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Author:	**Dr. Krzysztof Bukiel (OZZL)**		

FEMS Permanent Secretariat: Rue Guimard 15, B-1040 Brussels/ Belgium
Tel.+32 27 36 60 66, Fax +32 27 32 99 72, e-mail: info@fems.net, http://www.fems.net

OGÓLNOPOLSKI
ZWIĄZEK ZAWODOWY
LEKARZY

ZARZĄD KRAJOWY
ul. GDAŃSKA 27
85-005 BYDGOSZCZ
tel/fax 52 372 08 83
biuro@ozzl.org.pl

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National Report Poland
Dr. Krzysztof Bukiel (OZZL)

Report on the state of public health care and the medical profession in Poland

The state of public health care in Poland

The state of public health care in Poland is determined by two basic principles, which are regarded as permanent and inviolable by all successive governments:
1) the amount of public funds allocated to health care must be as low as possible (it is the lowest in the EU, calculated as % of the GDP and equals slightly over 4% of the GDP),
2) the formal scope of reimbursable health services must be as wide as possible and all these services must be available to patients "free of charge".

It is obvious that these two conditions are mutually exclusive and in practice, cannot actually intersect, which causes a series of specific, negative effects. These effects shape the real picture of the public health care system in Poland. Two of these are the most significant:
- **administrative limiting of reimbursable health services** (with few exceptions), which causes long waits for treatment, a lack of development opportunities for health care facilities and their poor financial situation (permanent debt),
- **lowering the prices (the amount of the reimbursement) for health services by the public payer**, which results in indebtedness of hospitals, lowering of salaries for medical personnel, lowering the quality of services, reducing the employment of doctors and nurses in hospitals and throughout the health care system (the number of doctors in Poland per 10 thousand residents is 2, and the number of nurses is 5).

The organisation of the public health care system in Poland has – apparently! – a market character. This means that health care facilities, including hospitals, must operate as businesses that sell their services and have to generate a profit, as well as compete with each other for patients and the money that "follows the patient".
In reality, these market assumptions are distorted and deformed by the following solutions:
- prices for health services are not "free", market prices, but are dictated by the public payer and are, as a rule, lower than the costs that must be incurred,
- money paid to the hospital by the public payer do not take into account the costs of the amortization and maintenance of the equipment and buildings – the hospitals must obtain the money for these goals from other sources; in the case of public hospitals, these sources are local government subventions,
- hospitals (and clinics) can provide ("sell") only as many services as the public payer has determined (limits).

Thus, hospitals have no influence over their own profits; they can only limit costs. The material situation of a hospital does not depend on how good a hospital is, but on the wealth and generosity of the public authorities acting as the hospital owner, which supplement the deficit of the funds received by the hospital from the public payer. The chaos is deepened by the fact that some of the reimbursable health services are better priced (i.e. more adequately to the costs) and other are less well priced (most often below cost) by the public payer. All in all, the fate of the hospitals depends entirely on the decisions of the public authorities at various levels, and is not the result of their success in the health care service market. The fact is that the few reimbursable health services, which are properly priced in Poland and, additionally, are unlimited, have reached the highest level in terms of their quality and availability to patients. This is the case with interventional cardiology or with dialysis.

Summing up: the picture of the public health care in Poland is made up of the following phenomena:
- steady and significant shortage of funds in relation to the scope of services reimbursed,
- excessively low valuation of most health care services financed from public funds,
- administrative limiting of the majority of reimbursable health services,
- widespread waiting times for treatment,
- permanent indebtedness of hospitals and drastic savings measures taken by hospitals, which pose a threat to patients and physicians,
- a great shortage of medical staff, especially doctors and nurses,
- an excessive number of work hours of medical staff (overwork), especially doctors,
- a few “islands” of normality, that is services, which are available without a waiting period and at the same time at a high level of quality.

Added to this must be the lack (among political parties) of a substantive program of repairing the public health care system, which would take into account the fundamental problem of the imbalance between health care expenditures and the range of free health services.

The situation of doctors

The situation of doctors in Poland is very diverse. Doctors are a very heterogeneous group. In the general social awareness, doctors in Poland are one of the best-paid occupational groups. In the general awareness of doctors, they are one of the most economically abused groups in Poland. Where do these differences come from? I will explain below.

The underfunding of Polish hospitals is so great, that in order to run only on the money they receive from the public payer, they would have to completely stop paying their employees. Any amount paid to doctors is too high for Polish hospitals. In such a situation, it is difficult to expect that hospital directors will voluntarily pay their doctors properly, that is fairly. Especially since Poland does not have any legal regulations defining the level of wages for doctors, nor are there any procedures for negotiating doctors’ pay between the trade union of doctors or another of their organisations and the public payer. A doctors’ trade union may negotiate with the director of their hospital, according with the general provisions of labour law, but everyone knows (both the director and the doctors) that such negotiations, conducted in a “peaceful” manner are pointless, because the hospital does not have – of course – enough money.

Therefore, the only way to improve doctors’ salaries are actions that threaten the normal operations of the hospital or cause social unrest in the country, i.e. strike or mass, organised resignation of doctors. The National Trade Union of Doctors (OZLL) has organised such actions many times. On a national scale, such strikes took place recently in 2006 and 2007, and on a smaller scale in 2008. They led to higher wages – at the time, doctors got even 100% more. Since that time, they take place only locally, in specific, individual hospitals. Currently, the

monthly gross salary (before taxes) for a specialist doctor (i.e. one with 10-20 years' experience) in Poland is approximately PLN 5,000 (approx. EUR 1.200) with all additions (without the on-call hours, that is without the overtime hours).

There are two other (in addition to strikes or taking time off from work) ways of increasing revenue for doctors, and both are widely used.

The first way is changing the base of employment from an employment agreement to a so-called "contract" (a civil law contract). The doctor goes from being an employee to being a one-person business, or a self-employed person. This manoeuvre means that the amount of money that reaches the doctor's account increases by 30-40 percent, with the same costs for the hospital. This is a result of lower social insurance rates, a lower tax, and the possibility of reducing the tax base for the contractor-doctor compared to the employee-doctor. Doctors use this method quite often, even though it also associated with significant risks.

The second way of temporarily increasing income by doctors is, of course, additional work, particularly as on-call physicians. This is facilitated by a great shortage of doctors in Poland. The EU directive on working hours is generally bypassed by the fact that doctors working on contracts (rather than employment agreements) are not obliged to abide by it.

In this way, a doctor whose monthly salary for working in one full-time position is PLN 5 thousand (EUR 1.2 thousand) if working as an employee, can earn 2 or 3 times more if he moves to a contract, and additionally takes 6-8 or over a dozen shifts a month. Thus the differences in the assessment of the financial situation of doctors in Poland. In addition, the situation is complicated by the fact that some doctors are actually entrepreneurs, running private medical practices and private clinics, which have direct contact with the public payer.

Doctors in Poland are such a heterogeneous group that the organisation of nationwide general activities by a trade union, aimed at improving working conditions and wages of doctors, which would cover most doctors, is virtually impossible. Therefore, OZZL activities in this matter are focused primarily on local actions in individual hospitals.

Krzysztof Bukiel
The president of the OZZL National Board