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The Impact of Privatisation on the Forms of Employment: The Example of the Poviat Hospital

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Abstract

Purpose: The aim of the article was to show the impact of privatisation on the forms of employment of medical staff on the example of the poviat hospital. The proper functioning of any organisation, including a healthcare entity, requires having and maintaining the staff capable of guaranteeing the implementation of its objectives.
Design/methodology/approach: The article uses the following research methods: a literature review, the method of economic analysis, qualitative and quantitative analyses and the method of deduction in the inference phase.
Findings: The results of the research are the basis for the conclusions supporting the validity of introducing the possibility of concluding subcontracts with medical staff, which allows entities to flexibly organise work in the situation of a shortage of physicians.
Research limitations/implications: This is associated with certain financial implications, but at the same time it is more efficient in terms of using the existing human resources and it gives greater opportunities to provide a higher quality of medical services to more patients.
Originality/value: The privatisation process in the Polish healthcare sector seems to have been necessary and it has shown that it is worth undertaking such measures, if for no other reason than to improve patients' treatment standards. The results of the research carried out in this field show that transforming hospitals into private institutions is a good move.

Keywords: privatisation, forms of employment, hospital.

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Wpływ prywatyzacji na formy zatrudnienia na przykładzie szpitala powiatowego

Streszczenie

Cel: ukazanie wpływu prywatyzacji na formy zatrudnienia personelu medycznego na przykładzie szpitala powiatowego. Prawidłowe funkcjonowanie każdej organizacji, w tym podmiotu opieki zdrowotnej, wymaga posiadania i utrzymania personelu zdolnego do zagwarantowania realizacji jego celów.

Metodologia: w artykule wykorzystano następujące metody badawcze: przegląd literatury, metodę analizy ekonomicznej, analizy jakościowe i ilościowe oraz metodę dedukcji w fazie wnioskowania.

Wyniki: wyniki badań stanowią podstawę do wniosków potwierdzających zasadność wprowadzenia możliwości zawierania umów podwykonawstwa z personelem medycznym, co w sytuacji niedoboru lekarzy pozwala podmiotom elastycznie organizować pracę.

Ograniczenia/implikacje badawcze: jest to związane z pewnymi implikacjami finansowymi, ale jednocześnie jest bardziej wydajne pod względem wykorzystania istniejących zasobów ludzkich i daje większe możliwości zapewnienia wyższej, jakości usług medycznych większej liczbie pacjentów.

Oryginalność/wartość: wydaje się, że proces prywatyzacji w polskim sektorze opieki zdrowotnej był konieczny i pokazał, że warto podjąć takie działania, choćby z innego powodu niż poprawa standardów leczenia pacjentów. Wyniki badań przeprowadzonych w tej dziedzinie pokazują, że przekształcenie szpitali w instytucje prywatne jest dobrym posunięciem.

Słowa kluczowe: prywatyzacja, formy zatrudnienia, szpital.

1. Introduction

A priority task for the healthcare system is to meet the health needs of a society, while ensuring effective use of available resources. The aim of the article was to present the impact of privatisation on the forms of employment of medical personnel as exemplified by the poviat hospital. With regard to medical facilities, human capital or, more precisely, forms of employment gain in importance as they exert a direct impact on the quality of medical services (Rozpędowska-Matraszek, 2014). The factor determining the proper functioning of the healthcare system in a country is the size and quality of medical staff. The privatisation process in the Polish healthcare sector seems to have been necessary and it has been shown that it is worth undertaking such measures, if for no other reason than to improve patients' treatment standards. The results of the research carried out in this field show that transforming hospitals into private institutions is a good move (Romanowska & Kowalik, 2017).

2. The Essence and importance of privatisation and commercialisation processes

The proper functioning of the healthcare system is based on continuous transformations in order to adapt to the changing socio-economic environment. Clearly, such adaptation processes are privatisation and

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commercialisation. Pursuant to the Polish commercial law, these concepts are defined in the Privatisation Act of August 30, 1996 on *Commercialisation and Privatisation of State-Owned Enterprises* (Journal of Laws (Dz. U.) of 1996, No 118, item 561 as amended). According to this Act, privatisation consists in transformation of a state-owned enterprise into a company, without a change in the ownership structure. Despite the fact that the Act concerns state entities, it is commonly accepted that commercialisation is a process of transforming a public entity into a commercial law company while maintaining the existing ownership structure (Dubas & Szetela, 2013). In relation to privatisation, the legislator distinguished its two forms: direct privatisation (i.e. the sale of a state-owned enterprise) and indirect (i.e. transferring shares held by the State Treasury to companies). In relation to the ongoing ownership changes in the healthcare system, privatisation is defined:

1. as processes aiming at increasing the share of non-public health institutions among healthcare providers, which can be implemented by creating private ownership institutions that enter the market or
2. by privatising entities that have operated on the market (Tymowska, 2000). It is the process of transferring state assets to private entities, which may take place through the sale or transfer thereof.

