

RADBOUD UNIVERSITY NIJMEGEN

Learning from benchmarks?

**The analysis of challenges and barriers hampering the introduction of systemic reforms
in the Polish health care system nowadays, with reference to the Dutch model,
as well as the feasibility of Dutch reforms for Poland**

Natalia Domowicz

s4479378

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Specialisation: Comparative Politics, Administration and Society (COMPASS)

Department of Public Administration, Faculty of Management Sciences

Radboud University Nijmegen

Supervisor: Dr. J.K. Helderman

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Preface

This master thesis represents the completion of my master programme in Public Administration and marks the end of great effort I have made to finish my studies at Radboud University Nijmegen. The most important aspects elaborated in this thesis are: the challenges, barriers for introducing systemic reforms in Polish health care nowadays (with reference to the Dutch model), as well as the feasibility of Dutch reforms for Poland. The subject of this thesis is not only extremely topical nowadays in Poland, but it is also a matter concerning everyday life of citizens, and that motivated my choice for this research.

The completion of my master thesis would not have been possible without my supervisor, Dr. Helderman. I would like to express my gratitude for your valuable guidance and critical comments, which helped me substantially bring my thesis onto a higher level.

Studying at Radboud University Nijmegen has been a challenging and enriching experience. I would not have been able to accomplish this success without the great support of my family and my partner. Rafał, mum and dad, thank you for believing in me and lifting my spirits every time I needed it. Arend, thank you for always being there for me, for your patience, and commitment. I could not have had a better support.

Finally, it remains for me to wish you enjoyable reading.

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1. Introduction

Health as well as its protection is of great importance for every citizen, that is why its provision and quality of service has always been of major interest not only for patients and providers, but also for the government. Since the organization and structure of health care is multifaceted, ensuring an efficient and well-functioning system is a challenge for many countries (Nojszewska, 2011). One of such countries, where the functioning of the health care system is not only debated but also considered to be very poor, is the Republic of Poland. Long waiting times to receive treatment, low salary for doctors, and corruption, are only a few issues amongst a wide range of problems, caused by an inefficient construction of the Polish health care system (Krzeczewski & Pastusiak, 2012).

The Dutch health care model, by contrast, is regarded as one of the finest in Europe. Moreover, the Netherlands is the only European state which has kept its top position in the ranking since 2005. It is considered to perform remarkably well in comparison with other European countries, and it is found to be a tremendous example to learn from (Health Consumer Powerhouse, 2014).

The aim of this study is to explain the lack of systemic reforms in Polish health care nowadays, as well as investigate the feasibility of Dutch reforms for Poland. Therefore, in this thesis I will analyze challenges, barriers, and potential facilitators of reforming Polish health care, with reference to the Dutch model. Moreover, I will elaborate on the characteristics of best practices in health care and Dutch reforms, in order to determine if these reforms are feasible for Poland. The theoretical perspective on institutional change and policy challenges will guide my research.

1.1 Problem outline

The Polish health care system is ranked as one of the worst in Europe, scoring 31th place out of 37 in 2014 in the European ranking, and without doubt, its functioning leaves a lot to be desired (Health Consumer Powerhouse, 2014). The question how to improve the system has been a subject of many public debates and heated discussions in the Polish parliament for many years (Kolwitz, 2010).

The main aspects on which Poland performs weakly are primarily related to the financing as well as the provision of health care. Namely, the problems and challenges faced

by the Polish health care system are: 'limited funding of medical services, monopoly of the National Health Fund (NFZ), lack of competition amongst insurers, unequal status of public versus private health care providers, indebtedness of public health care institutions and limited access to health care' (Kolwicz, 2010, p.131). In response to these problems, various reform plans were proposed, however they did not enter into force. Major, systemic reforms in the Polish health care system have not been introduced for years, while recent suggestions to eliminate or divide the National Health Fund misfired. The reason for the failure relates to, among others, lack of crystallization of ideas and unconvincing arguments by policy makers to receive any support on the political, and the electoral arena (Magda & Szczygieski, 2011).

In the beginning of 2015, the most recent reform called the oncological package was introduced in health care, however it is not a systemic change. It is a package of statutes which assumes quick diagnosis and access to specialists (oncologists) for patients. Thus, the most important aim is to shorten the waiting times to receive cancer treatment – in effect, ensure fast and effectual health care provision. However, doctors have serious concerns that the reform will do more harm than good. The reason for it is connected with the ambiguity of regulations, the lack of professional equipment, and insufficient financial resources to make the process of treatment actually function more effectively (Niesłuchowska, 2014). According to B. Hawro (personal communication, June 2, 2015), postulates of the oncological package would bring positive effects in a long run. It was a sudden and an unexpected reform, while the doctors and other professionals were completely unprepared for the implementation phase. Therefore, the reform should have been introduced gradually, with a proper adjustment of institutions and staff (B. Hawro, personal communication, June 2, 2015).

Life expectancy in Poland, despite the positive growth over the years, is still considerably lower in comparison with the Netherlands and other western countries. The satisfaction of citizens with the current functioning of the system is equally low (Sagan et al, 2011). The fundamental problem is said to be related to a very low expenditures on health care in Poland, while the problem of limited access to health services is only growing (Wołodźko, 2012). Without doubt, introducing institutional reforms is necessary, however major reforms are always very demanding, long-standing processes, constrained by a various range of barriers and nearly impossible to achieve (Bannink & Resodihardjo, 2006). The introduction of market-oriented reforms in imitation of the Dutch regulated competition, aimed at enhancing efficiency and sustainability, may be one of the solutions to improve its functioning.

1.2 Aim of thesis and research questions

The focus of this thesis will be on the Polish health care system and the aspect of regulated competition in the above-mentioned model. More specifically, we ask to what extent and in what ways the Netherlands can be treated as a benchmark for Poland. Preconditions, which are necessary for the successful implementation of regulated competition are: transparency, efficient market regulation, financial incentives, risk equalization, freedom to choose insurers, contract selectively, and competition on the market (Van Kleef, 2012). Overall, they cover the aspects of provision and financing of health care, which will be thoroughly analyzed in further chapters of this thesis.

The aim of this thesis is to answer the following research question: *How can we explain the lack of systemic reforms in Polish health care nowadays, and how feasible are the Dutch reforms for Poland?* The sub-questions, which compel to reflections are: How can we analyze institutional reforms? What are the characteristics of the exemplary Dutch health care organizational structure, and how does the Polish model compare to it? What are the main challenges in both models and how do they differ? Which institutional arrangements are introduced in both health care systems to face described challenges and what is the effect of these arrangements on addressing them?

1.3 Societal and scientific relevance

The benchmark model in the European context, seems to be the Dutch one. The choice is legitimated by its remarkable acknowledgement across countries in the above-mentioned area, which is a sign of its high effectiveness. Moreover, not only is the Dutch model regarded as the best system in Europe in the overall Euro Health Consumer Ranking, but it is also explicitly stated in the Euro Health Consumer Report that other countries should learn from its practices (Health Consumer Powerhouse, 2014).

The analysis of Polish health care, in reference to the Dutch benchmark system, not only provides an overview of differences and similarities between one of the best and one of the worst health care systems in Europe, but may also help to answer the question which institutional reforms introduced in the Netherlands are feasible for the Polish system to function more effectively and efficiently. Therefore, an appropriate transfer of knowledge and solutions introduced in other countries, in the aspect of health care, is of great importance for policy-makers. It may shed new light on which barriers are hampering reforms in Poland,

which institutional changes should be introduced, and eventually how feasible introducing reforms actually is. Hence, Policy makers (and consequently citizens) may profit from the obtained knowledge, especially that it is a very topical issue in the country nowadays (Pastusiak & Krzeczewski, 2012).

1.4 Theoretical framework

In order to have a deeper comprehension of the above presented subject, the introduction of the theoretical framework is crucial. The main concepts and theories will be elaborated thoroughly as well as applied in following chapters, while hereunder the theoretical framework will be briefly drawn.

Reform plans debated in various European countries, have been related to such fundamental questions as: Should the state have a regulating and central role or should it act as a guardian, watching and monitoring from the distance? Should the system be based on public or private property, as well as on the involvement of private actors? Furthermore, to what extent should health care be dependent on market rules and conditions? Finally, should we implement drastic changes or introduce gradual ones in order to achieve successful, systemic reforms? (Kolowitz, 2010) .

The opinions amongst policy-reform scholars, especially regarding the last question, are incoherent. The theory of punctuated equilibrium assumes that major institutional changes can only be introduced at the critical junctures. Typically, a system is characterized by long periods of stasis, whereas only the spill-over of the policy image to the macro political agenda will result in major, systemic changes (True, Jones & Baumgartner, 1999). Thus, incremental changes will not bring any major transformations.

