Unpredictable Politics:
Policy Process of Health Reform in Poland

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Acronyms

AWS	Solidarity Alliance
COIEZ	Center for Health System Management
KLD	Liberal and Democratic Congress
KPC-OP	Confederation of Independent Poland
KRUS	Social insurance mechanism for farmers
KSRM	Government structure responsible for coordination of social policy
NRL	???
NSZZ Solidarnosc	Political group within post-Solidarity coalition
PC	Anti-Communist Alliance of the Center
PCh-S	Small Christian Party of Hanna Suchocka's government
PPS	Polish Socialist Party
PSL	Peasants' Party (formerly the ZSL party)
SdRP	Social Democrats of Poland (reformed communist party)
SLD	Alliance of the Democratic Left
UD	Democratic Union
Unia Pracy	Anti-Communist Labor Union
UW	Liberty Union
ZChN	Christian National Union
ZOZ	Soviet Period Districts or Municipalities
ZUS	Social Insurance Mechanism for the majority of insured

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Introduction

The beginning of 1999 marked a major step in the evolving reform of Poland's health system, the culmination of a nine-year transformation process from the Soviet style Semasko system. The new law established a system of universal and compulsory health insurance for most of the population. The insurance is to be administered by regional sickness funds and by "branch" funds for selected groups based on their employment status (people “in uniforms” like professional soldiers, policemen, firemen and similar groups—and members of their families). Individuals in the few groups that are not explicitly covered by the law can voluntarily join. Affiliation with the funds is usually based on place of residence and the act of affiliation and payment of premium are paid by employers or other agencies (i.e., welfare agency for unemployed and indigent and schools for students). Special groups are entitled to free access to care according to health problems (TB, contagious diseases, addiction), active military duty, and "homelessness".

The National Health Insurance Law was designed to separate financing from provision of services. The government has created sixteen public regional sickness funds that are responsible for inhabitants of the geographic "voivodships" and one country-wide "branch fund". [1] Services are provided by both public and private health care institutions and group or individual practices. The insurance funds enter into contracts with providers and may select either public or private providers. The funds are supposed to use efficiency criteria for selection of providers.

The funds are financed by a contribution of 7.5% of income of most employed and for farmers, a formula based on a uniform estimated production of farms (price of wheat times size of farm). Welfare agencies pay the premium for unemployed, disabled, veterans, and mothers on maternity leave. The contributions are taken out of the existing tax contribution so that no obligatory contributor experiences a loss of disposable income. Contributions are paid to the Social Insurance Office, an agency which collects for all types of social insurance, and is then transferred to the sickness funds. The funds are allowed to contract with providers using any payment mechanism, although usually it has been by capitation for primary care and illness episode for inpatient care. Regional funds receive contributions from the population within their jurisdiction and there is an equalization fund to compensate for regional differences.

This landmark legislation was only the latest step in a long and contentious reform process that is still on-going. The process has been quite unlike that of other innovative post-communist Central and Eastern European states, such as Hungary and the Czech Republic, in which major health reforms were adopted and implemented in the early years of the democratic regimes. In this context, the Polish reforms were not only implemented much later than other countries, but also were less oriented toward free market options.

This article will analyze the political process that has led from the initial vague reform proposals that were discussed in the early years of the democratic government, through a period of competing proposals and vacillating government decisions, to the final round of ratification of a major health insurance act and its amendments which produced the health insurance reform implemented in January 1999. Our objective is to describe the process and evaluate political strategies that might have influenced the adoption of the current reforms. To do this we will use a variety of political analyses -- stakeholder analysis, analysis of coalition governments, and assessment of the roles of incumbency and of technical advice. Where relevant we will also compare the process in Poland to those in Hungary and the Czech Republic to draw lessons within the framework of transitional political systems. Our central objective is to describe the process of health reform in democratic Poland and to address the following questions: Why has it taken so long for health reform to be decided and implemented in Poland? Why has Poland not adopted the proposals for greater involvement of market mechanisms that have been tried in

[1] Voivodships are the Polish equivalent of states or provinces in other countries

other Central and Eastern European countries? What political strategies might be used to continue the process toward a greater consensus on innovative health reform proposals?

The general trend of decisions about health reform followed an evolution of reform proposals that began with incomplete, vague and contradictory proposals in the first period of the post-Solidarity governments. This was later followed by the development of two enduring competing proposals and finally the decision to adopt a modified version of one of those proposals in the Health Insurance Act of 1997 -- a decision to adopt regional insurance plans. Along the way several other options have been rejected, although there remain strong advocates for these positions even now: 1) retaining budgetary financing for operating budgets of primary care facilities and services; 2) integrated plans based on the soviet period districts (ZOZ) or municipalities; 3) multiple competitive insurance plans; 4) mandated fee-for-service payments; 5) city management of health plans.

Many analysts of health reforms describe the process through a stakeholder analysis. This approach, based on the framework of interest group politics and bureaucratic politics, examines the different interests and positions of key actors to identify the positions they take on the issues and proposals. It then assesses the power of the actors to explain how a coalition of supporters were able to unite behind one reform proposal and amass sufficient power to put that proposal into practice. (Reich, 1995) We have found that coalition politics in Poland creates a degree of instability and uncertainty about positions and commitment that make straight forward application of stakeholder analysis difficult in Poland. As we will show below, there has been insufficient stability in the political system for us to identify most stakeholders with predictable interests and clear and sustained positions *vis a vis* different health reform proposals. Ideology has not been a consistent predictor for the positions taken by stakeholders.

In other processes of health reforms, analysts have found that a core group called a "change team" were important advocates for reforms (Gonzalez and Bossert, forthcoming). Change teams are small groups of technocrats who share an ideological commitment a particular type of reform and who have strong vertical networks of political supporters as well as horizontal networks of supporters in other economic and social sectors. While we did not find a consistent and strong group of technocrats which would qualify as a change team in Poland, we did find that the agile behind-the-scenes work of a few individuals was able to gain the adoption of a modified version of its initial proposals. These individuals were associated with the social democratic wing of one important but small political party. They did not have the obvious political powers nor a publicly identified position to prevail in the political struggles, but were nevertheless successful because of persistent participation and an unusual intervention by one powerful politician from another wing of the political party. We will also review other factors, such as technical advice from experts and international donors, internal bureaucratic politics, incumbency vs. opposition, and lobbying by special interest groups, that might have influenced the choices of the political actors.

Part of the difficulty of analyzing the political processes of health reform in Poland has to do with the institutional context of the particular Polish experience in political transition from soviet dominated communist state to a new democracy. Before we review the process by identifying actors and positions they took, it would be useful to assess this institutional context.