High and deepening indebtedness of medical entities and limited funds for financing health needs forced attempts to reform the healthcare system. The creation of an effective system in the conditions of an open market economy that will satisfy the health needs of a society is a very difficult task (Rabiega-Przyłęcka, 2013). Therefore, a very important element of the process is to introduce solutions that are designed to enable medical entities to reduce their debt, and then operate effectively in a limited financial envelope.

3. Reforms in the Health Sector

Justifying the choice of the topic, the attention should be paid to the very important issue of healthcare reform, which concerns ownership changes. The first significant change took place in 1991–1998, when the Act of 30 August 1991 on *Healthcare Institutions* was implemented (Journal of Laws (Dz. U.) of 1991, No 91, item 408 as amended, repealed on 1 July 2011). The first modifications of this law were not very radical as they focused on the issue of decentralisation of the healthcare system and on the consent to the so-called founding privatisation of clinics and specialist medical practices. At that time, the most important change was that state hospitals were granted full autonomy as to the budget management and taking responsibility for their decisions. The subsequent improvement of the system resulted in the implementation of the Act of 6 February 1997 on *National Health Insurance* (Journal of Laws (Dz. U.) of 1997, No 28, item 153 as amended), which

was an important element in the process of transformation and reforms in the healthcare system. The changes were noticeable primarily in replacing the budgeting of the healthcare system with the insurance system, which was based on compulsory health insurance financed from health contributions, thus replacing a centralised system based on the state budget (Mądrala, 2014). The next important stage in the healthcare reform was the Act of 23 January 2003 on *National Health Insurance in the National Health Fund* (NFZ) (Journal of Laws (Dz. U.), No 45, item 391), which replaced the previous legal act. The decisive element of the abovementioned Act was the replacement of the Sickness Funds of the National Health Fund and the introduction of a centralised fund management system that collected funds from health insurance contributions (Wielicka, 2014). The continuous adaptation of the healthcare system to the changing environment in Poland entailed two more reforms and amendments. On 1 July 2011, the Law of 15 April on *Medical Activity* entered into force, which was a continuation of previous attempts to commercialise public hospitals, aimed at reducing their debt and improving the efficiency of management. Another reform of the healthcare system was initiated by the amendment to the Act on *Medical Activity*, which came into force on 15 July 2016 (Journal of Laws (Dz. U.) of 2016, item 1638 as amended). The aforementioned Act of 10 June 2016 amending the Act on *Medical Activity* and some other acts led to a halt of the commercialisation and privatisation processes of public hospitals. The change, which has been in force until today, entered into force on 26 April 2017. This is the Act on the so-called networks of hospitals concerning the amendment to the Act on *Healthcare Services* financed from public funds (access: 6 February 2019).

The Independent Public Health Care Centre (SP ZOZ), studied for the purpose of this article, was transformed into the Non-Public Health Care Centre (NZOZ), thus changing the legal form of the entity into a commercial law company, namely a limited liability company. A hospital that is a limited liability company relies heavily on the image of the unit and a high quality of fulfilling patients' needs. The owner should not achieve negative financial results and should care for the financial liquidity, thus contributing to its future existence. For the purpose of this article, the authors performed a comparative analysis of human resources, considering the periods before and after the transformation and focusing on the forms of employment in the institution.

4. Employment in Medical Institutions

The source of building a competitive advantage is human capital, which is particularly important in healthcare institutions as it translates into the quality of medical services. The knowledge, skills and the effectiveness

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of employee motivation systems all have an impact on the quality of services and the performance of the healthcare system. Well-educated and motivated medical staff is the basis for achieving health goals (Włodarczyk & Domagała, 2011).

One of the few professional groups whose employment issues are regulated separately are medical employees. There are references to both the Labour Code and specific regulations, in particular the Act on *Medical Activity* (Journal of Laws (Dz. U.) of 2016, item 1638 as amended).

The staff of medical institutions is employed on the basis of:
- the employment relationship (in accordance with the Labour Code),
- another legal relationship, e.g., a relation under civil law (in accordance with the Civil Code).

One of the basic assumptions of the corrective programmes was to change the wage conditions of medical staff. The reduction of costs was possible due to a change in the form of medical staff employment as employment contracts were replaced by civil law contracts because employment contracts are based on the so-called job security, including the termination of a contract, paid leave, minimum wages and settling disputes by labour courts.

