and higher levels in the administrative structures should relinquish ambitions for setting uniform standards and methods for serving citizens[10]. Decentralization harmonizes with NPM rhetoric

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[4] E. Øverbye, *Disciplinary Perspectives*, (in:) F. G. Castles, S. Leibfried, J. Lewis, H. Obinger, C. Pierson (eds.), *The Oxford Handbook of the Welfare State*, Oxford 2010, p. 162.

[5] R. Heintzman, L. Juillet, *Searching for new instruments of accountability: New political governance and the dialectics of accountability*, (in:) H. Bakvis, M. D. Jarvis (eds.), *From new public management to new political governance*, Montreal 2012, pp. 342–379.

[6] D. A. Rondinelli, J. R. Nellis, G. S. Cheema, *Decentralization in Developing Countries: A Review of Recent Experience*, "World Bank Staff Working Papers" 1983, No. 581, pp. 13–31.

[7] C. Pollitt, G. Bouckaert, *Public management reform: A comparative analysis*, Oxford 2004, p. 87.

[8] K. J. Meier, C. G. Hill, *Bureaucracy in the Twenty-First Century*, (in:) E. Ferlie, L. Lynn, C. Pollitt (eds.), *The Oxford Handbook of Public Management*, Oxford 2005, p. 54.

[9] P. J. Andrisani, S. Hakim, E. S. Savas, *Introduction*, (in:) P. J. Andrisani, S. Hakim, E. S. Savas (eds.), *The New Public Management: Lessons from Innovating Governors and Mayors*, New York 2002, p. 4.

[10] L. Dicke, P. Boonyarak, *Ensuring Accountability in Human Services: The Dilemma of Measuring Moral and Ethical Performance*, (in:) H. G. Fredericton, R. K. There (eds.), *Ethics in Public Management*, New York 2005, p. 186.

with regard to increasing managerial autonomy and empowerment correlated with accountability[11].

On the other hand, there is an increasing awareness of the following risks, challenges and negative impacts of decentralization (in health care and in the general perspective):

− Increasing inequalities in access to health care. Particularly decentralization of responsibility for financing the health services provision may dramatically diversify the conditions for access to health care and its quality across regions or other administrative units. This is a natural consequence of regional differences in the level of economic development and income. Undermining cohesion in access to, and quality of, services appears to be the trickiest outcome of extensive decentralization and usually requires special legal and financial measures, like cross-subsidies. On the other hand, their implementation creates another problem – political tension between units receiving additional subsidies and units financing them.

− Diminishing the steering capacity of central government (setting goals, strategies, framework laws, executing accountability mechanisms). Within a decentralized health care system the central government cannot enjoy the traditional instruments of the vertical coordination of policies and their implementation.

− Growing concern for "joined-up government" and "cross-cutting issues". The legally protected autonomy of regional/local governments creates a much more complicated institutional landscape, in which hierarchy has to be replaced with collaboration and negotiation. In a network state only horizontal coordination based on cooperation between autonomous administrative units is available.

− Particular risks associated with decentralization in post-socialist states. It needs to be stressed that CEE countries did not have well established and stable mechanisms preventing the negative impacts of decentralization. Local democracy in our region is still "unfinished business" and extensive decentralization in the most vulnerable areas of human services (health care, education) appears to be particularly risky and linked with numerous obstacles and challenges[12].

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[11] J. Hart, *Central Agencies and Departments: Empowerment and Coordination*, (in:) B. G. Peters, D. J. Savoie (eds.), *Taking Stock. Assessing Public Sector Reforms*, Montreal 2005, pp. 285–286.

[12] K. Davey, *Decentralization in CEE Countries: Obstacles and Opportunities*, (in:) G. Peteri (ed.), *Mastering Decentralization and Public Administration Reforms in Central and Eastern Europe*, Budapest 2002, p. 37; V. Bankauskaite, R. B. Saltman, *Central issues in the decentralization debate*, (in:) V. Bankauskaite, R. B. Saltman, K. Vrangbæk (eds.), *Decentralization in health care*, London 2007, p. 16.

3. EMERGENCE OF A PARTIALLY DECENTRALIZED MODEL OF HOSPITAL MANAGEMENT IN POLAND

Decentralization was one of the pillars of the transformation of the Polish state initiated in the early 1990s. Reforms aimed at the disassembling of a monolithic, extremely centralized structure of government affected all key areas of public management, including the provision of public services. The decentralization movement in post-socialist Europe was not linked to the NPM programme, yet was based on similar objectives and rationale. Advocates of decentralization in Poland argued that public services can be managed effectively only at a local level. Empowering local communities also triggers citizens' energy and encourages their active involvement in policy making and implementation. Furthermore, decentralization was also meant to let the central government focus on strategic issues and long-term policy planning instead of dealing with day-to-day services delivery to citizens[13].