Polish Political System in Transition

Transitions from communist systems to new democracies have intrigued political analysts throughout the 1990's. First, it is clear that, contrary to the monolithic image of communist systems, the previous regimes were not models of rational planning and uniform centrally directed administration. The internal political processes, while not based on interest group politics, were much more contentious than the Soviet model suggests. The systems might better be described as patronage political processes in which political entrepreneurs developed networks of patrons in the governmental structure so that they could gain exceptions from the general administrative rules and accomplish their particularistic goals, usually to the benefit of their network of clients. (Bartlett, 1997) The legacy of this patronage system is that the post-communist politicians have had experience working together in trusting networks, while those outside the communist parties did not. This lack of experience by the non-communist political actors in informal political processes and in building trust and consistency may explain why stakeholders in the political system have not been able to develop sustained positions and strong coalitions. Evidence of this lack of consensus and consistency has been observed not only in the health sector but also in general economic policy and other social sectors. (see: Roszkowski, 1997; Kubik, 1989; Ost, 1991) Political parties (with the exception of some of the post-communist parties) themselves continue to be weak coalitions of shifting individuals and with little voter loyalty. (Kaldor and Vejvoda, 1997)

Some have observed that a central basis for a functioning democracy may be the creation of "social capital" by which citizens learn from experience in groups in civic society to behave in trustworthy ways, with some consistency and orientation toward consensus building.(Putnam, 1993) It may be that the communist system allowed communist party members to develop an instrumental trust of the patronage system but that the general public was not able to develop the social capital that Putnam finds essential in civic social groups. The experience of Solidarity in forming opposition groups to the communist government, apparently did not result in sufficient building of social capital to be sustained during the period after it achieved the end of the communist system. Solidarity members became politically active as protesters and the skill of successful protest may not have required the same level of interactive consensus and trust building that is widespread in routine political processes.

Secondly, it is clear that the different countries experienced both the prior communist period and the transitions in significantly different ways. (Parrott, 1997; Michta, 1977; Ekiert and Kubik, 1994) In Poland the relatively liberal policy of the communist government in the domain of culture and academic freedom, combined with the retention of a strong Catholic Church and individual agriculture through out the communist period, set the stage for contentious civic social organizations and the creation of an independent trade union movement that emerged as Solidarity. However, the imposition of martial law in 1981 led to a break in relations between the government and opposition and almost no communication between them until the Roundtable talks in 1989. In Hungary the "Goulash Communism" of Janos Kadar allowed more liberal policies to be implemented earlier with greater involvement of the opposition during the late period of communism and during the transition to democracy.(Kornai, 1996) In the Czech Republic the communist regime was much more rigid and oppressive and it was not until the end of 1989 that the communist party, by then political bankrupt, began reluctantly to approve the first liberalizing steps. Early in the new government, physician interest groups were able to capture the Ministry of Health and impose a reform which strongly favored their economic interests. (Potucek and Radicova, 1997)

Thirdly, in some countries a broad consensus emerged that changes in the social sectors should be postponed, or be less aggressively pursued, until after the transitions in the general economy had taken hold. Retaining a "social cushion" was seen as a means of reducing opposition to the economic reforms among the broad population that would suffer from the initial impact of recession and privatization. (Gedeon, 1995)

In Poland the political system in the post-communist period involved an alteration of power between two major blocks of coalitions. The first non-communist coalition governments held power for four years from September 1989 to September 1993 and were dominated by post-Solidarity parties, with Prime Ministers, Tadeusz Mazowiecki, Jan Bielecki, Jan Olszewski, and Hanna Sochocka. In 1993 the post-communist coalition was swept into power for four years under Prime Ministers, Waldemar Pawlak, Jozef Oleksy and Wlodzimierz Cimoszewicz. The post-Solidarity coalition came back to power in November 1997 under Jerzy Buzek. The post-Solidarity coalition members shifted from period to period and included NSZZ Solidarnosc, the famous trade union, the Christian National Union (ZChN), the anti-communist Alliance of the Center (PC), the liberal Ruch Stu "Movement of One Hundred", and the "Confederation of Independent Poland" (KPN-OP). This group formed the "Solidarity Alliance" AWS in 1997 to successfully return to power. It was supported in the parliamentary and governmental coalition by the Democratic Union (UD) which in 1993 merged with the Liberal and Democratic Congress (KLD) to form Liberty Union (UW). The leftist but anti-Communist Labor Union (Unia Pracy) tried to play a role of the “third force" offering conditional and selective support to either side. Post communist coalition members formed the Alliance of the Democratic Left (SLD), which included the reformed communist party, the Social Democrats of Poland (SdRP), the Polish Socialist Party (PPS) and trade union groups. The Peasants’ Party (PSL -- formerly ZSL) also supported the post-Communist coalition. (Dudek, 1997)

In general the post-communists can be seen as being on the left and in favor of more social democratic positions -- with a significant role for the state in both the economy and social sectors. The Liberty Union and its precursors tended to be of the center with one wing, identified with Jacek Kuron who had been imprisoned by the communists for 10 years, that supported more social democratic positions on social services and another wing, identified with Balcerowicz, the architect of the successful introduction of market reforms, that supported market solutions for economic policy. The AWS and its precursor parties tended to be on the right, favoring use of the market for economic and social policies. However, these generalizations often did not hold on specific policies and the ideological positions of the different parties often changed. (Wolff-Paw ska, 1998, Bogucka, 1997) For instance, the trade union orientation of some members of AWS tended to favor some limits on market economy, putting it at odds with the general economic policy of post-Solidarity governments. Some smaller parties represented specific interests -- such as the Peasants' Party that defended the interests of farmers. Others were competing pro-market parties that had different views on the role of Catholic Church on social issues of abortion and divorce. As noted above, a defining feature of many political actors was the roles that they had played in the movements to overthrow the communist regime.

In general political parties did not define themselves clearly on health policy. Their positions evolved over time and were often due to an interaction between technocratic outsiders and individual party members' participation in the development of government proposals and opposition counter proposals. As we will see in the following section, the platforms of the parties were poor guides to the actual positions and proposals that emerged from the internal processes of policy design. Post Solidarity parties promoted at different times proposals that favored expanding the markets in health and increasing municipal roles and others which restricted them. The major social democratic party also favored different health care policies, with one wing of the party favoring markets and the other favoring government controlled insurance monopolies.

Interest Groups in Health

The major interest groups in health, as in most countries, were the providers' professional associations and unions of health workers. Consumer associations and associations of special illnesses (such as cancer societies) were not important actors in this process, nor was the association of hospital administrators. No health insurance lobby was established. The associations of local governments also played no major role, although they stood to gain or lose significant control over the health system.

The Physicians' Chambers, operating since 1989, as well as Pharmacists' Chamber and Nurses' and Midwives' Chamber established later, had gained a legal right to issue their opinions on behalf of medical professionals. These official associations were supplemented by less formal societies, such as the Polish Physicians' Society.

These organizations were joined since 1992 by a separate trade unions representing physicians, nurses and midwives, surgeons, surgical specialists, anesthesiologists, and a health workers union associated with Solidarity.

It was mainly through Solidarnosc participation in the post-Solidarity coalitions that unions and professional associations played a role. They were instrumental in orienting this proposal toward the German model of competing small-scale insurance plans and the use of physicians associations for negotiations with insurance entities, both of which would give physicians greater negotiating power on contracts and payments. On some specific legislative initiatives that they sponsored, were temporarily tabled in legislative proposals -- for instance they introduced a tax exemption for medical expenses in 1995 and a fee-for-service provision in 1998. However both of these initiatives were later killed in the legislative process. While professional associations and unions would support Solidarnosc proposals with protests and strikes, these tended to be short lived and ineffective means of promoting the proposals.