A contract is usually referred to as an agreement in which a healthcare entity subcontracts self-employed practitioners to perform services exclusively for the particular medical institution. The terms of a contract include the number of people in healthcare services, benefits, wage conditions, duration of the subcontract and reasons for its early termination (Moroz & Orzeł, 2014). The growing number of civil law contracts in the form of a subcontract carries the opportunities and threats that were exhaustively presented by Klimek (Klimek, 2010) (see Table 1).

Result of subcontracted form of work	Addressees	Opportunities	Threats
Civil liability of subcontracted workers	Doctors, nurses	– Increased sense of responsibility for patients.	– Shifting liability onto insurance companies. – The occurrence of side effects of the treatment after the expiry of an insurance policy.
	Employers	– Reducing operating costs as insurance costs are incurred by subcontracted employees.	– Loss of trust or patients' claims when a subcontracted employee fails to meet the claims.

Table cont.

Result of subcontracted form of work	Addressees	Opportunities	Threats
Higher salaries	Doctors, nurses	– Improving the current quality of life.	– Lower pension especially if a subcontracted employee belongs to a national insurance system without any additional pension plans.
	Employers	– Better work atmosphere. – Increasing acceptance of structural changes. – Higher attractiveness of medical professions reducing a deficit of doctors, limiting migration to the EU, giving greater opportunities to hire doctors from abroad.	– Allocating revenues to increasingly higher remuneration of subcontracted employees. – The opportunity to *hide* the actual amount of remuneration in the costs of external services.
No limits on working hours	Doctors, nurses	– Greater independence in organising work time.	– Fatigue due to unlimited work time. – The occurrence of errors and negligence due to fatigue. – No time for professional development.
	Employers	– Avoiding the problem of a shortage of specialist doctors. – Increased number of subcontracted workers. – Possibility to sign a contract with the National Health Fund for services unavailable due to the lack of specialist doctors.	– Possibility of worsening the quality of work.
A change in the legal relationship between the parties to the contract of employment.	Doctors, nurses	– The employer and the subcontracted employee become equal partners in legal terms.	– No employer’s support in professional development, in particular in gaining medical specialty certification.
	Employers	– Reduction of employment costs by eliminating social and health insurance premiums as well as by simplified remuneration mechanisms. – Fewer problems with the organisation of work, in particular with on-call duties.	– Weak identification of the employee with the employer. – The shift of selected purchases onto the subcontracted employee.

Tab. 1. Opportunities and threats resulting from the subcontracted form of work in healthcare institutions. Source: Klimek (2010), p. 13.

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5. An Analysis of Changes in Employment in the Privatised Poviat Hospital

The effect of successfully conducted privatisation of medical facilities is the acquisition of new patients, the development of activities, broadening the range of medical services and even increasing the volume of contracts with the National Health Fund (Romanowska & Kowalik, 2017a). A particularly important element of this phenomenon is the improvement of the standard of services because the facilities are fully renovated, equipped with new equipment, and what is the most important is the fact that the employment of additional specialists increases.

The comparison of the size of employment of medical staff before and after the privatisation shows that there was a decrease in almost all departments (see Table 2). In total, the decrease was 23.08 people, including 17.83 FTEs, and 7.25 fee-for-task workers. Only the Health and Care Centre (ZOL) recorded an increase by 1.45 in total employment, including 0.25 FTEs, 0.5 subcontracts and 0.7 fee-for-task workers. The largest fall of 6.6 was recorded by the surgical department, including 6 people working full-time and 0.6 fee-for-task workers. As for outpatient clinics, noticeable changes occurred in the X-ray, USG and mammography labs – there was a decrease in employment by 2.92 FTEs, whilst before privatisation (SP ZOZ) it was 1.46 FTEs and fee-for-task workers. In total, in clinics, the employment decreased by 2.42 persons. A number of fee-for-task workers decreased by 3.46, and there was an increase in subcontracted workers by 1 person and in full-time employees by 0.4.