In the context of health care, shift towards decentralization began in 1998/1999 when the second phase of local government reform was implemented. The package of legislation passed in June 1998, which came into force on January 1, 1999, consisted of two core elements:

− Restoration of *powiat* (county) as a second, supramunicipal tier of local self-government, traditional for Poland. Pursuant to the new legislation, 314 counties began to operate after January 1, 1999. Earlier, in autumn 1998 the elections for counties' councils were carried out.

− Creation of self-government at regional level based on the 16 voivodeships (regions, provinces). They replaced 49 small voivodeships managed by the central administration.

As a result, a three-tier self-government system was created. Communes and counties perform the functions of local government and voivodeships operate at regional level. Within this system, the counties took the major responsibility for hospital management. A much smaller number of public hospitals have been taken over by the new regional self-government units (voivodeships). However, decentralization of hospital management was not combined with decentralization of the funding scheme. The reforms of 1998/1999 introduced a purchaser-provider split to the Polish healthcare system, whereby the local governments have been assigned with responsibility for managing providers, while the independent regional health care funds have been tasked with contracting health services delivery.

[13] A. Piekara, *Aksjologiczne i pragmatyczne aspekty samorządu terytorialnego*, "Samorząd Terytorialny" 1991, No. 1–2, p. 78–79; J. Regulski, M. Kulesza, *Droga do samorządu. Od pierwszych koncepcji do inicjatywy Senatu (1981–1989)*, Warszawa 2009, pp. 75−76.

In addition to this, the public hospitals, including hospitals acquired by the local governments, have gained the special legal status of public law entities ("independent public health care providers"). They gained managerial autonomy from the local governments that established them. Their formally independent status means, in practice, that they finance their activities from their own revenues and other available resources. The organizational and legal statuses of independent public health care providers are complex. They can be defined as public law entities equipped with certain qualities of private law bodies, such as the right to conclude contracts and benefit from property rights. However, independent public health care providers are protected against insolvency, which is the major difference compared to private health care providers.

The 2003 reform of health care system enhanced central control over the contracting authority. Instead of independent regional health funds, a central National Health Fund was created under direct supervision of the Ministry of Health. The position and legal status of hospitals governed by local governments remained unchanged. Also, the rules for contracting provision of health services have not been modified and the whole system was saved in the formula of internal market.

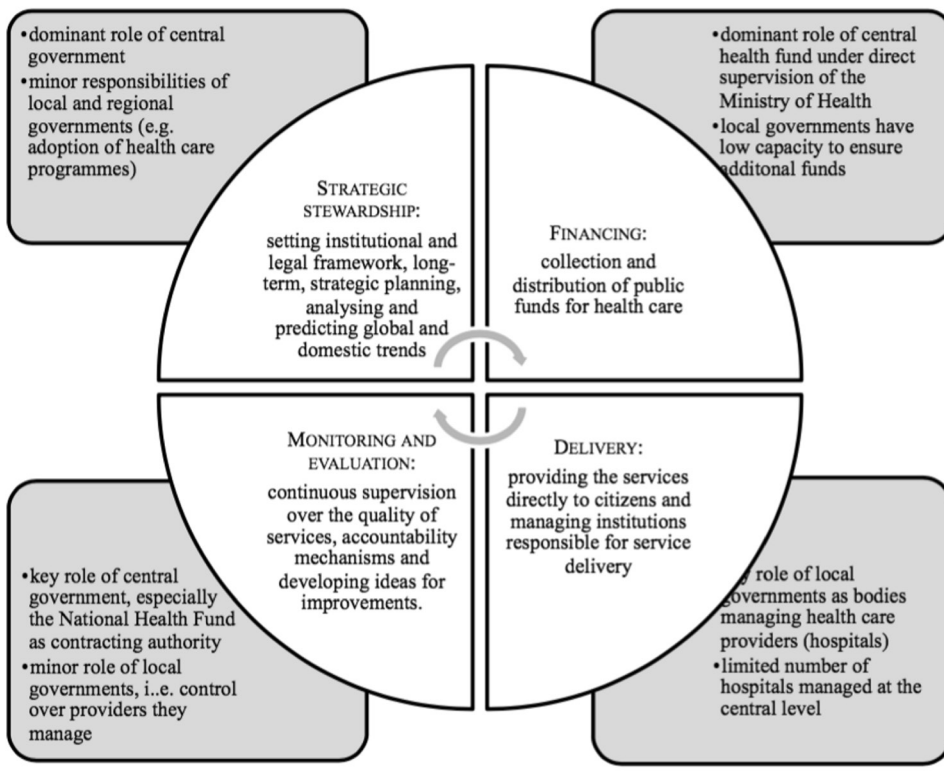
The last milestone in the transformation process of the essential framework of the healthcare system in Poland was the Act of April 15, 2011 on medical activity (Journal of Laws No. 112, item. 654, as amended). It opened the way for, and even introduced, significant incentives to transform independent public health care providers into companies (joint-stock companies or limited liability companies) equipped with the full status of a business entity. Previously, such a transformation was not explicitly permitted, although in practice was applied on a limited scale. The new regulation significantly simplified the mechanism for the corporatization of public health providers.