The Health System and Health Reform

The Semoszka health system imposed during the 40 years of Soviet domination was a single monopolistic centralized state run health system, available to all citizens and funded through the national government budget. Even with social security contributions, which since 1986 were collected through an independent institution—Social Insurance Fund--there was no separate fund for health. Physicians were paid on a salary basis. In the original model, there was no room for local autonomy nor private practice. The system was organized into separate integrated health districts with a network of comprehensive health clinics, called ZOZ. The ZOZ and local hospitals were managed by the regional representatives of the central government, the Voivoidships. This system began a slow deterioration at the end of the communist period with the emergence of some local autonomy ("mayors' clinics"), the creation of a separate physician's association, and some private practice.

When the communist regime collapsed in 1989, proposals for change in this system emerged along with reforms in the rest of the economy. As in the Czech Republic and Hungary, proposals ranged the gambit from minor tinkering with the system to full-fledged use of market mechanisms.

The Process of Health Reform

The process of health reform is embedded in the changing governments. Annex 1 presents an overall guide to the major governmental periods and the major proposals and legislation in each period. The major actors involved in the reforms were political parties; the Ministry of Health

and the Ministry of Finance; the medical associations of physicians, nurses and other health professionals; technical advisors from public health institutions and international donors.

The process of health reform in Poland followed a sequence of stages of health policy changes that culminate in the 1999 implementation of health insurance reform. The stages begin with the Round Table Negotiations of 1989 in which a commitment to national health insurance was first articulated. This stage was followed by Draft Proposals of the first post-Solidarity government and the Proposal of Independent Experts in 1989. These proposals were not adopted and the next phase was the adoption of a Health Institutions Act and a proposal prepared for the World Bank Project 1992. It was during the following period under last of the initial post-Solidarity governments of Hanna Suchocka in 1992-3 that a series of competing and ultimately enduring proposals were made that would shape the debate and the subsequent legislation. The next to final stage involved post-communist government which in the period 1993-97 was able to pass first the Large Cities Act and later the Health Insurance Act. In 1997 the post-Solidarity parties again took power and amended the Health Insurance Act, but retained its major features.

The following narrative will show how most political actors changed their positions vis a vis different health reform proposals but that a small group of individuals within one party -- Liberty Union -- was able to maintain a consistent and ultimately successful strategy to adopt the form of health insurance reform that was ultimately passed and is being implemented. Annex 2 presents a brief summary of the different proposals.

Round Table Negotiations 1989

Health was not a major issue during the Round Table Negotiations at the end of the Communist period. There were many structural and institutional issues of the design of the new political system which were more contentious and for which at least some kind of tentative consensus had to be worked out. Nevertheless, during this period the idea of transforming the centralized budgetary funded health system into a universal health insurance system was included in the formal Round Table Document. This document articulated a vision of an insurance system in which all Poles would be entitled to services, premiums would be paid by a tax on the wealthy and by businesses, but not by employees, and should vary according to region and types of businesses.

The First Post-Solidarity Government Proposals

In the Mazowiecki government, a representative of the ZSL party (the Peasants' Party) Andrzej Kosiniak-Kamysz, was made Minister of Health, as part of the formal coalition agreement. The Peasant Party position on health reform was never well articulated, but it tended to defend peasants' special rights to health care within whatever general proposal was made. Within the Ministry however there was a strong Solidarity group which held key positions. The composition was a combination of both old and new political powers in the coalition government. There was however a lack of clarity about who was responsible for making proposals for health reform, resulting in different proposals emerging from different parts of the government. Solidarity sent two members to the Ministry with the mission to prepare and implement the reform.

The First Deputy Minister, Piotr Mierzewski, a strong political figure was responsible for the Ministry's formal proposal along with the Representative for Reform, Wanda Majewska, a health economist. However, in the Ministry there was another person, Andrzej Wojtczak, a deputy minister, who was put in charge of implementing the Round Table agreements. Following his mandate he set up a strong team of experts which did produce the formal "Official Proposal". At the same time another group of experts, outside the government, prepared another proposal known as the “Independent proposal”.
The two draft proposals that emerged during this period were remarkably similar suggesting a general consensus at the time in favor of a single universal national social health insurance

policy and with an emphasis on public providers. The Official Proposal would have created an independent Central Health Insurance Fund with separate branches to manage a universal insurance system in which employers and public funds would pay the premiums. It envisioned primarily insuring access to public providers but also considered other forms of ownership. Payment would be based on types and quantities of services but not simple fee-for-service. The Independent Proposal also envisioned a central fund but it would not be independent of the Ministry of Health, and, as with the Official Proposal, was primarily concerned with funding for public providers. Premiums would, however, be paid by both employers and employees and there would be partial co-financing from the budget. Payment would be made by an ex-ante global budget to cover all expenses in the coming year, rather than payments by type and quantities of services. Neither of the proposals envisioned significant private participation or competition among providers.

Despite these similarities, there was considerable emotional conflict among the participants and confusion about the roles of the different groups making the proposals. The Ministry appeared to favor the Independent Proposal but felt bound to respect the formal process of the Round Table Agreements which produced the Official Proposal. The confusion resulted in no clear decision to follow either proposal. The consensus conferences, organized with the assistance of international organizations and foreign experts, which were often used for resolving difficult issues were not effective in bringing together the different groups.[2]

Beginning in March 1990, a new expert team started to operate in the Center of Health Care Organization and Economics, under Cesary Wlodarczyk.[3] This group had weak formal authority but was seen as a respected "think tank" that offered advice to the ministry." They produced a number of documents that attempted to create a compromise on the outstanding differences between the Independent Proposal and the Official Proposal.

The short lived, second and third post-Solidarity governments had replaced the old coalition members of the Ministry of Health and Social Welfare with pro-reform strong political figures and respected professionals. Wladyslaw Sidorowicz, a representative of pro-reform Solidarity groups, and an effective record of underground Solidarity activity in the 1980's, became the first Minister. He was followed by Marian Miskiewicz, who had been a long-term Deputy Director of the largest ministerial institute and had co-authored a break-through Report of the "Experience and Future" Club, which had been the first fully independent intellectual group active ten years earlier in the communist period. Miskiewicz however was not strongly identified with any political group, which made his mission very difficult.

Although these governments lasted less than two years, they were able to pass one key law – the Health Care Institutions Law in 1991– and began a loan development process with the World Bank which produced reports that led to a loan agreement to support health sector reforms. The Law introduced the basis for a purchaser/provider split and authorized new and independent forms of provider institutions. It allowed contracting between Voivod governments as payers and health care provider institutions. It also allowed different ownership forms for provider institutions, taking into consideration local preferences and conditions. Health care institutions now could be owned by both public and private owners, including religious associations, insurance companies (national and foreign) and private citizens. Providers now could also include independent solo practices, group practices or other forms. Furthermore, public health care institutions could assume different levels of autonomy. They could continue to be funded

2 The First Conference on Health Policy in Poland Organized by the Ministry of Health and Social Welfare, Co-sponsored by WHO Regional Office for Europe, World Bank, and Project Hope, Held in Warsaw, February 9-11, 1990. More than 100 representatives from Poland participated in these conferences. (Wlodarczyk 1990)

3 The other experts were:. Katarzyna Tymowska from University of Warsaw and Stanislawa. Golinowska from the Institute of Economy

directly by the government as budgetary units, or become extra-budgetary units under the direction of the government. They could also become independent, self-managing units. The level of autonomy depended on proven managerial competencies.