	SP ZOZ (before transformation)				NZOZ (after transformation)				Difference in performance			
	1	2	3	4	1	2	3	4	1	2	3	4
Hospital Departments												
Internal	23.00	3.00	0.00	**26.00**	22.00	3.50	0.00	**25.50**	-1.00	0.50	0.00	**-0.50**
Obstetrics and Gynaecology	20.00	2.00	2.08	**24.08**	18.92	3.00	0.00	**21.92**	-1.08	1.00	-2.08	**-2.16**
Neonatal	5.00	1.00	1.00	**7.00**	4.00	1.00	0.50	**5.50**	-1.00	0.00	-0.50	**-1.50**
General Surgery	21.00	3.40	4.60	**29.00**	15.00	3.40	4.00	**22.40**	-6.00	0.00	-0.60	**-6.60**
Anaesthesia and Intensive Care	16.00	2.00	3.00	**21.00**	13.00	2.00	1.00	**16.00**	-3.00	0.00	-2.00	**-5.00**
O.R.	12.00	1.65	1.35	**15.00**	9.00	1.65	0.00	**10.65**	-3.00	0.00	-1.35	**-4.35**
Health and Care Centre (ZOL)	13.75	0.00	7.50	**21.25**	14.00	0.50	8.20	**22.70**	0.25	0.50	0.70	**1.45**
E.R.	12.00	1.68	2.62	**16.30**	9.00	1.68	1.20	**11.88**	-3.00	0.00	-1.42	**-4.42**
TOTAL	**122.75**	**14.73**	**22.15**	**159.63**	**104.92**	**16.73**	**14.9**	**136.55**	**-17.83**	**2.00**	**-7.25**	**-23.08**

Table cont.

	SP ZOZ (before transformation)				NZOZ (after transformation)				Difference in performance			
	1	2	3	4	1	2	3	4	1	2	3	4
Outpatient Clinics												
General Surgery	3.00	4.00	1.00	**8.00**	3.00	4.00	1.00	**8.00**	0.00	0.00	0.00	**0.00**
Pulmono-logy	0.00	1.00	0.00	**1.00**	0.00	1.00	0.00	**1.00**	0.00	0.00	0.00	**0.00**
Obstetrics and Gynaeco-logy	1.40	0.00	0.00	**1.40**	1.40	0.00	0.00	**1.40**	0.00	0.00	0.00	**0.00**
Urological	0.00	1.00	0.00	**1.00**	0.00	1.00	0.00	**1.00**	0.00	0.00	0.00	**0.00**
Cardiology	0.00	1.00	0.00	**1.00**	0.00	1.00	0.00	**1.00**	0.00	0.00	0.00	**0.00**
Gastroscopy Lab	1.00	1.00	1.00	**3.00**	2.00	1.00	0.00	**3.00**	1.00	0.00	-1.00	**0.00**
X-ray, USG, Mammo-graphy Labs	8.46	1.00	3.46	**12.92**	7.00	1.00	2.00	**10.0**	-1.46	0.00	-1.46	**-2.92**
Cardio-logical Lab	1.00	1.00	0.00	**2.00**	1.00	1.00	0.00	**2.00**	0.00	0.00	0.00	**0.00**
Visiting / Home Primary Health Care (POZ)	0.00	0.00	2.00	**2.00**	0.00	1.00	1.00	**2.00**	0.00	1.00	-1.00	**0.00**
Hospital Pharmacy	1.00	0.00	0.00	**1.00**	1.50	0.00	0.00	**1.50**	0.50	0.00	0.00	**0.50**
The Central Sterile Services Department (CSSD)	3.00	0.00	0.00	**3.00**	3.00	0.00	0.00	**3.00**	0.00	0.00	0.00	**0.00**
TOTAL	**18.86**	**10.00**	**7.46**	**36.32**	**18.90**	**11.00**	**4.00**	**33.90**	**0.04**	**1.00**	**-3.46**	**-2.42**
Additional Medical Services												
Emergency Medical Services „S”	15.00	1.00	7.00	23.00	7.00	4.70	2.50	14.20	-8.00	3.70	-4.50	-8.80
Emergency Medical Services „P”	10.00	10.00	0.00	20.00	0.00	10.50	0.00	10.50	-10.00	0.50	0.00	-9.50
Emergency Medical Services „P”	10.00	10.00	0.00	20.00	0.00	10.50	0.00	10.50	-10.00	0.50	0.00	-9.50
Non-emergency Medical Transportation	5.46	0.00	2.46	7.92	1.00	0.00	0.00	1.00	-4.46	0.00	-2.46	-6.92
Dispatcher	5.00	0.00	3.00	8.00	3.00	0.00	1.00	4.00	-2.00	0.00	-2.00	-4.00
TOTAL	**45.46**	**21.00**	**12.46**	**78.92**	**11.00**	**25.70**	**3.50**	**40.2**	**-34.46**	**4.70**	**-8.96**	**-38.72**

1 – Full-Time Equivalent (FTE)
2 – Subcontracts
3 – Fee-For-Task
4 – Total

Tab. 2. Number of employees by the form of employment. Source: Own study based on medical records of the examined hospital.