The transformation is optional and depends on the will of the entity constituting the independent public health care provider, e.g. local government units. The exception is a situation in which independent public health care providers have a negative financial balance, and the supervisory body (local government unit) is not able to cover the loss. Such a solution should be interpreted as a stimulant for corporatization, given the difficult financial situation of many independent public health care providers. According to the new regulation, creation of new independent public health care providers is forbidden. In addition, the Act on medical activity does not introduce any restrictions on the sale of shares in companies that replaced independent public health care providers. In practice this opens the way for at least a partial privatization of health care providers. With regard to independent public health care providers any form of privatization was not possible.

To sum up, the Polish health care system is rather centralized, especially in terms of managing and distributing financial resources. The capacity of local

and regional governments in strategic stewardship and financing is rather limited. They are primarily focused on managing the institutions responsible for direct service delivery.

Figure 1. Distribution of roles and responsibilities in the management of the Polish health care system.



It should be noted that in recent years the central government addressed in some policy documents the need for extending the role of local and regional governments in managing health care. The National Development Strategy 2030 adopted in 2013 prioritizes fostering the local/regional self-governments' autonomy in all areas of public policy, including health care[14]. The National Health Programme 2007–2015 underlines that the ideas and policy concerning public health should be initiated primarily at local level, according to the constitutional

[14] Council of the Ministers of the Republic of Poland, National Development Strategy 2030. Third Wave of Modernity, Warsaw 2013, p. 9.

principle of subsidiarity[15]. However, those general policy plans have not yet been translated into more specific legislative proposals.

4. FROM DECENTRALIZATION TO CORPORATIZATION AND PRIVATIZATION?

The 2011 Act on Medical Activity set the procedure for the corporatization of hospitals managed by the local governments and eliminated obstacles to their privatization by selling shares in newly created companies to non-public bodies. However, it should be noted that the corporatization and privatization of hospitals managed by local governments was – under specific conditions – possible also prior to the adoption of a clear procedure for that. According to the previous regulations, corporatization of independent public health care provider could have been conducted in a complex process consisting of three stages:

1) The setting up of a joint-stock company or limited liability company by the local government unit and/or private investor;

2) Liquidation of independent public health care provider;

3) Transferring the property and all rights (contracts, licences) of the liquidated independent public health care provider to the newly created company[16].

Although this process was complex and risky in legal terms and also created high transaction costs, numerous local governments decided to follow this scheme. Figure 2 below shows the number of hospitals managed by local/regional governments that have been transformed into companies (corporatized) between 1999 and 2010.

The 2011 Act on Medical Activity enhanced the process of corporatization, not only by providing a clear and simplified procedure for that, but also by launching a programme of subsidies from the central budget available to local governments that decided to enter into corporatization. It should be noted that the initial draft of Act on Medical Activity envisaged mandatory (*ex lege*) corporatization, yet strong opposition against this idea from the general public resulted in "softening" the initial proposal by incentivizing rather than imposing corporatization.