The new law allowed a significantly increased scope of financial independence. Self managed independent structures were to raise their own revenue, sign contracts and sell services. Even institutions still operating under budgetary rules were allowed to retain up to 80% of their annual savings to be spent at their own discretion. The new law also introduced the concept of patient rights, a significant departure from general practice in Poland.

This new law was developed by a small technical team that included Tymowska, Mirsevski, Wlodarczyk and a lawyer from the Ministry of Health, Dorota Safian. They used the British Hospital Trusts as a model for the law. Surprisingly, there was almost no public debate about this major reform. It appears to have been seen as basically a management issue not so much a major restructuring. Nevertheless, it would have profound impact on future reforms, especially those involving decentralization to municipalities.

This post-Solidarity government also initiated a loan process with the World Bank. This process produced several key reports that are interesting in that they were completely rejected by subsequent developments of the health reform. These reports were developed with the National Center for Health Systems Management, now headed by Dr. Jacek Ruszkowski. The Ministry officials involved included two members of UD, the First Deputy, Piotr Mierzewski and, after his resignation, Marek Balicki.. The proposals which emerged as the World Bank project were remarkable in that they did not follow the usual World Bank promotion of market solutions.(Preker, 1990) The World Bank Proposal rather, retained the integrated ZOZ model and focused on more traditional centralized approaches of reducing duplication of services among different public providers. It proposed retaining central budgetary funding with new taxes, local government contributions, and co-payments, providers would be paid through budgetary transfers rather than fee for service or capitation, The proposal did have some pilot innovations which involved creating larger health districts as health consortiums.
The proposal was approved for the Bank in April 1992. Given the more radical proposals even within Poland for changes, it is surprising that the World Bank proposal was oriented more toward retaining the old regionalized health system and focused on coordination and planning rather than competition and insurance. The direction of the Bank document was entirely opposite to the way of thinking of the overwhelming majority of political and medical establishments. The document could hardly attract broader political support because it looked too similar to rules of the old "socialist care". It was clear that, despite being an effort supported by the Ministry, especially a fraction of the UD members, and the World Bank, this proposal was developed without the backing of major political actors. When the loan agreement was signed, the recommendations were totally ignored by consecutive groups of reformers and played no role in influencing concepts applied in the reform process. They were soon superceded by a series of competing proposals in the final post-solidarity government before the post-communists returned to power.

Competing Proposals of the Hanna Suchocka Post-Solidarity Government 1992-3.

In Hanna Suchocka's government, the Minister of Health, Andrzej Wojtyla, represented one of the weakest political parties participating in the coalition: PCh-S, one of a few small Christian parties. The First Deputy Minister, Marek Balicki, represented UD. As was often the case in coalition governments, the alternating of party members in high positions in ministries immediately caused communication difficulties that evolved into policy differences. In addition, the complexity of the political system supporting the government led to developing several centers working on health care reform.[4]

[4] The group headed by Mr. J.M. Rokita concentrated on the public administration reform, Mr. P. Laczkowski's team and the Social Committee of the Council of Ministers was involved in social issues, with Mr. J. Kuron and Mr. M. Boni as leaders.

The lack of clarity within the Ministry was replicated throughout the government. There was no clear decision taken in the Sejm, nor by the Council of Ministers of the government and there were competing groups finally ready to present different conceptions of health insurance reform.

Four major proposals were developed during this short period.

- The KSRM Proposal prepared by the Health Insurance Team of the Social Committee of the Council of Ministers (Government of Poland 1992a);

- The Solidarnosc Proposal, prepared by the Joint Parliament and Trade Union Health Insurance Team (Solidarity 1993);

- The Proposal of the Inter-Ministerial Team for Social and Health Insurance Systems (Government of Poland 1992b);

- The County (Poviat) Health Care System Proposal prepared by the Government's Representative for the Public Administration Reform (Government of Poland 1993);

The first team worked on behalf of KSRM, the structure responsible for the coordination of the whole social policy in the government, assuring compatibility with economic policy. The Chairman of this team was a representative of one of the Christian parties who did not formally participate in the proposal preparation. The second team was dominated by a very influential political group within the post-Solidarity coalition, NSZZ Solidarnosc, which initially supported the government and later caused its collapse by withdrawing from the coalition. The Solidarnosc proposal was developed by a group drawn from the union movement, including Teresa Kaminska (who would later play a crucial role in the second post-Solidarity period), and others with strong links to physician groups (Committee in Defense of Health Care Reform) and Elzbieta Seferowicz, a chairperson in the Solidarity Health Committee.

The third team was composed of representatives of the Ministry of Health, Ministry of Labor, and Ministry of Finance, which were directly responsible for both the development of the social policy vision and its practical implementation. All the members of the Inter-ministerial team came from UD. The MOH took the lead under Baliski and drew support from the National Center for Health Systems Management -- in particular, Mr. Koronkiewicz, who reemerges to play a crucial role later in the process. The fourth team from the Government Representative's Office was at that time one of the most active parts of the government working on the strategic public administration reform. It was also dominated by the representatives of UD, a wing that was not associated with social democracy but rather favored decentralization.

While most of the participants in the development of these proposals were not party members, they were all active politically in the initial post 1989 period. For all of them, breaking with the communist past attained through the process of pro-democratic transformation constituted an essential element of their political self-identification. Nevertheless, their positions reflected some of the different fragments within each party and the competing visions of different groups within the governing coalition.
Two of the major proposals, those of KSRM and Solidarnosc, were not significantly different and enjoyed the support of both the major government policy structure and the trade union base of the coalition. The KSRM and Solidarnosc proposals would have created a large number of small independent insurance institutions, privatized provider organizations, and strengthened the decision-making roles of physicians, especially those working in outpatient care, and it divided hospital from ambulatory care, negating the concept of integrated care. This was consistent with the general trade union orientation of Solidarnosc and the privatization, competitive and anti-

bureaucratic ideological orientation of the post-Solidarity governing coalition.[5] It would be an enduring proposal favored by significant members of these groups.

The Inter-Ministerial Team, dominated by UD members, proposed regional health care planning and financing systems, with maintaining public organizations, especially in the hospital sector. It begins to introduce the concept of regional health insurance mechanism and payments through contracting, and although it emphasized integrated care and public provision it did open the way to more private provision of services at the outpatient facilities. Despite the detailed thinking backing this proposal, there were significant lacuna in the administrative and organizational aspects. The Inter-Ministerial proposal was dominated by a more social democratic approach, reflected the ideology of one wing of the UD -- the wing that continued to take charge of health care reform. It retained much of the public orientation of the initial thinking of the World Bank reports that had emerged from the Ministry and the UD think tanks in the previous government. As we will see, this approach would eventually emerge, with significant modification, as the successful proposal in the post-communist government.

The final proposal had its origin in the proposals for a reorganization of the public administration which involved the recreation of the county governments (poviats) and was primarily interested in carving out a health care role for these governments. It did not really address insurance issues and would have retained public responsibility for both organization and financing of the health system -- through the proposed poviat governments. The interest in poviats was the ideological position of another group within UD. This proposal however, was not seriously considered by the government as a significant measure for health reform.

Surprisingly, the medical interest groups initially rejected all the new proposals. The Physicians' Trade Union announced national protests as early as on January 6, with one of their slogans reading "pseudo-reform government activities." However, soon the National Physicians' Council realized that the KSRM and Solidarnosc proposals were in their interest and "firmly" rejected the Inter-Ministerial Team proposal.[6] Trade unions of physicians also came to favor the KSRM and Solidarnosc proposals.