However, academics such as Cortell and Peterson (1999) questioned the theory by alleging its incompleteness in regard to understanding of change. According to above-mentioned scholars, incremental adaptation of institutions is often more possible to occur than episodic and radical change (Cortell & Peterson, 1999).

The concept which proposes a more sophisticated understanding of change, is the theory of gradual institutional change. It assumes that established institutions frequently undergo subtle and progressive changes in the course of time (Mahoney & Thelen, 2010). ‘Although less dramatic than abrupt and wholesale transformations, these slow and piecemeal changes can be equally consequential for patterning human behavior and for shaping substantive political outcomes’ (Mahoney & Thelen, 2010, p.1). Thus, despite the fact that

changes are gradual and not impetuous, they are still transformative (Mahoney & Thelen, 2010).

Four mechanisms of gradual institutional change may be distinguished: layering, drift, displacement and conversion, which will be closely elaborated in the third chapter. Moreover, dimensions which are explanatory for institutional change are: ‘the characteristics of the prevailing political context and the change-inducing characteristics of targeted institutions’ (Helderman & Stiller, 2014, p. 816).

The theory of gradual institutional change is valuable regarding distinguishing mechanisms of change. Nonetheless, in order to explain the lack of systemic reforms in Polish health care, more emphasis will be placed on theories, elaborating barriers and facilitators of change in a more sophisticated manner.

As many scholars argue, reforms are practically impossible to achieve. The myths supporting this concept are related to path-dependency, lock-in effect, lack of institutional crises or the absence of a strong, charismatic leader. Yet, reforms somehow still take place. (Bannink & Resodihardjo, 2006).

There are various barriers effectively constraining change such as decision making structures, policy paradigm or vested interests. The occurrence of reform is dependent on diminishing barriers and facilitators, which enable change.

The problems with introducing effective reforms in Polish health care are believed to relate to such aspects as the difficult budgetary position, various concepts of interests groups as well as politicians. Moreover, there is an absence of professional knowledge and accurate vision of how the system should be organized in order to be effective.

Over the last decades, both Poland and the Netherlands have experienced reforms in the area of health care (to a larger or smaller extent). Nowadays, the process of introducing market-oriented reforms in health care has become visible, but its development and the extent to which changes have been introduced may differ in both countries, as a consequence of different mechanisms – layering, conversion, displacement or drift. By applying the theoretical framework, not only can we gain a better understanding of the depth of gradual institutional change, but most of all, grasp which barriers and challenges stand in the way of achieving market-oriented reforms in Poland.

1.5 Thesis outline

The following chapter will elaborate on policy challenges, and provide a general framework of the Dutch and Polish model in the above-mentioned context. Subsequently, it will also present potentially best practices in health care. The third chapter will reflect different mechanisms of change and subsequently, barriers as well as facilitators of reforms. In the fourth chapter, the methodological framework will be explained. Furthermore, the Dutch benchmark system with respect to its reforms, organizational structure, and challenges, will be analyzed. In the sixth chapter, challenges, historical background, barriers for reforms in Polish health care, as well as the feasibility of Dutch reforms for Poland will be discussed. Lastly, in the conclusion of the thesis, the answer to the main research question as well as the sub-questions will be provided, followed by reflections and the further research agenda.

2. Policy challenges and institutions

In this chapter the emphasis will be placed on the elaboration of the concept concerning policy challenges and institutions. Firstly, the policy analysis perspective as well as the institutional perspective will be elaborated, and subsequently, the inquiries which these perspectives entail will be discussed. Furthermore, for a better comprehension of the policy challenges and institutional arrangements introduced to counter them in practice, a brief introduction of the Polish system and the Dutch model in the above-mentioned context will be provided. Subsequently, potentially best practices in respect of health care will be presented, with the focus placed on the Netherlands, seen as a mirror case for Poland.

2.1 The policy as well as institutional perspective

Political choices made in the past condition the present policy legacies. The changes which influence these legacies as well as socioeconomic constructs, result in vulnerabilities (challenges) which must be faced by policy makers (Scharpf, 2000). Factors which influence the ability of a system to create an efficient policy response in face of challenges are: ‘the nature of the policy problem, the orientations of policy actors, and the characteristics of the institutional setting’ (Scharpf, 2000, p.772-773).

Table 2.1: Institutional as well as policy perspective

		Institutional Perspective	
		genetic	consequential
Policy Perspective	problem oriented	(1)	(2)
	interaction oriented	(3)	(4)

Source: Scharpf, F.W. (2000). Institutions in Comparative Policy Research. *Comparative Political Studies*.

As we can see in the table 2.1, the policy analysis perspective relates to the problem oriented nature of policy analysis as well as the interaction oriented policy inquiry. The problem oriented context reflects the analysis of the nature as well as reasons of social problems, which the policy is supposed to efficiently address. The interaction oriented perspective, by

contrast, focuses not only on the relations among policy makers, but also on the factors that condition (either hamper or facilitate) the possibility of actors to introduce efficient policy solutions, that is, solutions identified by the problem-oriented analysis (Scharpf, 2000).

Regarding the institutional perspective, the literature focuses on two views of institutions – the first one, the genetic perspective, relates to the consequences of institutions on policy makers, while the second one focuses on the alteration of the internal institutional structure. Namely, the analysis in institutional perspective places an emphasis on the effects that institutions have on actors and their activities, as well as on the institutional arrangement itself (Scharpf, 2000).

If the two above mentioned perspectives are combined, certain questions may be distinguished. The first cell in the matrix relates to the question of which institutional arrangements may address certain issues. Regarding increasing the effectiveness in health care, it could be connected with establishing a system of regulated competition. The second cell entails such an inquiry as the impact of these arrangements on particular policy challenges (for instance, does regulated competition enhance efficiency?). The third one focuses on the historical contingencies of existing arrangements (why do we have such arrangements?), while the fourth cell reflects the ability of institutions to affect the relations among policy actors (how do institutions influence actors' possibilities to act?). Thus, institutions can either facilitate or constrain policy options (Scharpf, 2000; Helderma, 2014).

With regards to health care, the first cell in the matrix relates to creating feasible solutions, helping to solve challenges in the system. The focus of the remaining cells is placed on the reasons for certain arrangements in health care, and effects they have on the challenges as well as policy makers' capabilities (barriers and facilitators). In order to grasp what are the challenges and institutional arrangements in the Polish system and the Dutch health care model, a short introduction may be helpful at this point.

2.2 The Polish system - challenges and solutions

Poland is a post-communistic country, and since its political transformation in the 1990', changes in many areas have been introduced, amongst others, in health care. Since 1999, a heavily centralized and ossified health care system has been transformed into a decentralized model, which included an obligatory health care insurance and funds provided by both the state and sub-national authorities budgets (Sagan et al, 2011). In order to address the problem

of the ineffective, post-communistic health care system, the government planned to boost private initiatives and the competition, which provides an answer to the first question in the matrix. Nonetheless, the privatization has been introduced to a varying extent throughout the country due to systemic barriers, and consequently caused an ambiguity in the functioning of the system (Kaczmarek et al, 2013). A failure to improve the system is believed to be connected with the misconception of the first reform, difficulties with its implementation, and too quick diversion in another direction in 2003. The latter led to the centralization of health care funding, by creating the National Health Fund (NFZ - *Narodowy Fundusz Zdrowia*). Such an arrangement did not solve the problem of the malfunctioning health care either - the intentional goals to improve the efficiency and functioning of the system, by the reform implemented in 2003, have not been reached. Hence, the impact (effect) of the arrangements on the above-mentioned challenges has been infinitesimal.

The reason for the manner in which the Polish health care structure is arranged relates to a number of aspects. Mental, political, historical, as well as economic predispositions conditioned current arrangements of the Polish health care model (S. Manulik, personal communication, May 22, 2015) and will be analyzed extensively in the sixth chapter.

In what way do institutional arrangements influence participating actors and their capabilities? The Ministry of Health as well as the Parliament are in charge of the policy-making and regulating the system (heavily regulated). Civil society groups do not have major influence regarding the legislative procedure and the initiative. Various advisory institutions have been created to support the Ministry of Health, nonetheless the system of monitoring and coordination has been poorly developed. The NFZ is responsible for financing and making agreements, concluded with both public as well as private providers. As the sole payer, in practice, the NFZ enforces the conditions of agreements with providers and consequently, capabilities of actors to compete and negotiate are extremely limited. There are 16 NFZ branches in the country which receive citizens' contributions, raised by intermediary bodies. Only two percent of the whole population is not covered by the obligatory health insurance, while the rest of the citizens, in theory, is granted access to health care assistance (Sagan et al, 2011). Nonetheless, in practice it does not function properly, and the right to receive access to health services is often neglected. The reason for such limitations is related to the bounded financial resources of the National Health Fund (Sagan et al, 2011).