The biggest changes occurred in the group of additional medical services. In total, the drop amounted to 38.72 people, from 78.92 to 40.2, including an FTEs decrease of 34.46 and 8.96 for fee-for-task. An increase of 4.7 was recorded among the subcontracted employees.

Table 3 presents a synthetic summary of the total number of employees divided into three units, i.e. hospital departments, clinics and additional medical services. It shows that the total employment decreased in the first year after the transformation into NZOZ in comparison to the last year as SP ZOZ – a decrease by 64.22 people, i.e. by 23.36%. The biggest drop, of 49.06%, was recorded by additional medical services, the lowest by outpatient clinics – 6.66%, i.e. from 36.32 persons (SP ZOZ) to 33.9 (NZOZ).

UNIT	SP ZOZ	NZOZ	Growth rate (id)
Hospital Departments	159.63	136.55	85.54%
Outpatient Clinics	36.32	33.9	93.34%
Additional Medical Services	78.92	40.2	50.94%
TOTAL	**274.87**	**210.65**	**76.64%**

Tab. 3. Total employment and employment rate. Source: Own study based on medical records of the examined hospital.

The declining employment of the medical staff did not adversely affect the hospital's income, i.e. the size of funding from the National Health Fund, which reflects the correct employment policy pursued during its privatisation, which is confirmed by the decrease in total employment of 23.36% and a simultaneous increase in revenues of 13% (see Table 4), recorded by NZOZ in comparison to SP ZOZ.

UNIT	Revenues (PLN)		(%)
	SP ZOZ	NZOZ	
Hospital Departments	13 235 614	14 694 728	111%
Outpatient Clinics	900 445	1 160 114	129%
Additional Medical Services	1 309 315	1 523 440	116%
TOTAL	**15 445 373**	**17 378 282**	**113%**

Tab. 4. Revenues from the National Health Fund. Source: Own study based on medical records of the examined hospital.

The analysis of the revenues divided into three units (see Table 4) shows that the highest growth rate was achieved by the clinics, i.e. 129%.

Hospital departments operating as NZOZ, compared to SP ZOZ (before privatisation), generated an income higher by 11%, whilst additional medical services earned 16% more. Such a situation reflects an improved performance of the employed medical staff, which can be assessed by the size of revenues per 1 employee (see Table 5).

UNIT	SP ZOZ	NZOZ
Hospital Departments	82914.33	107614.27
Outpatient Clinics	24791.99	34221.65
Additional Services	16590.41	37896.52
TOTAL	**56191.56**	**82498.37**

Tab. 5. Revenues from NFZ per 1 employee (PLN). Source: Own study based on medical records of the examined hospital.

In total, in the first year of operation as NZOZ in comparison to the last year as SP ZOZ, the size of revenues from the National Health Fund per 1 employee increased by PLN 26,306.81 (46.8%), hospital departments recorded an increase of PLN 26,699.94 (29.8%), outpatient clinics a rise of PLN 9,429.66 (38%) and additional medical services – of PLN 21,306.11, which is an increase of 128.4%.

6. Conclusion

The long-term goal of improving the financial performance of medical entities is a proper adjustment of the employment structure to the activity profile. The transformation resulted in a decline in employment, however as a result of the growing demands from employees, wages are still increasing. This is the reason for the still existing problems with achieving a satisfactory financial situation of SP ZOZ. The report covering 22 hospitals prepared by the Supreme Audit Office (NIK) shows that staff costs are the dominant part of total hospital expenses. They range from approx. 47% to more than 85%. Medical staff employment costs range from 80% up to 90% of all remunerations. Medical centres are trying to cope with the existing shortages of doctors by hiring subcontracted workers, which enables a more flexible organisation of work. However, this may also cause significant differences in the remuneration of the medical staff at identical positions in various medical units.

However, quality and safety, together with certainty and speed of access to services, are key elements in ensuring that patients can trust the system. The basic problem of the healthcare system is that “anyone can do anything” as long as they meet the standards set by the regulations. However, these

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are mainly standards relating to equipment or medical staff. Nowadays, the quality of the services provided depends mainly on the ability to perform medical procedures, and this in turn depends on the experience of the medical staff (number of treatments performed so far). Respecting patients' rights and ensuring their safety when using health services is one of the major challenges for the health system.

As reported by the Supreme Audit Office, further processes of restructuring independent public healthcare institutions are necessary, keeping in mind the health needs of residents. It will be possible thanks to a map of health needs the introduction of which is envisaged by the amended Act on *Health Benefits*.

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