The competing proposals set up an embarrassing conflict within the government with the Deputy Minister of Health, who was Chairman of the Inter-Ministerial Team, supporting his proposal against the Deputy Prime Minister, KSRM Chairman, who supported the KSRM proposal, although he did not author it.

The Parliamentary Health Committee of the Sejm evaluated two proposals submitted by the two government agencies KSRM and the Inter-Ministerial Team. During discussions, the Inter-Ministerial Team proposal did not receive even a single vote and was "completely" rejected. It was criticized as simply supporting the existing system and not a major health sector reform. It did not reflect public expectations for a more far-reaching health reform that had been promised from the initial Round Table agreements. The majority of the representatives of the political parties, including the opposition PSL and SLD supported the Solidarnosc and KSRM proposals and called for the immediate implementation of a joint proposal. ZChN offered moderate support, calling for careful proceedings, and only the representative of the UD voiced his reservations publicly.

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[5] Significantly, the proposal has many similarities to the German health insurance system, with the many small insurance plans, and the split between hospital and ambulatory care. The German Physcians Chambers organized a series of seminars for the Polish Physician Chambers to promote some of these ideas

[6] NRL meeting of March 5-6: the majority votes for the insurance system of financing health care. Proposals of the Inter-Ministerial Team for Health Insurance Reform have been rejected "for centralization of management and discrimination of the private sector," GL, No. 3/93.

The apparent unity of support within the government really masked vicious internal conflicts - especially between the UD and the rest of the post-Solidarity coalition which saw UD attempting to take control of the government. Despite the need for some compromise and unity in the coalition politics of the regime, as we noted above, these divisions became more exaggerated in time. The government delayed formal ratification of the proposals for competitive insurance and privatization of provision, in failed attempts to mediate differences among the proposals. These mediation attempts were mainly political efforts and did not contribute much to the substantive discussion of the technical merits of the different proposals. The delay meant that no health reform proposal was approved before the fall of the post-Solidarity government in 1993.

The Post-communist Government Proposals and the Passage of the Health Insurance Law

The new post-communist government of the SLD coalition attempted to assure the electorate and international community that they were not the old communists. Their legitimacy depended on continuing many of the policies of the post-Solidarity period and on assuring that the changes they made were in line with more liberal social democratic views than with strong anti-market central government control. In health they embraced the social democratic proposals of the Inter-Ministerial team of the previous government, although not explicitly.

During almost the whole four-year period of the post-communist government, the Ministry of Health and Social Welfare was managed by the same person – Jacek Zochowski (who died before the end of his term). Although he was recommended by SLD, neither he, nor his close associates, Vice Minister in charge of health reform Krzysztof Kuszewski and Andrzej Koronkiewicz, head of the team on heath insurance legislation and manager of the Center for Health System Management, were considered to be associated with any particular party.

This new team took charge of the health reform process and built on previous proposals, although not explicitly. It established a process of conferences to create political consensus and developed a technical review process that had been lacking in the post-Solidarity period. It also moved quickly to turn proposals into draft bills for consideration by the Sejm. The Center for Health System Management reemerged as a major think tank for this government, despite its earlier association with the post-Solidarity governments. It is important to note here that a crucial member of the Center's technical team now contributing to the post-communist government proposal was Mr. Koronkiewicz, who had been a member of the Balicki team responsible for the Inter-Ministerial Team proposal in the previous post-Solidarity government. Mr. Koronkiewicz is the single link between the InterMinisterial proposal and the successful post-communist governmental proposal.

The process appeared to get off to a good start. Early in 1994, several consensus-building conferences were organized to establish agreement on basic principles of health reform. The opposition was invited to these conferences but generally did not attend. These conferences produced consensus on the need to establish a guaranteed list of services -- a basic package -- to which all Polish citizens would have access. It was also agreed that the insurance system be based on large regional insurance funds that would negotiate contracts directly with both public and private providers. All public providers would contract with the regional insurance agencies as independent units -- eliminating the role of municipal governments, while allowing for some contracts with integrated services. Funding of the system would come from premiums paid by both employee and employer at a rate set annually by the Sejm. Separate government financing would provide additional specific services, public health programs and technology assessment, and would pay the premium of unemployed and farmers.

By December 1994, the health reform team had developed a bill encompassing these agreements and presented it to the Sejm (Ministry of Health 1994). It stated that the goal of the new regulation was to "replace the existing health service provision system, basically financed from the government budget, by a health insurance system financed from premiums." Most of

the recommendations approved during consensus conferences were repeated in that document, however, there were two important compromises that changed the bill. The final proposal held the employee would be fully responsible for the premium payments rather than a shared responsibility with the employer, which may have been a technical issue. More important, a compromise was made to allow additional competing insurance funds -- "branch" funds of separate industries to allow greater choice in what had been a regional insurance monopoly. This change was made to gain political support from the opposition groups in favor of freedom of choice of insurance plans.

In early1995, the Council of Ministers approved the principles of the bill that was returned to the ministries for consultation only three months later (Ministry of Health and Center for Health Systems Management 1995). The final draft was prepared and submitted to the Sejm later in July (Government of Poland 1995a).

While the government was preparing its bill, the post-Solidarity opposition also prepared a competing proposal, based on the earlier KSRM/Solidarnosc proposal. This proposal was submitted to the Sejm by President Walesa (Government of Poland 1995b). This proposal reintroduced the competitive insurance and privatization ideas that were significantly different from the government's regional health insurance proposals.

In the summer of 1995, an Extraordinary Committee of the Sejm was appointed to prepare a uniform, agreed proposal by November 1995. The task was not easy. The post-Solidarity opposition was effective in delaying approval of the government proposal (AWS 1995). The committee was deluged with new expert opinions and new ideas. Its work was significantly delayed so that it was not until a year later that a new draft bill emerged and gained approval by the governing SLD coalition caucus in the Sejm, without support of the opposition. The failure of the Executive committee to gain consensus with the opposition was one of the first parliamentary failures in the post -1989 era.

The new health insurance bill retained the principles outlined in the original government proposal and represented an evolution of the thinking within the social democratic post-communists and the social democratic wing of the UD, now transformed into the Liberty Union (UW). While still primarily based on the Inter-ministerial Proposal, the new law opened more room for competition -- giving up its strong emphasis on integrated provision.

The Extraordinary Committee draft bill was approved by the SLD Caucus and eventually passed the lower house after vicious partisan attack by the post-Solidarity opposition (Jonczyk 1997).

The discussion in the Senate was less conflictual (Government of Poland 1997). Here, the bill was supported not only by the governing coalition senators, but also representatives of other political orientations, including the UW. The accepted bill was returned to the Sejm and approved on February 6, 1997. It was scheduled for implementation in January 1999 to give time to prepare the needed regulations and develop institutions required for the regional insurance plans.

The picture of a relatively smooth although lengthy process toward the ratification of a modified version of the Inter-Ministerial Proposal through the four years of the post-communist government is marred by another bill that, for a time, opened an alternative process of health reform through decentralization: the Large Cities Act.

In 1995 the government passed the Large Cities Act, which transferred responsibility for outpatient health care and some hospitals to the large cities. This law, in contrast to the health insurance act, gave some municipalities a strong role in ownership and management of the local health care system. It allowed cities to decide whether to manage the provider services or to contract them out to private providers. A wave of new innovative mechanisms were developed in different cities as a consequence of this legislation.