2.3 The Dutch model - challenges and solutions

Turning now to the Netherlands - it is a rich country, and its health care roots derive from a Bismarck system - based on a general (statutory) health insurance. It was not a pure Bismarck model but a hybrid one, based on the mixed financing. The funds for health care derived from both the state budget and the insurance premiums paid by citizens (thus, the government-funded and the individual-funded) (Pastusiak & Krzeczewski, 2012). Despite the fact that it was efficient in serving the universal health care coverage, the system did not escape from facing the challenge of sustainability. Addressed problems were related to quality of care, the highly fragmented insurance industry, and health care expenditures (Perrott, 2008). Dutch health care is characterized by the institutional adaptation and gradual changes, which started in the end of the 1980s. The Dutch government recognized the danger of weakening sustainability and eroding solidarity of the health care system, and decided to introduce systemic reform of regulated competition (Helderman & Stiller, 2014). Hence, the first question of the above matrix has been answered and consequently, significant changes in governance arrangements were introduced in order to solve above-mentioned challenges. Policy makers replaced the 'highly socialized, two-tiered system to that of a regulated, free market health care model' (Perrott, 2008, p.16). The system, characterized by the latitude of contracting, effective regulation, competition on the market, and financial incentives to increase efficiency (Więckowska, 2010).

What are the effects of market-oriented arrangements on the efficiency and sustainability of health care in the Netherlands? It is still too early to explicitly assess the effects of introduced arrangements, nonetheless without doubt the results are promising (Perrot, 2008). The system performs remarkably well with universal access and high quality of care. Nonetheless, the challenge of constantly growing expenditures on health care, which is extremely topical in the Netherlands, has not been resolved (Economist Intelligence Unit, 2013).

Table 2.2: The results of the Polish and the Dutch health care system in six sub-disciplines in the Euro Health Consumer Index 2014.

Sub-discipline	The Netherlands	Poland	Maximum score
1. Patient rights and information	146	96	150
2. Accessibility	188	100	225
3. Outcomes	240	104	250
4. Range and reach of services	150	88	150
5. Prevention	89	71	125
6. Pharmaceuticals	86	52	100
Total score	898	511	1000
Rank	1 out of 37	31 out of 37	x

Source: Accommodated from Health Consumer Power House (2014) Euro Health Consumer Index. Report retrieved from http://www.healthpowerhouse.com/files/EHCI_2014/EHCI_2014_report.pdf

As we can see in the table 2.2, not only the Netherlands performs remarkably better than Poland, but it seems that the challenges which both system face, amongst others, accessibility of health care and patient rights, are accommodated with a greater effect in the Netherlands.

The answer to the third question in the matrix relates to the reason for certain arrangements, in this case, to opting for a marked-oriented, social insurance health care system. It originates as the result of a long-standing path of reforms. The reason for the systemic reform, introduced in 2006, was connected with, amongst others, the goal to eliminate the fragmentation of the health care system and the provision of high-quality service (The Ministry of Health, Welfare and Sport, 2011). The competition and the freedom to negotiate/contract was implemented in order to provide efficiency incentives, and limit costs (Perrot, 2008). Moreover, the reforms from 1980s as well as 1990s turned out to be a failure, while there was a growing demand for patient involvement as well. Additionally, the burning urgency to control growing costs strengthened policy makers in the belief that systemic reforms were inevitable (Schafer et al, 2010). A more elaborate explanation of the Dutch reforms and health care arrangements will be provided in the fifth chapter.

The answer to the last question relates to the manner in which institutional arrangements affect the capabilities of actors to act. Since 2006, there is a certain freedom given to insurers to negotiate with providers regarding such aspects as the price and quality of care. The government has no longer a direct steering role, but rather monitors and guards the process from a distance. The responsibility lies with the patients, providers as well as insuring companies. The aspects which are under control of the government are related to the quality of care, the access to health care, and its affordability. In order to prevent problems, “watch dog” entities have been established. Moreover, self-regulation is a significant aspect of Dutch health care. There is a well-developed structure of advisory, professional institutions, and associations that together are responsible for the improvement of the quality of health care as well as its development (Schafer et al, 2010; Health Consumer Power House, 2014).

Despite the fact that the Dutch health care system is performing remarkably well in comparison with Poland and other European countries, a constant innovation and introduction of new sorts of arrangements in health care is necessary for its sustainability (Choińska & Szpak, 2011).

Hence, there is no ideal or universal model of a health care system that works perfectly, and is applicable (with positive effects) to every country. Nonetheless, there are some benchmark practices which other states may draw an inspiration from, when it comes to enhancing the efficiency and sustainability of their own health care arrangements, and will be presented in the following section (Hady & Leśniowska, 2011).

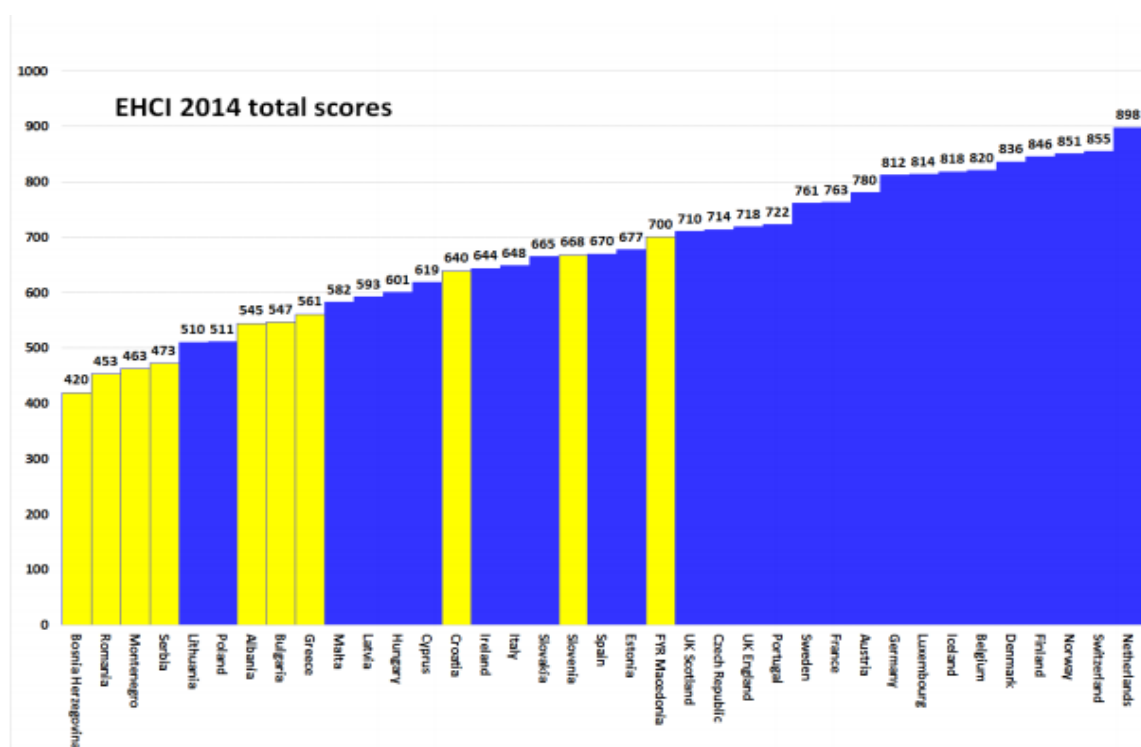
2.4 The Dutch model as a potentially best practice

The comprehension of solutions introduced in other models may contribute to a better assessment of countries’ own systems, and lead to a possible improvement in accommodating the policy challenges. Complete systems (or partial reforms in these) are regarded as institutional models, within the meaning of Scharpf’s matrix – precisely, genetic problem oriented perspective.

One of such remarkable systems is the Dutch one, appraised as the best one in Europe in 2014, and considered to be a great example to follow. Moreover, it has been the only state which has kept its position in the top three in the overall ranking incessantly since 2005 (Health Consumer Powerhouse, 2014). The Netherlands was followed by Switzerland, Scandinavian countries, as well as Belgium (Roberts, 2015).

The figure below (2.1), may provide useful insights in determining the performance and functionality of health care systems, however such rankings focus mainly on technical conditions, neglecting the political dimension at the same time. Moreover, the focus of benchmark promoters is placed on the problem oriented analysis, and negligence of the interaction oriented analysis (cell number three and four in the Scharpf's matrix) at the same time, which may compel to reflection about the usefulness of benchmark models.