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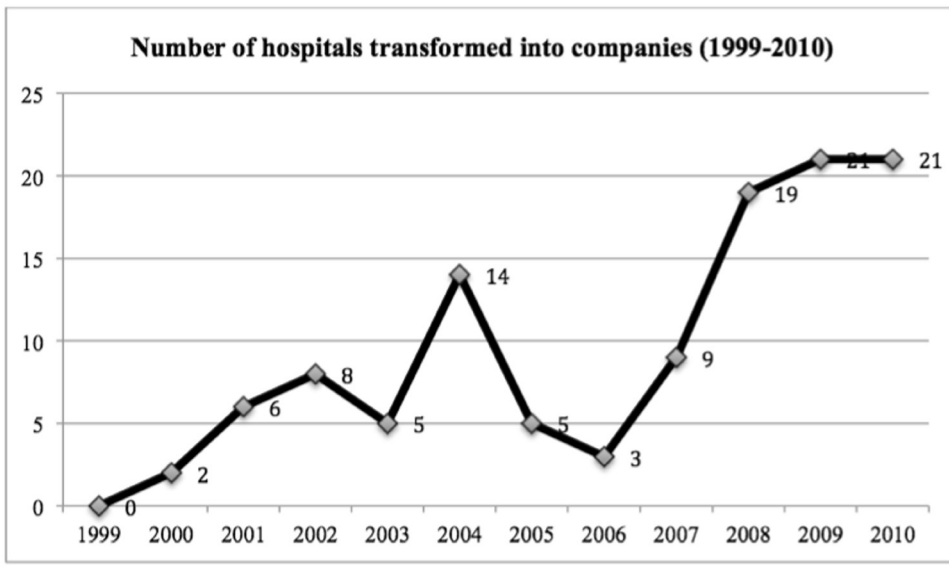
[15] Council of the Ministers of the Republic of Poland, National Health Programme 2007–2015, Warsaw 2007, p. 47.

[16] M. Wójcik, *Przekształcanie formy organizacyjnoprawnej szpitali na podstawie regulacji zawartych w ustawie o działalności leczniczej. Nowe wyzwanie i odpowiedzialność samorządów terytorialnych*, (in:) E. Nojszewska (ed.), *System ochrony zdrowia. Problemy i możliwości ich rozwiązań*, Warszawa 2011.

Figure 2. Statistical data on the number of independent public health care providers managed by local/regional governments that were transformed into companies (1999−2010).



Source: Data provided by the Ministry of Health.

The financial incentive was expected to be particularly effective in the context of the Polish health care system, as the issue of overdue debts is an immanent feature of the Polish health care sector. According to Sowada, overdue debts of the hospitals have been reduced from 6.2 billion zloty in the middle of 2005 to about 2.1 billion zloty at the end of September 2014, but they still account for over 20 per cent of all debts of public hospitals[17]. Local governments – especially major municipalities – face growing problems with managing debts created by the intense investment policy for recent years and their capacity to subsidize hospitals is decreasing.

An additional factor fostering or at least enabling the privatization of hospitals managed by local/regional governments is the jurisprudence of the Constitutional Court and other courts. In their caselaw there was a discussion on how to interpret the responsibility of self-government units for health care. The major dilemma was: Does this responsibility require local/regional governments to run the institutions providing health services to citizens or is their responsibility limited to ensuring that within their territory there is some provider of publicly-funded health services, regardless its status as public or private entity? In the

[17] C. Sowada, *Zadłużenie publicznych szpitali w Polsce w latach 2005–2014. Nierozwiązany problem zobowiązań wymagalnych*, "Zdrowie Publiczne i Zarządzanie" 2014, No. 3, pp. 258−270.

judgment of January 7, 2004 the Constitutional Court (K 14/03) concluded that the constitutional standard of equal access to health care does not require the state administration bodies to run public health care providers. The major requirement is to ensure that every citizen has an equal access to publicly-funded health services and the character of the institutions providing services is not relevant. This approach has been confirmed by the caselaw of administrative courts considering the complaints against privatization of local public hospitals.

Taking those factors into account, one may predict the rapid expansion of the corporatization and privatization of hospitals governed by local government. However, the statistical data provides rather mixed conclusions in this matter. First of all, the number of hospitals that have been corporatized according to the new law is much lower than the government expected (figure 3). The effect of the subsidy mechanism turned out to be limited. Although there was a significant increase in the number of hospitals transformed in 2013 (the last year when the subsidies were available), it still covered less than 10 per cent of the total number of hospitals managed by local government (453 hospitals in total). What also should be noted is the fact that the impetus of transformation dropped when the subsidy scheme expired.

Figure 3. Statistical data on the number of independent public health care providers managed by local/regional governments that were transformed into companies (2011−2015).

Source: Data provided by the Ministry of Health.

Secondly, the number of privatised hospitals remains low and does not exceed 10 per cent of all hospitals established by local or regional governments. According to the National Audit Office 38 hospitals established by local governments are now fully controlled by private shareholders and in 14 hospitals the local government keeps a minority share[18]. In comparison to this, as the Ministry of Health informed, at the end of 2015 there were 127 hospitals operating in the form of a company, where the local government was the sole shareholder. In six cases the local government units retained the majority of shares (50% + 1).