The Large Cities Law allowed forty-six cities to take over ownership and management of health care provider institutions that had been managed by the Voivod governments. The cities would receive a global budget for all sectors and could assign budgets to health without regulation or interference from the central government. The law allowed the city governments to be both payer and provider of services.

The large city law was passed by a very specific alliance in favor of decentralization which was made up of almost all members SdRP (the governmental coalition) and a significant part of UW (who were in the opposition). Some members of the SdRP saw the agreement as a means of encouraging UW members to support SdRP candidate Kwasniewski in his in his race for presidency.

It should be stressed that the large city law was prepared and passed at the same time when the insurance law was being processed by the same Sejm. The Large Cities Law was ratified before the Health Insurance Act, and its elements were significantly restricted by the final Health Insurance Act. The role of the cities was significantly curtailed. With the sickness funds assuming the function of "payer" with the right to contract directly with independent institutional providers and with individuals, the cities role was limited to ownership of public facilities and indirect participation in the governance of the sickness funds. The passage of this bill by the same parliament that subsequently passed the Health Insurance Act which negates most of its elements, challenges the assumptions of linear health reform processes and offers a caution to policy advocates and analysts.

The Return of post-Solidarity Government and Amendment of the Health Insurance Act

In 1997 the new post-Solidarity coalition, AWS, returned to control the government. Major actors within the coalition were clearly set to modify the 1997 Health Insurance Act and to revise the Large Cities Act which they saw as post-communist government initiatives. As in the past, Jerzy Buzek's government alternated political affiliation of ministers and deputy ministers to assure representation of coalition members. In the case of the Ministry of Health, Wojciech Maksymowicz, a member of AWS was appointed Minister and, Michal Kornatowski, his first deputy was from UW. However, in practice the Ministry was clearly dominated by AWS. The representatives of UW were practically eliminated from the reform process carried out by the Ministry.. The power of AWS was additionally strengthened by appointing Minister-Coordinator of Social Reforms, which was a new position in the government. Teresa Kaminska, co-author of the Solidarnosc proposal of 1993, was appointed to this position. However, UW retained significant power in the government since the Ministry of Finance was again headed by Leszek Balcerowicz, who would exercise key influence at critical points in the process of health insurance reform.

Establishing the Governmental Proposal

AWS electoral platform suggested that it would resurrect its earlier proposals for health insurance reform and replace the post-communist Health Insurance Act of 1997, although the coalition agreement was not specific on the details of the reform. In addition to its dominance in the Ministry and in the Social Sector Coordinating Ministry, with its own proposal, a revised version of the 1993 and 1994 Solidarnosc proposals, the AWS appeared to have significant advantages over its partner, the UW. Isolated within the Ministry, UW although it had participated in the earlier World Bank and Inter-Ministerial proposals (and indirectly the Health Insurance Act of 1997) , did not have a new version to propose for the new government. Despite its apparent weakness, UW, through Balcerowicz's timely interventions, was able to modify the Solidarnosc proposal significantly so that the bill which emerged made only limited modifications

to the 1997 Act.[7] As Finance Minister Balcerowicz was primarily concerned with balancing the budget and combating the financial deficit that would emerge with a retrospective fee for service system as proposed by earlier Solidarity proposals. Setting up insurance companies supplied from contributions was attractive in this perspective as it removed their funds from the government budget. However, the insurance was attractive under one crucial condition: the companies (regional funds) had to be financially self-sufficient and not to generate deficit. Therefore, the Minister was in favor of all solutions increasing control over spending. For the sake of defending the budget the Minister appeared to be willing to give up his deep pro-market convictions by not advocating strongly for private insurance and unregulated fees.

The government bill that was presented to the Sejm in April 1998, was significantly modified from the original Solidarnosc proposal which was proposed in March.[8] It retained the large regional health insurance agencies, now called "Sickness Funds", with some room for competition from "branch" agencies, rather than a system of a large number of competitive smaller insurance plans. Funds were not charged with collecting premiums as originally proposed, rather existing social insurance mechanisms (ZUS for the majority of the insured and KRUS for farmers) were retained. The new Sickness Funds would be appointed by Regional Assemblies associated with the public administration reform (see below), and not by general election as originally planned. While the March proposal included provisions for direct negotiation between physicians associations and insurance funds, the April version eliminated this forum and required direct negotiation with individual providers. It also dropped earlier proposals of fee-for-service payments which had been introduced by the physician's chambers.[9] In one important change from the original Health Insurance Act of 1997, there was an enforced separation of hospitals from ambulatory care, denying the option of integrated services. As in the original Act, there was no role assigned to the municipalities.

As in previous post-Solidarity governments, an alternative proposal emerged from within the governing coalition, a bill called "Health Care System Controlled by Local Governments."[10] Presented by a "group of UW deputies" from the governing coalition, this proposal would have restored municipal control of health facilities, funded the system through the local government budget and co-payments, provided incentives for integrated hospital and ambulatory care. This proposal was a mix of the poviat proposals and earlier World Bank proposal that completely negated the Health Insurance Act of 1997 and the Solidarnosc proposals. This proposal did not rely directly on the Large Cities Law - the team members who produced the draft explicitly denied any links - but the proposal did favor local government management of health care funding and provision, which was clearly opposed to plan for regional insurance funds. After a public controversy, it was rejected by both the leadership of the UW and by the other members of the governing coalition. The Ammended Act that finally passed denied a role to the local governments.

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[7] In the letter of the Government's Representative for the Implementation of the General Health Insurance of April 15, 1998, there is a note stating that "the changes were implemented in accordance with the wishes of Mr. Leszek Balcerowicz, Deputy Prime Minister, expressed during the meeting of the Council of Ministers..."

[8] Act Changing the General Health Insurance Act. Draft of March 20, 1998.

[9] The next draft was dated April 6, 1998. Amendments were made in it only on April 9, during the meeting of the Council of Ministers.

[10] Draft Bill of Health Care Controlled by Local Governments, prepared by a team headed by Ms. Katarzyna Tymowska.

The position of the medical interest groups was first one of support for the original Solidarnosc proposals but after the government bill was presented, with its retention of most of the previous law's elements, the Physicians chambers began a campaign against the government.

By the end of June, the management of the physicians' chambers came to the conclusion that "the Government's Representative for Health Insurance Reform and some Regional Representatives were unwilling to cooperate with physicians' chambers in the implementation of the new system (Physicians' Chamber 1998a)." The idea of appointing Sickness Fund management by Regional Assemblies was treated as "breaking election promises by AWS regarding the keeping financial decisions concerning health care free of any political influence." The physicians attacked the low premium, lack of guarantee of contracts with all providers, lack of the requirement to conduct negotiations with a body representing all the physicians working for insurance funds, and granting non-insurance physicians the right to issue referrals. The physicians backed their demands with protests and refusals to fill out required forms (Physicians' Chamber 1998b). However, when the amendment of the insurance law was approved, medical circles accepted it with moderate support, since they could not effectively mount an alternative proposal (Stankiewicz 1998).