Figure 2.1: Overall ranking of 37 countries EHCI in 2014 (European Health Consumer Index, 2014)



Source: Accommodated from Health Consumer Power House (2014) Euro Health Consumer Index. Report retrieved from http://www.healthpowerhouse.com/files/EHCI_2014/EHCI_2014_report.pdf

As we can see in the figure (2.1), the Netherlands performs remarkably better than Poland in respect of health care. The Dutch success is a result of a number of reforms related to the introduction of market-driven rules with respect to provision and financing of health care. Introducing a system of regulated competition consequently led to a more efficient resource exploitation and higher quality of service (Hady & Leśniowska, 2011). Over the previous decade, the goal of the government, in specific the Ministry of Health, Welfare and Sport, was related to the improvement of three major aspects: access, quality, as well as costs (Schafer et al, 2010).

Along with the introduction of the Health Insurance Act in 2006, the health care system has been reestablished in line with the model of regulated competition (Van Kleef, 2012). Despite the fact that the reformed health care system was introduced in the country in the beginning of 2006, the development of reform plans on increasing efficiency and sustainability already started in 1980's. Hence it is a result of gradual institutional change rather than the outcome of an abrupt reform (Hady & Leśniowska, 2011).

A large number of competitive insurance providers, who operate in the separation of hospitals as well as caretakers, is one of the aspects which characterizes the Dutch system. Another noteworthy element standing behind its success, is a greatly structured arrangement of the patients' involvement in the legislative process with respect to health care. The accessibility, which is problematic for many other countries, has been addressed by the Dutch policy makers as well (Health Consumer Powerhouse, 2014). Moreover, there is an emphasis on the tradition of formalized solidarity, supposed to treat all citizens equally.

It took a number of years for the results to be visible, nonetheless, introduced transformations brought profound changes and already positive results (Hady & Leśniowska, 2011). Additionally, the Netherlands is at the top of OECD group with respect to such aspects as short waiting times, rights of patients, as well as the range and availability of health service (Healthcare Industry, 2013). Results of previous Dutch Health Care Performance Reports confirm simple access to health care by showing advanced network of services, which are approachable within a very short time from home (Van den Berg et al, 2010). However, not only the Netherlands is considered to perform remarkably - there are several other potential benchmarks systems worth mentioning as well.

2.5 Other potential benchmark systems

Swiss health care, which has many similarities with the Dutch model, is considered to be the European benchmark system as well. Shared characteristics of both models are related to rules of universality as well as equality, which is granted to the citizens by the possibility of obtaining health insurance from private entities. Moreover, the support in the form of financial assistance for individuals with low earnings, as well as the regulation of the insurance market to protect citizens, is also provided in both countries. In comparison with other states, the health care outcomes as well as patients' satisfaction remain very high. The Swiss system is characterized by the universal health coverage via social health insurance and excellent results (Daley & Gubb, 2013a). Social health insurance systems, to which also

Germany as well as the Netherlands belong, are market-oriented, and driven by the needs of patients, treated as consumers (Niemietz, 2015, p. 8).

Furthermore, the Norwegian health care system has been appraised as a benchmark model as well, which has been changing positively over the years, and consequently earning its high position in rankings (Health Consumer Powerhouse, 2014). The emphasis of recent health care reforms (amongst others, the Coordination Reform in 2012) has been placed on such aspects as the improvement of the coordination among health care providers, high quality of care, as well as protection of patients. It is characterized by universal coverage and it is semi-centralized (Mossialos et al, 2014). Noteworthy about the above-mentioned system is the Norwegian sustained engagement and investment in health care over the years, which lead to building a comprehensive and well-functioning model. That is why other countries may draw the lesson from the Norwegian commitment (OECD, 2014).

Despite the noteworthy performance of above described potentially best practices, they are certainly not irreproachable. All of the above mentioned countries face similar challenges with respect to health care (to a smaller or larger extent) and struggle with accommodating them. However, that does not change the fact that other countries, struggling with keeping the sustainability of health care as well as its efficiency on a larger scale, may consider incorporating market-driven practices introduced in benchmark systems.

Despite the fact that there is a number of potentially best practices in Europe, the Netherlands is chosen as the benchmark for Poland in this thesis not without reason. The Dutch exemplar is considered to be the most important one, and ranks as the best health care system in Europe. The widespread, international acknowledgment of its performance proves the high effectiveness of the Dutch regulated competition in health care (Health Consumer Powerhouse, 2014).

Moreover, the Dutch model is a remarkable example of creating balance between, on the one hand competition, and on the other social solidarity. The risk selection is highly guarded, while the competition is enhanced on the level of the quality and provision of service. Therefore, the Dutch model would fit the needs of the Polish nation (such as an equal access to health care and social solidarity), rooted in the Christian tradition of the country. (Walczak, 2011).

The current state of the Polish health care leaves a lot to be desired, and is facing a number of burning challenges. The Netherlands is struggling with similar problems as well (for instance, efficiency and sustainability of health care), nonetheless the Dutch model seems

to accommodate the policy challenges incomparably better. That is why, the implementation of the Dutch market-oriented arrangements may become of interest for Poland, which is considered as one of the worst in Europe (Health Consumer Powerhouse, 2014).

2.6 Conclusion

The aim of the chapter was to elaborate on the general, theoretical framework of policy challenges and institutions in order to gain a deeper comprehension of the concepts. Moreover, a brief introduction of the Polish system and the Dutch one in the above context should contribute to a better understanding of the theory in practice.

Potential benchmark systems, which were subsequently presented in this chapter, are characterized by the high quality of care, solidarity, accessibility, remarkable outcomes, and efficient arrangements designed to not only protect consumers, but also ensure sustainability and efficiency of health care. The Dutch model has been chosen for Poland not without reason, and will serve as a reference point when analyzing Polish health care.

The focus of this thesis in the following chapters will be placed on the interaction oriented perspective in order to investigate which barriers and facilitators influence reforming the Polish health care system. Moreover, the problem-oriented analysis of the functioning of the Polish health care system will be taken into consideration as well, when examining policy challenges, institutional arrangements introduced to counter them, as well as the effects of these solutions on elaborated challenges.

In order to accommodate challenges, introducing reforms in the system is crucial. Nonetheless, various barriers can stand in the way of its development and consequently, hinder a proper functioning. The concepts illustrated in this chapter do not elaborate on barriers and facilitators of reform in a sufficient manner, while the benchmark propagators and rankings neglect the interaction oriented analysis perspective, which is crucial for the comprehension of costs, barriers and facilitators of reforms. Hence, in order to gain more sophisticated knowledge about, amongst others, institutional constraints, the introduction of the following chapter is necessary.

3. Theoretical perspective on institutional change

This chapter will elaborate and critically discuss the concepts concerning gradual and abrupt change. Subsequently, barriers and facilitators of reform will be elaborated. The introduction of the theoretical framework is crucial in order to have a deeper understanding of changes undergoing in health care systems. Additionally it serves as a useful guideline for conducting empirical research and analysis.

3.1 Gradual versus abrupt changes

According to Mahoney & Thelen (2010), putting focus on aspects of the political context as well as attributes of aimed institutions is essential in order to comprehend the process of institutional change. These dimensions are considered to be adequate and vital contextual preconditions for change. Moreover, they explain the kind of institutional alteration which one may expect (Mahoney & Thelen, 2010). The studies on the above-mentioned subject distinguishes four kinds of gradual institutional change – drift, displacement, layering, and conversion (Helderman & Stiller, 2014)

Such a construction of framework is based on the comprehension of institution and its dynamics. The occurrence of various kinds of institutional change is dependent on political context as well as the characteristics of targeted institutions. Hence, aspects such as veto opportunities in hands of actors opposing reforms may successfully hamper achieving any major transformations. ‘Political institutions (...) are the object of on-going skirmishing as actors try to achieve advantage by interpreting and redirecting institutions in pursuit of their goals (Streeck & Thelen, 2005, p.19). Institutional principles may relate to the amount of discretion determining the extent of freedom actors have in interpreting the law (Mahoney & Thelen, 2005). Thus, the possibility to introduce changes depends on the conditions (either favorable or not) created by the above-mentioned two dimensions. They lead to the certain mechanisms of change, which are presented in the table below (3.1) (Benz & Broschek, 2013).

Table 3.1: ‘Matrix relating characteristics of institutional and political context to mechanisms of gradual institutional change’ (Helderman & Stiller, 2014).