Therefore, we may observe rather a conservative approach of local/regional governments to the new legislative framework. Both corporatization and privatization are progressing, yet only to a limited extent. It would be difficult to specify the full catalogue of factors influencing the lack of common enthusiasm towards corporatization and privatisation among local/regional authorities. However, drawing from available data, we may develop some hypothesis explaining the relatively little progress in corporatization and privatization of hospitals managed by self-government units:

− Strong opposition among citizens against privatization of public hospitals. According to 2014 survey, 64 per cent of respondents consider privatization as disadvantageous for patients. Over 3/4 of respondents were against privatization of their local hospital[19]. Local elected representatives are fully aware of citizens' attitude towards privatization and the political calculations discourage them from corporatization and privatization unless it is inevitable because of the financial situation of the municipality or county.

− The risk of bankruptcy or loss of potential support from state or local government budgets. Those two factors have been indicated as an obstacle to corporatization in the survey conducted among representatives of public hospitals governed by local and regional governments[20]. It is believed that the formula of independent public health care provider safeguards against bankruptcy not only formally, but also because in the past the central government regularly launched bailouts for them, reducing or cancelling their debts. In other words, the mechanism of "soft budgetary constraints" is well-established in the management of the Polish health care system and there is a concern that it would not be applicable to corporatized or privatised hospitals.

− Lessons learnt from the hospitals that went through corporatization and/or privatization. Available case studies illustrate the rather mixed effects of corporatization and particularly privatization. Although some "champions" and success stories can be found, there are also examples of failed privatisations that

[18] Najwyższa Izba Kontroli, *Działalność szpitali samorządowych przekształconych w spółki kapitałowe*, Warszawa 2015.

[19] See http://www.rynekzdrowia.pl/Finanse-i-zarzadzanie/Wiekszosc-Polakow-nie-chce-prywatyzacji-szpitali,137183,1.html (visited April 7, 2016).

[20] Magellan, *Sytuacja finansowa szpitali w Polsce*, Warszawa 2014.

resulted in e.g. temporarily depriving residents of hospital care or limiting the scope of services provided by privatised hospitals to few most profitable medical procedures. Another problem noted in some cases was a dramatic deterioration of work standards in privatised hospitals.

− The lack of positive financial effects of corporatization. According to National Audit Office report covering 12 hospitals transformed into companies, only four of them achieved a positive financial balance and the remaining eight hospitals continue to generate a loss[21]. Thus, corporatization did not lead to an immediate improvement of the financial situation.

− The immature market of private operators of hospitals. Long-time domination of public entities on the hospital market creates an obstacle for expansion of private operators. At the moment there are only few companies/holdings having the capacity and know-how for acquiring and managing hospitals taken over from local or regional governments.

5. CONCLUSIONS

The Polish health care system – with a special focus on hospital management – is rather centralized. Although the majority of hospitals are managed by local or regional governments, the central government maintains control over resources as the role of purchaser (contracting authority) is monopolized by a special agency under direct control of the Ministry of Health (National Health Fund). The 2011 reform extended the scope of managerial autonomy of local/regional governments in hospital management by providing clear procedures for the corporatization of hospitals and abolishing obstacles to the privatization of public hospitals transformed into companies. Expanding the autonomy of local/regional governments did not lead to extensive corporatization and privatization of public hospitals. Despite financial incentives for corporatization and budgetary constraints potentially enhancing privatization, both processes are progressing only to a limited extent. This could be partially explained by strong opposition among citizens to "depublicisation" of health care providers, but another factor is the concerns among local governments and hospital managers about the financial stability of the hospitals operating in a formula that does not protect from bankruptcy.

[21] Najwyższa Izba Kontroli, *Informacja o wynikach kontroli przekształceń własnościowych wybranych szpitali w latach 2006–2010*, Warszawa 2011.

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Summary

Decentralization and privatization have been the key elements of the new public management agenda for reshaping public services. Both trends have also affected the area of health services, with particular focus on hospital management. This paper describes the process of decentralization of healthcare and hospital governance in Poland for recent decades and discusses whether the increasing role of local and regional governments in hospital management has triggered the process of privatization of healthcare units. Deriving from statistical data and qualitative assessment, it concludes that while privatization of hospitals in one of the important trends in the Polish health policy, its scope is limited by several obstacles of economic, political and social nature.

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SŁOWA KLUCZOWE

decentralizacja, prywatyzacja, szpitalnictwo, nowe zarządzanie publiczne