The Amended Health Insurance Act passed the Sejm as the original had, with only the support of the governing coalition. With little time before the January 1999 implementation date, this act required significant clarifying regulations which were not passed as the amendment process proceeded. In addition the Health Insurance Act depended in part on the parallel adoption and implementation of the Public Administration Act which would establish the formal regions and the administrative and electoral processes necessary for the regional insurance plans to be implemented. Although formally coordinated, these two acts were not consistent and left major issues to be decided by regulations that were not forthcoming. Nevertheless, the post solidarity government now takes responsibility for successful implementation of the health insurance system that was basically approved under the post-communist government. Having failed to significantly modify the act according to the orientation of the original Solidarnosc proposals, even the AWS members of the government who had fought for changes, feel responsible for the success of the implementation. They feel that the electorate will hold them accountable for failure, even if it is not the kind of insurance program that they had originally proposed.

Explaining the Process of Health Reform

Coalition Politics in New Democratic Transitional Political Systems

Political positions on health reform were slow to emerge in Poland. Clear alternatives did not present themselves until the competing proposals that were debated in the Hanna Suchocka post-Solidarity government of 1992-3. Once these positions were established however, there were two groups that appeared to retain commitment to different ideologically driven proposals. The first group is the original Solidarity groups who supported the KSRM and Solidarnosc proposals and came back to power in the coalition government in1997. They favored competitive private insurance, private provision of health service and separation of ambulatory and in-patient services. The second group was the social democratic wing of the UW and its precursor which supported the Inter-Ministerial Proposal, which contributed later to the post-communist Health Insurance Act through the Center for Health System Management think-tank. This group favored regional insurance monopolies, mainly public provision, and integrated care.

The lack of experience in developing consistent technical positions and in the political skills for effective compromises, especially in the post-Solidarity coalitions, led to fruitless efforts of negotiation and long delays in ratification of proposals which appeared to have significant support -- such as the original 1993 Solidarnosc and KSRM proposals. Rapidly changing post Solidarity governments were followed by the weak post Communist government which nevertheless was successful in creating sufficient support for a Health Insurance Act after three years of failed attempts at compromise with the post-Solidarity opposition. This Act was a version of Inter-Ministerial Proposal of the post solidarity period -- the proposal with the least support within that coalition. It appears that the post-communist as they moved right on the political spectrum to seek more legitimacy and the social democratic wing of the post-Solidarity Liberty Union found common cause in the Inter-ministerial proposal. This political convergence was lent technical support though a think-tank, the Center for Health Systems Management, that was used by both post-Solidarity and post-Communist regimes. The post-communists also were able to use compromise strategies, modifying the initial proposal to draw in sufficient support to pass the legislation.

Once the Health Insurance Act was passed it became hard for the returning post Solidarity governments to change it. Again, although the AWS had dominant positions, it could not mobilize support for significant changes in the law. We might expect that coalition politics played a part in this since the UW was part of the governing coalition and its social democratic wing might have been counted on to protect its commitment to the regional health insurance program. However, this group was weakened in the health sector and blind-sided by the "deputies proposal". It was UW Finance Minister who ultimately squashed efforts to introduce significant changes in the health insurance system.

The Role of Incumbency

Incumbency is a strong determinant of political success in many heath reform processes. Shaping the agenda and making the initial proposals as well as having crucial weight in gaining formal adoption of key laws and promoting implementation are advantages of incumbency. However, in Poland incumbency did not help the initial post-Solidarity governments come to a agreement on a proposal for health reform, nor did it allow the first administration in the second post-Solidarity period to revise the legislation passed by the post-Communists. As noted above it was the post-Communist government that was able to negotiate sufficient support to pass the legislation. Incumbency may provide some advantages but coalition politics requires additional skills of compromise and trust that the post-Solidarity governments did not achieve in either period.

Once legislation is passed, incumbency also may be a two edged sword. Failing to gain sufficient support for an alternative favored by the AWS, the post-Solidarity government assumed responsibility for a health insurance program largely designed under the previous post-Communist government and quite different from the coalition's initial proposal. The post Solidarity government funds itself accountable for successful implementation of a reform it did not want.

The Role of Lobbying

The major interest groups with a stake in health reform are the medical and nursing chambers. These institutions were particularly active in lobbying in the political process. They appear to be quite close to the post-solidarity parties but also were influential in the post-communist period. Despite their importance, they were not successful in gaining support for their major proposals. They failed to get a fee for service payment requirement passed and were unable to gain increases in government health allocations.
They were successful in gaining legislation for partial tax exemption for some medical expenses - examinations and treatment by private providers, and medicines. Significantly, they also failed to obtain support for setting up regional associations of providers that could negotiate as a more equal partner with the regional monopoly insurance funds, leaving the providers in a much weaker position to negotiate the terms of their contracts. The protests arranged by trade unions grouping medical professions had been broadly backed at the beginning, but began to lose popular support later when they become troublesome for patients.

While lobbying is a major and legitimate form of influence in a democratic process and one that is crucial for understanding political processes in some of the mature democracies -- particularly in the US -- it is not so consistently explanatory in the Polish case. In contrast to the Czech Republic where the medical profession was able to "capture" the health reform process, the medical associations in Poland, while strong and influential, were countered by the active interest in health policy by the political parties, the government bureaucracy and the international donors.

The Role of Organizational Politics

The role of the enduring government bureaucracy in the process of decision making has been well described by one of Graham Allison's famous three models of decision-making, the "organizational process model" (Allison, 1971). This model stresses the power of organizational routines and standard operating procedures in a decision-making process. While seldom a central explanation for a broad policy process where consensus building, log rolling and ideological commitments have major influences, the foot dragging and interests of governmental institutions like the Ministry of Health may shape the process and provide explanations for choices and events when other models fail. Poland has a particularly entrenched bureaucracy that carries over from the communist period and is openly threatened by many of the market-oriented reforms. However, it appears that the Ministry itself was largely bypassed in the process of developing health reform proposals. Most of the proposals were developed by special teams of political and technical experts outside the Ministry. Even during the post-Communist period, when the major reform team was led by several officials of the Ministry, it was at the Center for Heath Systems Management and in the Extraordinary Committee of the Sejm that the reform proposal was completed.

While organizational politics may not explain the process of the design and ratification of the major legislative initiatives which have been the central focus of this analysis, it appears that the Ministry's failure to develop sufficient regulation to assure smooth implementation has had a major impact on the initial phase of the reforms.

The Role of Technical Information

Few now believe that technical information dominates the process of decision-making. The Rational model of decision-making, which placed technical information at the center of the decision making process has long been rejected as a guide to most policy making decisions. (Allison, 1971) However, information is likely to play some role even in bureaucratic or ideological processes of decision-making. It is the hope of many health reformers that the information that they provide to the political process will be used by some of the actors to gain legitimacy and to persuade others to join their coalitions of power. (Berman, 1995)

The process in Poland has utilized experts in both the design and implementation of several of the proposed reforms. As noted above there was significant participation of experts in the initial World Bank proposals and official and independent teams of experts in the design of other major proposals. Expert reports were prepared with support from the European Community, AID and others. Significant participation of experts from the Jagiellonian University and the University of Warsaw as well as the Institute of Public Administration in Warsaw. This information was crucial in preparation of technical arguments for rejecting proposals for fee for service payments and rejecting multiple insurance agencies. However; expert advice was also rejected by policy makers. The World Bank proposals were never seriously considered and an attempt to reintroduce municipal role in the financing of health systems supported by technical experts at Jagiellonian University and Harvard University, were also ignored.