	Low Level of Discretion	High Level of Discretion
Strong Veto Possibilities	layering	drift
Weak Veto Possibilities	displacement	conversion

Source: Helderman, J.K., Stiller, S. (2014) The Importance of Order and Complements: A New Way to Understand the Dutch and German Health Insurance Reforms. *Journal of Health Politics, Policy and Law*

The question which compels policy-makers as well as scholars in institutional analysis to reflections is related to the following dilemma: should we aim at implementing drastic changes or should we introduce gradual ones in order to achieve successful, systemic reforms? (Kolwitz, 2010). The opinions of scholars are not coherent in this matter, even contradictory.

Some academics have argued that only critical junctures may cause systemic and major reforms. One of the main theories supporting such a view is the punctuated-equilibrium theory. Even though it includes the whole policy system, the focus is placed on subsystems – iron triangles and policy networks. Those subsystems have a certain policy image. The image refers to the way in which policies are understood and characterized. The equilibrium of a stable policy making is the result of the domination of the policy image, which consequently leads to introducing slight change. Nonetheless, the policy image is vulnerable and may collapse at some point. The moment it happens and gets into macro political agenda will result in the appearance of major changes – punctuated equilibrium policy making. Thus, major changes will only occur as the result of critical junctures such as crises (True, Jones & Baumgartner, 1999).

Cortell and Peterson (1999) criticized the above-described theory for its insufficient comprehension of change. According to these scholars, less abrupt changes may also result in reforms, while a gradual institutional adaption is more feasible to occur than an episodic change. An episodic change is described as the reinvention of patterns, destroying the prevailing traditions and schemes. Incremental change is limited to a certain policy field.

Such gradual events as progressive domestic developments, non-abrupt elections, or alterations in administration can result in the same changes as the well-known critical junctures. Moreover, the punctuated-equilibrium theory underestimates the role of actors in influencing institutional change. Institutions do not change themselves, but they are changed. Thus, the role of individuals as agents of change is very significant in the whole process (Cortell & Peterson, 1999).

Hence, in the literature targeted at institutional reforms, some scholars focus on external junctures or shocks, which cause radical and abrupt transformations. At the same time, according to Mahoney and Thelen (2010), these scholars tend to neglect the possibility of internal developments, which appear incrementally. Along these lines, gradual changes may be of great importance on their own account and consequential for various outcomes. Thus, the theory of gradual institutional change offers more sufficient and sophisticated understanding of change.

There are four distinct mechanisms of gradual institutional change acclaimed: drift, layering, conversion, as well as displacement. Drift may be understood as purposeful neglecting transformations or/as well as an institutional preservation, despite the existence of both external and internal challenges. These challenges may be connected with economic crises or caused by institutions themselves. Drift is also defined as ‘changes in the operation or effect of policies that occur without significant changes in those policies structure’ (Hacker, 2004, p. 246). This mechanism undergoes without a prompt control of decisive actors, and consequently appears as natural and unplanned. It can also become a result of intentional actions to hamper institutional adaption in the occurrence of shifting circumstances (Hacker, 2004). Drift is likely to occur when the veto possibilities are large, as well as a high degree of discretion (Helderman & Stiller, 2014). One of the examples of drift may be found in the American health care policies, where despite new circumstances, purposeful decisions were made not to adjust current institutions to it (Hacker, 2005).

Conversion and displacement demand more active involvement of the political agency, ‘although the extent or scope of institutional change varies between them’ (Helderman & Stiller, 2014, p. 819). Radical displacement is similar to an introduction of a systemic reform and punctuated equilibrium theory, where the current institutions are replaced by completely new structures (Mahoney & Thelen, 2010). Gradual displacement is possible as well, where new solutions and arrangements are gaining the importance next to dominant ones, and continuously replace them. Displacement is likely to occur when there are weak veto possibilities as well as low level of discretion (Helderman & Stiller, 2014). It is

common for displacement to adapt foreign traditions and enhance a novel logic of taking actions inwards current institutional framework (Streeck & Thelen, 2005).

Another mechanism – conversion, refers to the introduction of novel functions as well as purposes and adopting institutions to new goals, depending on the policy-makers' interests. Conversion is likely to appear when, similar to displacement, there are weak veto possibilities, however there is a high leverage allowing for discretion (Helderman & Stiller, 2014). According to Hacker (2004) conversion can be understood as the inner adjustment of existent policies. Redirection as well as reinterpretation of existing rules is a common mechanism in conversion (Streeck & Thelen, 2005).

In the situation where the existent policies withstand the process of conversion, while the political or institutional structure allows for introducing novel policies, the mechanism of layering can occur (Hacker, 2004). It can be regarded as attaching new elements to already existing structures – thus, what is crucial to understand, is the fact that it is not a process of replacement but attachment, which gradually changes the status of institutions as well as their structure. The example of layering can be adding actors, rules, or organizations to current institutions (Mahoney & Thelen, 2010).

There are many patterns of institutional change, not only sole one, 'whether it be the big bangs of sudden transformation or the silent revolutions of incremental adjustment' (Hacker, 2004). Shifts can have various shapes, while approaches taken to deal with institutional change may vary due to such aspects as character of institutions or political structure they are settled in (Hacker, 2004).

Instead of the punctuated equilibrium theory, the concept of gradual institutional change will be chosen for further research in this thesis. It is valuable and comprehensive when distinguishing as well as understanding different mechanisms of change.

However, its elaboration on aspects which enable or hamper achieving reforms is limited. The focus of this thesis is especially placed on explaining the lack of systemic reforms in Polish health care nowadays and the feasibility of Dutch reforms for Poland. That is why a more elaborate and detailed study of barriers and potential facilitators of change, than a general theory of gradual institutional change, will be taken into consideration in the following section.

3.2 Barriers to reform

As already mentioned in the introduction, achieving reforms is a very complex and long-standing process, sometimes regarded even as the goal impossible to accomplish. Reforms do occur, but the way to success is tangled and constrained by various barriers (Bannink & Resodihardjo, 2006).

The concept itself is defined in different manners, nonetheless it may be described as ‘the fundamental, intended and enforced change of the policy paradigm and/or organizational structure of (and organization within) a policy sector’ (Bannink & Resodihardjo, 2006, p.4).

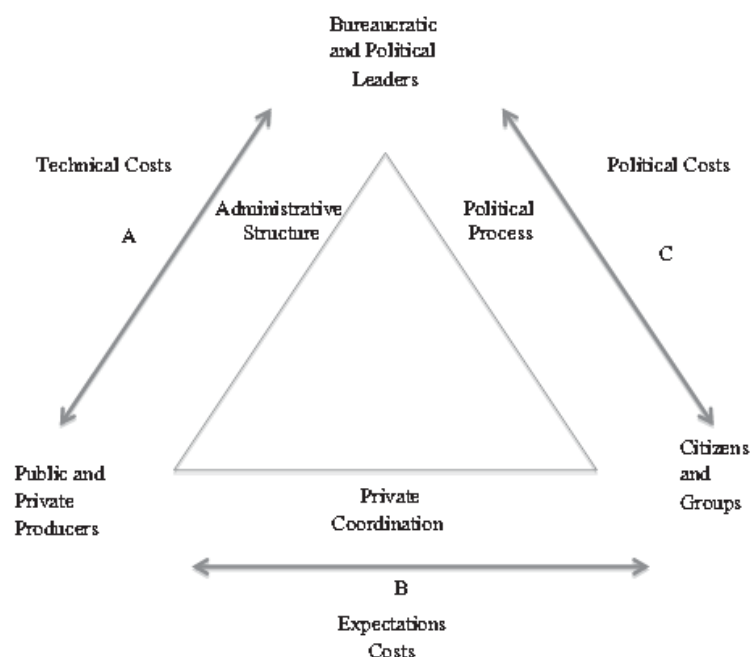
In order to introduce reforms, certain costs have to be made. Hence, costs of change are of importance when analyzing barriers hampering reforms. Three types of costs - technical costs, political costs, as well as expectations costs account for the reason for institutions being periodically more open for change than other institutions (Gingrich, 2015).

During the process of changing the institutional structure, it is likely that certain investments will be required. These investments relate to such aspects as providing various offices, facilities or hiring new personnel. Such types of costs are known as technical ones and may constrain actors capabilities to achieve deliberate goals. These costs mirror the relations between, on the one hand policy-makers, and on the other market-based contractors responsible for delivery of services (Gingrich, 2015). Hence, technical costs may be classified in the characteristics of targeted institutions.

Another type of costs – political ones, relate to resistance of voters for change and consequently, lost votes. Additionally, it also involves a negative financial return, cause by lost support of relevant groups. They reflect the relations between policy makers and citizens (Gingrich, 2015). Thus, political costs belong to the characteristics of the political context.