Also it is important to note that there was never a clear technical consensus in favor of any one of the major proposed reforms. While most experts agreed that Poland needed to change its existing system, there was no clear "best" alternative that most major stakeholders could agree on. Also as time went on, it became clear that the extreme market solutions that were implemented in the Czech Republic and the moderate market solutions in Hungary were not as advantageous as their promoters had suggested. Internationally, the initial enthusiasm for health reform that was best summarized in the pro-reform 1993 World Bank *World Development Report: Investing in Health* is now tempered by complexities of implementation of reforms. The lack of consensus in Poland reflects this lack of international consensus among technical experts and policy makers in the field.

Conclusion

We set out at the beginning of this article a set of questions to be addressed for which we now have only partial answers.

Why did it take so much longer for health reform to be decided and implemented in Poland than in other Central and Eastern European countries? Part of the answer to this question is the lack of a sufficiently strong coalition of actors committed to any one health reform proposal. Right from the beginning no national political actors were able to place health reform on the initial agenda of the early democratic governments. Unlike in Hungary and the Czech Republic, there were no political actors committed to major reform in health in the initial governing coalition of post-Solidarity parties. As time progressed the different actors developed inconsistent and shifting positions on health reform and at critical times, prior to 1997, failed to gain a clear legislative majority to pass reform proposals. The first post-communist government did finally approve a health insurance act, seven years after the fall of the Communist regime. The Act was then modestly amended by the subsequent post-Solidarity government, delaying the development of adequate regulations and institutions.

Why have the proposals for greater involvement of market mechanisms been less successful in Poland than in other Central and Eastern European countries? Here again, we only have partial explanations. Our analysis shows that the inconsistent process of coalition politics and the inability to reach consistent consensus led to failures of the more market oriented Solidarnosc proposals to be implemented. We consider this failure to be partly due to the inexperience of the major political actors in the post Solidarity coalitions who had not sufficiently developed the consensus building skills required in democratic processes. In contrast, the post-Communists, although politically weak were able to develop the coalition building skills and make the compromises necessary to draw their partners together to pass the major legislation for health insurance. Finally, as time went on and the experiences of Hungary and the Czech Republic became known it became less clear that market mechanisms would solve the problems that they were reputed to solve, adding a note of caution to the policy debates within Poland.

The current situation requires significant attention by the coalition in power. The delay in developing regulations has created a relatively chaotic period of initial implementation in which local initiatives may be filling the vacuum. While these initiatives may produce useful innovation, it is important that the experiments be monitored to develop appropriate national policies and regulations. The opportunities for growing inequalities, growing deficits and sustaining inefficient and low quality providers are great. As Peter Berman argues, it is important to develop the necessary underpinnings in the institutional development and behavioral changes needed to successfully implement the economic restructuring of health insurance legislation. (Berman, 1998)

What political strategies might be used in this period to assure the effective implementation of the health reform? Currently, the post-Solidarity government appears to be taking seriously its responsibility to successfully implement the health insurance reform. In order to implement this legislation, the coalition of support will have to be strengthened to overcome the resistance and immobility of the institutions required to implement the reforms. The new insurance institutions require training and experience to strengthen their capacities both technically and as major new stakeholders. The Ministry of Health needs to be reformed to take on a stronger regulatory role and to create the consensus necessary to develop and gain compliance with new regulations. Coalition politics within the government now require that the post-Solidarity political actors

strengthen the skills in bargaining and give-and-take that are essential to the process of building and maintaining strong coalitions. If they fail and are held responsible by the electorate, the post-Communists, with their stronger coalition building skills, a residue of their experience in patronage politics of the Communist period, could again return to power and reshape the process of health reform.

Annex 1

Politics and Health Reform in Poland (preliminary table for review)

	Political Context	Health Reforms
1989	Round Table Negotiations	• Commitment to Universal Health Insurance
	Post Solidarity Governments	
1990	Premier Muzowiecki	• Official Proposal • Independent Proposal • Center of Health Care Organization and Economics
	Premier Bielecki	
1991	Premier Oleksy	• Health Care Institutions Law • World Bank Loan Document
1992	Premier Suchocka	• KSRM Proposal • Solidarnosc Proposal • Interministerial Proposal • Poviat Proposal
	Post Communist Governments (Minister Zochowski)	
1993 1994	Premier Pawlak	• Consensus Conferences • Government Reform Bill tabled
1995?	Premier Oleky	• Post-Solidarity Bill tabled
1996? 1997	Premier Cimoszewicz	 • Large Cities Act • Health Insurance Act
	Post Solidarity Government	
1997 1998	Premier Buzek	• Government Revision of Health Insurance Bill tabled • Health Care by Local Governments Bill tabled • Government Restructuring (Viovoids and Poviots) Bill • Revision of Health Insurance Act

Annex 2

Major Health Reform Proposals (preliminary table for review)

Proposal	Sponsor	Major Elements
Official Proposal (1990)	Post Solidarity Government	• Autonomous Central Insurance Fund • Employer and Public Financing • Little or no private participation
Independent Proposal (1990)		• MOH-Directed Central Insurance Fund • Employees, Employer and Public Financing • Little or no private participation
Health Care Institutions Law (1991)	Expert Team supported by Government	• Purchaser/provider separation • Autonomy and privatization of providers
World Bank Document (1992)	World Bank and counterpart team	• Retain central budgetary funding • Payment by fixed budget • Integrated services and regional planning
KSRM Proposal (1992)	Council of Ministers	• Many small independent insurance institutions • Privatized provider institutions • Division of in-patient from ambulatory care
Solidarnosc Proposal (1992)	Solidarnosc Union	• Same as KSRM Proposal
Interministerial Proposal (1992)	MOH, MOF,MOL (dominated by UD)	• Regional planning and integrated care • Regional health insurance • Primarily public provision but opening toward contracting with private
Poviat Proposal (1992)	Local government wing of UD	• Health care provided by new administrative unit, the Poviat (County) • Public financing and provision
Post Communist Insurance Reform Bill (1993)	Government Health Reform Team	• Universal Basic Package of Services • Regional insurance funds with territorial monopoly • Funds have elected representatives of local governments • Contracts with public and private providers • Premiums paid by employee and employer • No role of municipalities as payers
Post Solidarity Reform Bill (1993)	Post Solidarity Health Reform Team	• Competitive insurance plans • Privatization of providers
Large Cities Act (1995)	Government Local Government Team	• Large cities take over health care provision • Global budget assigned to each city • City as payer and provider
Health Insurance Act (1997)	Government (with significant opposition support)	• Modifications in 1993 bill to allow "branch" insurance funds, and more competition among providers
Post-Solidarity Bill to Amend Insurance Law (1998)	Government Health Reform Team	• Modify 1997 Health Insurance Act to remove elected representatives on regional insurance plans and replace with appointments from Regional Assemblies • No allowance for integration of ambulatory and inpatient services

Health Care by Local governments Bill (1998)	UW deputies (within Governing coalition)	• Municipal control of health facilities • Funding through municipal budget • Integrated care
Ammendment to Health Insurance Act (1998)	Government (without opposition support)	• No modifications of 1998 Bill
Public Administration Reform Act (1998)	Government	• Established new administrative regions and poviots with administrative and electoral processes compatible with regional insurance

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