The last type, expectation costs, refer to the costs of reshaping the behavioral coordination between private actors and institutions. Over time, expectations of private actors get stronger, and may demand taking certain costs from policy makers - for example establishing new institutions. It will boost and assure cooperation, whereas by providing financial impetus, increase motivation for behavioral shift. Hence, these costs reflect relations between private actors, contractors, as well as citizens, which influence new opportunities for behavioral coordination (Gingrich, 2015). Together with technical costs, expectation costs belong to the characteristics of targeted institutions. The following figure shows above-described types of costs and relations between involved actors.

Figure 3.1: Costs as well as changing path inwards the state



Source: Gingrich, J. (2015), *Varying Costs to Change? Institutional Change in the Public Sector*. Governance.

Various cost structures may not only differ to a major extent, but they also allow for specific modes of change. Moreover, these changes have an important impact on how institutions function. They may take the form of back-end, informal or front-end changes (Gingrich, 2015).

The first kind of change occurs when the technical costs are decreasing, while expectation and political costs still remain on a high level. The fall is due to, for example, gaining more knowledge and administrative control during the process of production, as well as an increase of bureaucratic capacities. In health care it would be connected with gaining knowledge by policy makers about medical and financial actions of health-care providers, leading to reducing the costs of the learning process, and being able to rely more on their own judgment. Thus, back-end changes aim at altering the administration, and reflect shifts in structure of the service provision. At the same time, they do not considerably affect benefits citizens gain, and do not have to be automatically gradual (Gingrich, 2015).

A second form of change – an informal one, appears when the expectation costs are diminishing despite high technical and political costs. Its origins may be both internal as well as external. Examples of external changes are market deregulation or legal alterations, which result in encouraging new forms of behavioral coordination as well as a construction of

services. It is an informal change because it appears due to individual, non-state actors/companies, without large alterations in the formal structure (Gingrich, 2015).

The last form, front-end change, occurs when political costs are decreasing, while technical and expectation ones remain large. The decline of political costs happens due to, for example, lack of citizens' support in the current program. The source for it may be either internal or external. Shifts in international economy or crises may cause declining support. Nonetheless, changing ineffective programs is not easy – they entail generally high technical and behavioral costs. Introducing front-end changes of institutions may be less considerable than the previous described forms because it involves symbolic policies or shifts in the primary service goals, but not its whole structure (Gingrich, 2015).

It should be noted that decreasing one of the above-described types of costs does not automatically mean creating a change. Policy makers and other actors of change still have to take actions in order for transformations to occur. Additionally, changes appearing in one field may decrease costs in other areas. For example, citizens and companies involve in new types of behavioral coordination, inducing informal change, while at the same time electoral costs decrease. It is due to a lower involvement of above-mentioned groups in political process. Hence, the logic behind institutional change in various domains is interconnected and cannot be overlooked (Gingrich, 2015).

Costs of change are only a one type of barriers standing in the way of introducing changes. Hence, achieving reforms is largely dependent on the presence of the following barriers and facilitators, presented in Table 3.2.

Table 3.2: Barriers and facilitators of reform

Barriers		Facilitators
Opportunities	Preferences	Diminished barriers, for instance the decline in support for the policy inheritance or disrupted decision making process (often due to crisis)
Decision making structures	Policy paradigm	Reformist actors – leaders or entrepreneurs
Policy inheritance	Reform is upsetting and unsettling	Finding support for the well planned proposals
Policy lock-in	Policy makers can benefit because of existing institutional structure	Unfavorable media coverage, which may influence negatively the image of the policy sector
	Vested interests	Political developments such as elections, leading to the opening of window of opportunity

Source: accommodated from Bannink, D., Resodihardjo, S.L. (2006) The Myths of Reform, in: Heyse, L., Resodihardjo, S.L., Lanting, T., Lettinga, B. (eds) *Reform in Europe. Breaking the Barriers in Government*. Aldershot: Ashgate.

Barriers are demarcated into two groups – opportunities and preferences. Opportunities reflect that institutions wield influence on actors capabilities to influence policy making. In consequence, actors are given restricted possibilities to achieve reforms. The second group is related to preferences of institutions, which may result in opposing the reform.

A list of constraints is visible inwards both of these dimensions. Barriers such as decision making structures as well as policy lock-in belong to opportunities. Decision making structures can hamper an effective policy-making development due to diverse principles in a political structure, for instance veto rights. They relate to a possibility for an actor to block the proposition or to support it. Another barrier, namely policy lock-in, may lead to path dependence and relates to investing effort in particular aspects in the past (for instance, machines or buildings). In consequence, it is very difficult to swap it for another policy. Policy inheritance basically means following the footsteps of a former authority as well as inheriting the same laws. Actors of change possess restricted latitude with respect to amending prevailing principles and policies (Bannink & Resodihardjo, 2006).

The dimension of preferences include another group of barriers. The first one is a policy paradigm, and relates to such aspects as routines, values, as well as standardization of procedures pending policy development. Above mentioned elements establish certain facets which may be either accepted or not, in regard to problems solving or achieving desired goals. Hence, solutions which are in contrast to the dominant policy paradigm will not be backed by policy makers. Another preference barrier is related to vested interests. Actors making profitable investments oppose reforms (which would change their achievement and consequently, result in losing profit or/and the position). Additionally, policy makers who might benefit due to existing institutional structures may oppose reforms as well. Moreover, a major change may be upsetting as well as unsettling for individuals – transformation is related to disturbance, leading to large changes - that can be considered threatening or troublemaking. (Bannink & Resodihardjo, 2006).

Many scholars focus on diverse barriers hampering reforms as well as great difficulty to enable transformations. Nonetheless, in order to grasp how to accomplish reforms, the introduction of facilitators is necessary as well.

3.3 Facilitators of reform

Disrupted decision making process, usually preceded by such events as crisis, belongs to facilitators. Crisis is likely to occur when citizens are dissatisfied with the situation in the policy sector – lack of institutional fit, and may represent the view of the punctuated equilibrium theory (Bannink & Resodihardjo, 2006). Furthermore, disharmony may result in path dependency as well. Following particular path for a long period of time may cause citizens' dissatisfaction, and realization that the current situation is not desired (Kuipers, 2009). Politicians must face the challenge of existing policies being questioned or provoked by citizens, and in the end they demand introducing changes. Crisis may be related to such aspects as the unfavorable media coverage as well as the pressure from pro-reform actors (Bannink & Resodihardjo, 2006). Two approaches may be taken by agents of change: either a reformist or a conservative approach. A reformist approach aims at reconstructing the policy sector to adopt a novel 'fit' to changing circumstances, while the latter is connected to returning to a pre-crisis situation and consequently, restoring former policies and regulations. They can both either misfire or lead to success (Alink, Boin & Hart, 2001).

The concept of a window of opportunity belongs to facilitators as well. It might be opened in such cases as international and/or domestic events, crises, as well as gradual changes. In consequence, barriers are diminishing and the potential to alter existing policies and institutions appears. A change of the current governmental power or elections belong to domestic triggers, while international events entail international organizations and its established laws (Cortell & Peterson, 1999).

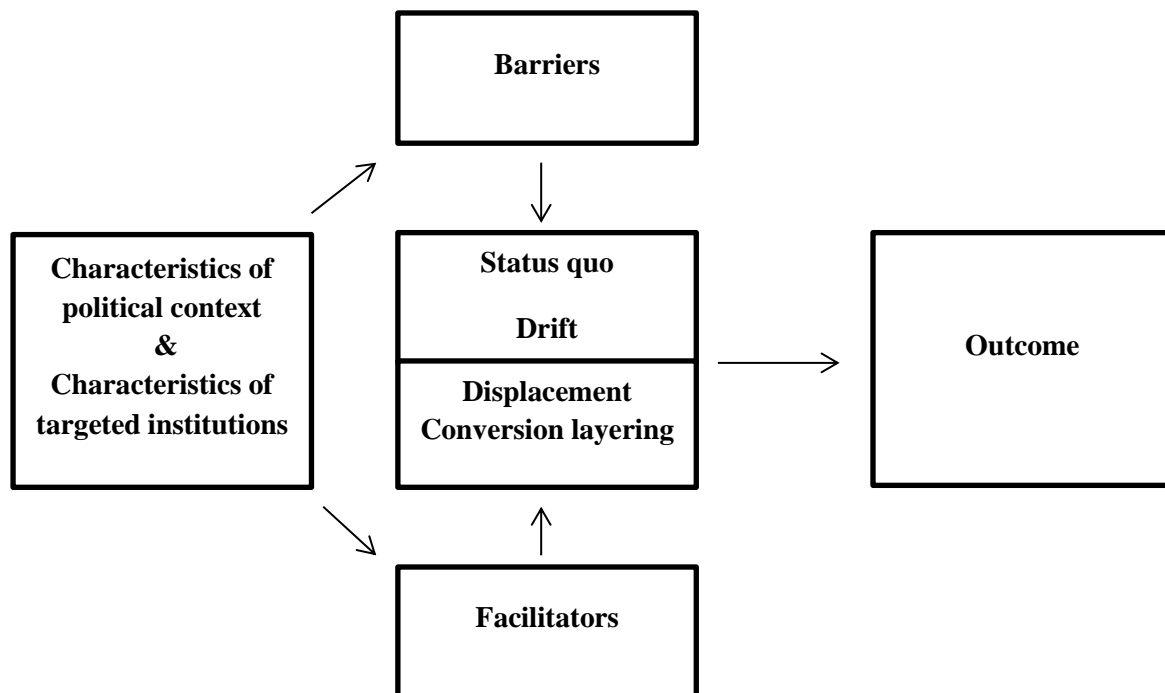
Other aspects which wield impact on the window opening are political developments as well as societal issues (they may lead to it either together or separately). Political developments may vary and relate to obtaining power by new actors, or entail more serious events (for instance, the murder of J. Kennedy) The latter – societal issues, draw attention of politicians to particular affairs and in consequence, create public claims, that are rather hard to neglect by policy makers.

Hence, in case of diminishing barriers, the window of opportunity may open (for instance, with elections). The size of the window is of importance as well. In the literature, macro and micro windows are distinguished. Macro windows occur when serious events take place, while smaller windows are the result of events happening on a minor scale (Keeler, 1993).

The window of opportunity may be explored by entrepreneurs whose goal is to draw attention to specific issues, introduce proper solutions, as well as establish favorable coalitions. They can have different motivations, but they all want to advocate for change (Mintrom & Norman, 2009).

Based on the theoretical analysis in this chapter, we can create the following conceptual framework (Figure 3.2). It reflects the relations of the institutional/political dimension with barriers and facilitators and different mechanisms of change.

Figure 3.2: Conceptual Framework



The political and institutional dimension (characteristics of political context and targeted institutions) may constrain or facilitate capabilities of actors to introduce changes. Hence, they create barriers and facilitators, which condition the likelihood of particular mechanisms of change to occur. Namely, barriers will most likely lead to preserving the status quo or drift, while displacement and conversion will be more dependent on the presence of facilitators. An outcome, as a final effect, is reliant on the appearance of a particular mechanism of change. In case of the Netherlands, a system of regulated competition was a result of a gradual conversion and layering.

3.4 Conclusion

The aim of the chapter was to describe in detail as well as clarify contradictory theoretical concepts related to introducing change in the policy sector. Hence, such aspects as significant explanatory factors of change, mechanisms of change, barriers, and facilitators were explained.

The theory of gradual institutional change, in contrast to the theory of punctuated equilibrium, presents a more sophisticated understanding of change. Therefore, it will guide the empirical research in terms of different mechanisms of change.

Nonetheless, the main focus of this thesis will be placed on elaborating challenges, barriers, and potential facilitators leading to the introduction of significant reforms in the Polish health care system, with a reference to the Dutch model. The gradual institutional change theory does not elaborate on them to a sufficiently detailed manner. That is why the emphasis during the analysis will be placed on investigating aspects, discussed in the two last sections of this chapter. In order to grasp how the research will be conducted, the introduction of the methodological framework is crucial.

4. Methodological framework

This chapter will explain the manner of conducting empirical research in this thesis. Firstly, the research design will be described and justified. Next, main variables will be operationalized and subsequently, data collection and analysis will be elaborated. Finally, the limitations of the research – validity, and reliability will be distinguished.

4.1 Research design

This section explains in what manner the study is managed. The type of research which has been chosen for conducting empirical analysis is a qualitative approach. In order to grasp what are the barriers hampering the introduction of systemic reforms in Polish health care, it is more appropriate to apply above-mentioned type of research because of a several important reasons.

In contrast to quantitative analysis, qualitative approach does not put emphasis on numbers, but focuses on observations and explanations of social phenomena. Moreover, its aim is related to the exploration of certain aspects, not a confirmation or denial of particular hypothesis (Mack et al, 2005). The focus of the following analysis will be placed on exploring as well as explaining aspects which account for lack of systemic reforms in Polish health care. Furthermore, there will be limited units of study taken into consideration, while for quantitative analysis a substantial number is crucial for conducting statistical tests.

The research design consists of a proper strategy, methods, and techniques which are applied. The strategy implemented in this thesis is a case study – with the emphasis on Poland, and the Netherlands considered as the benchmark to learn from.

Despite the fact that some aspects of the Dutch model (for instance, organizational structure) are compared to the Polish model, it is not a pure comparative case study. The Netherlands is treated as a reference point, while the main focus of analysis is on the Polish case. Hence, the emphasis is not placed equally on both of the health care systems and their comparison, but mainly on the analysis of the Polish system and the explanation of lack of reforms in Polish health care. To answer the second part of the central research question of this thesis – how feasible are Dutch reforms for Poland, the elaboration of the Dutch model is crucial. Therefore, the fifth chapter will introduce and analyze Dutch health care in terms of its organizational structure, mechanisms of change, reforms, and current challenges. The fifth chapter will consequently create a mirror case for the analysis of Polish health care, and serve

as a reference point for the sixth chapter. The reason for comparing several factors of both systems in the sixth chapter is related to distinguishing aspects in which Polish health care falls behind, and to determine the feasibility of Dutch reforms for Poland.

The country case study applied in the thesis is limited to two contrasting countries with respect to health care arrangements and functionality (with greater emphasis on the Polish system), and will be extensively analyzed in the following chapters. Hence, there are two units of study. Typically, case studies have a holistic approach, which will be taken into consideration in the following empirical research as well (Van Thiel, 2014).

The case study has an explanatory character. It investigates the complex phenomenon of ineffective Polish health care arrangements, and aims at explaining the reasons standing in the way of introducing regulated competition, leading to its possible improvement.

The strategies which will be used to address the research problem are: a case study and a desk research. Moreover, the methods applied during the study are: interviews (semi-structured) and a content analysis. For the topics from the field of Public Administration, including health care, such methods and strategies are generally the most suitable (Van Thiel, 2014).

4.2 Operationalization

The aim of the following section is to explicitly present what will be examined or measured – thus, convert the theory to assessable variables. Firstly, in order to avoid the unambiguity in understanding theoretical concepts, the provision of its definitions is crucial (Van Thiel, 2014). The clarification, elaboration, and mechanisms of the following variables is presented in Table 4.1 and 4.2: mechanisms of gradual institutional change, reform, barriers, facilitators and regulated competition. Lastly, Table 4.3 will elaborate concrete indicators of barriers and facilitators.

Table 4.1: Operationalization of mechanisms of change (dependent variables). Based on Streeck & Thelen (2005).

	Drift	Layering	Conversion	Displacement
Definition	‘the (deliberate) neglect of institutional maintenance and/or reforms in spite of exogenous and endogenous challenges to existing institutions’ (Helderman & Stiller, 2014, p. 818; Streeck & Thelen, 2005)	‘attachment of new institutional elements to existing institutions so that the latter gradually change in terms of their status and structure’ (Helderman & Stiller, 2014, p.819; Streeck & Thelen, 2005)	‘adding new goals and functions to existing institutions’ (Helderman & Stiller, 2014, p. 820; Streeck & Thelen, 2005)	‘old institutions are completely dismantled and displaced by new institutions, and as such, it can be understood in terms of a systemic reform, representing the traditional punctuated equilibrium image of institutional change that can be expected to occur only at critical junctures’ (Helderman & Stiller, 2014, p. 819; Mahoney & Thelen, 2010)
Mechanism	Purposeful neglect (if: strong veto, high discretion)	Diversified increase (if: strong veto, low discretion)	Redirection (if: weak veto, high discretion)	Desertion, abandonment (if: weak veto, low discretion)
Elaboration	‘Enactment of institutions changed, not by reform of rules, but by rules remaining unchanged in the face of evolving external conditions ‘ (Streeck & Thelen, 2005, p.31)	Novel institutional layer decreases the support for the old structures ‘New fringe eats into old core’ (Streeck & Thelen, 2005, p.31)	Loopholes in regulations as well as enactment, caused by such aspects as subversion or time – ‘changing contextual conditions and coalitions open up space for redeployment’ (Streeck & Thelen, p.31)	Institutional incongruity creates space for irregular behavior Implementation of external practices ‘Active cultivation of a new ‘logic’ of action inside an existing institutional setting’ (Streeck & Thelen, 2005, p.31)

Table 4.2: Operationalization of reform, barriers, facilitators, and regulated competition.

	Reform	Barriers of reform	Facilitators of reform	Regulated competition
Definition	‘the fundamental, intended and enforced change of the policy paradigm and/or organizational structure of (and organization within) a policy sector’ (Bannink & Resodihardjo, 2006, p.4)	Aspects preventing achieving reforms (Bannink & Resodihardjo, 2006)	‘the willingness to act (agency) and the ability to do so’ (Bannink & Resodihardjo, 2006, p.11)	A system in which involved actors compete and negotiate with each other on the price as well as quality of care, whereas the government safeguards public objectives (Van Kleef, 2012)
Mechanism	Enabled by facilitators, hampered by barriers (Bannink & Resodihardjo, 2006)	Institutional opportunities and preferences (Bannink & Resodihardjo, 2006)	Diminishing barriers (Bannink & Resodihardjo, 2006)	Conditioned by the fulfilment of proper preconditions (Van Kleef, 2012)
Elaboration	<p>‘defining priorities, refining policies and reforming the institutions through which those policies are implemented’ (Cassels, 1995, p.331)</p> <p>‘a deviation from existing structures or paradigms’ (Bannink & Resodihardjo, 2006, p.3)</p> <p>Transformations of policy and changing organisation (Bannink & Resodihardjo, 2006)</p>	<p>Decision making structure,</p> <p>Policy Lock-in,</p> <p>Policy inheritance,</p> <p>Unwillingness of citizens to change,</p> <p>Vested interests,</p> <p>Reform is unsettling,</p> <p>Policy paradigm,</p> <p>(Bannink & Resodihardjo, 2006)</p> <p>Political, technical and behavioral costs (Gingrich, 2015)</p>	<p>Disrupted making process,</p> <p>Window of opportunity,</p> <p>Entrepreneurship,</p> <p>Finding support,</p> <p>Negative media coverage</p> <p>(Bannink & Resodihardjo, 2006)</p>	<p>contestability of the market,</p> <p>effective market regulation,</p> <p>freedom to contract/negotiate,</p> <p>transparency,</p> <p>availability of consumer information,</p> <p>consumer choice of insurer,</p> <p>financial incentives,</p> <p>risk equalization.</p> <p>(Van Kleef, 2012)</p>

Table 4.3 Detailed indication of measured barriers and facilitators. Based on Bannink & Resodihardjo (2006).

Barriers Decision making structure	Indicators Actors possess limited opportunity to introduce reforms due to decision making procedures and rules (for example, veto rights). The more veto possibilities, the more difficult for the proposition to become accepted	Facilitators Disrupted decision making process	Indicators The decision making structures and rules diminish (due to for instance crisis), and the opportunity to push for reforms appear
Policy lock-in	Past decisions led to investing in particular products and hamper current reforming capabilities	Window of opportunity	Because of the diminishment of barriers, the moment appears in which actors gain an opportunity to push for reform (for instance, because of elections)
Policy inheritance	Current political power inherits policies made by former governments and consequently, the freedom of policy makers to change these policies is very limited	Negative media coverage	The criticism of media of current policies (does not have to be preceded by particular events), draws the attention of policy makers and consequently, creates the urge for policy makers to change the negative image
Vested interests	Actors made certain investments to obtain their goals and may oppose reform if it affects negatively what they have achieved	Entrepreneurs	'Policy entrepreneurs include a range of people, from outside actors such as unions to inside actors such as civil servants,

	(for instance, losing the position)		bureaucratic managers, and political masters' (Bannink & Resodihardjo, 2006, p.9) who can act on the window of opportunity created by crisis
Reform is unsettling for individuals	Reforms disrupt the life of citizens and introducing novel policies has impact on citizens – this may cause their unwillingness to change	Leaders	Reformist actors, who in contrast with entrepreneurs, may act without the occurrence of crisis
Policy paradigm	The pattern of routines, values, and standard operating rules conditions the way of achieving goals and addressing problems – hence, creating propositions against the paradigm is not probable to happen	Finding backing	Reformist actors in order to introduce changes have to obtain support for their proposals within an organization by for instance building coalitions and alliances
Benefiting from existing structures	Policy makers can benefit because of existing institutional structure and if reform changes it, they will oppose it		
Political costs	Relate to the relations of citizens and politicians – the bigger the resistance of citizens for change, the higher political costs (and consequently, lost votes)		
Expectation costs	Expectations of different groups may grow in time and demand from policy makers investing in, for		

Technical costs	instance, establishing new institutions During the process of change, certain financial investments have to be made – connected with establishing offices, new facilities, training experts, and hiring personnel		
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In general, it is possible to interpret and describe theoretical constructs in a number of ways, thus it is not limited to only a one kind of measurement (Van Thiel, 2014). Achieving reforms is dependent on the diminishing barriers as well as presence of facilitators which enable its introduction. Barriers identified in the theoretical framework (amongst others, decision making structure or policy lock-in) and facilitators (such as window of opportunity or charismatic leaders) are independent variables, while reform with respect to provision of health care and finance – regulated competition, are dependent variables. The relation between barriers and facilitators is that they can either lead to reform and institutional gradual change, or hamper it. If barriers are diminishing, facilitators may enable achieving changes. Barriers and facilitators also influence mechanisms of change – depending on, for instance, veto possibilities or characteristics of institutions, a certain kind of change is likely to occur. The extent to which preconditions are fulfilled conditions the success of implementation of the process of regulated competition, hence market-oriented reforms. They can be measured by detailed examination of particular preconditions. Thus, above mentioned concepts are interrelated with each other – one conditions the other, and influences its presence.

Existing data sources as well as interviews will be helpful in operationalizing the variables. Nonetheless, existing sources may impose some problems with the operationalization. In order to avoid this issue, obtained information and the data will be fitted into the needs of the research. Careful and well-considered choice will ensure that the data coincide with the research object (Van Thiel, 2014).

In terms of sampling, the population of interest in the following study is related to two cases taken into consideration, with respect to health care arrangements – the Netherlands as well as Poland, with the emphasis placed on Polish system, and Dutch one treated as the exemplar. The analysis will be strictly limited to the above-mentioned units.

4.3 Data collection and analysis

Data collection typical for case studies is related to compiling, amongst others, archives, documents, observations or interviews (Meyer, 2001). Desk research will be applied in the following study, by the collection of existing information and data sources. Hence, information and knowledge necessary to answer the research questions will be obtained from various references. Such sources as the Euro Health Consumer Index, newspaper articles, scientific journals, books, legal reports, and documents of the Polish government will contribute to gaining insightful, diverse, and accurate research results. Moreover, it will help to receive a proper comprehension of the functionality of the Polish health care system nowadays. The advantage of such a collection of sources, is enhancing reliability as well as improving validity of the research – triangulation (Van Thiel, 2014).

Moreover, during the data collection, such aspects as the quality of documents and the proficiency of authors will be well-considered. Desk research is appropriate for such aspects as an exploration of either a background or a context of particular problems (Van Thiel, 2014). That is why such a choice, when examining the functionality of the Polish health care system and explaining the lack of systemic reforms is suitable for conducting the above-mentioned kind of research. The obtained information will have a qualitative nature. The problem of an ossified and ineffective organization of the Polish health care system is a very topical issue nowadays, that is why gathering information of faced challenges should not be a problem. Nonetheless, the marketization of Polish health care is still a relatively fresh topic on the political agenda, treated as a “future direction”. That may be the reason posing difficulties to reach proper materials and a sufficient amount of information (Seredocha, 2013).

Therefore, conducting a number of interviews may be helpful in obtaining supplementary information. They will be conducted with experts in the field of health care and its management (background of interviewees can be found in the appendix A). In order to find the key respondents, the email with the request to take part in an interview will be send. The interviewees (three) will be approached personally. Interviews will be semi-structured, hence contain not only one open question, but a set of inquiries formulated in advance, with the goal to obtain non-factual information (Van Thiel, 2014).

The general topics, which will be discussed concern the occurrence of mechanisms of change in Polish health care, topical challenges faced by the Polish health care system, and possible solutions to address them. Moreover, the subject of regulated competition and the

feasibility of its introduction will be discussed. Finally, the topic concerning barriers of reforms will be debated.

The purpose of interviews is to gain additional knowledge concerning policy challenges and problems faced in Polish health care nowadays, as well as the feasibility of Dutch reforms for Poland. Obtained expertise will complement a secondary data, which is a main source of information used in this thesis.

Additionally, the role of the conducted interviews is to confront the theoretical knowledge with the application in practice. The approached interviewees work in the most important types of health care facilities in Poland – clinics and hospitals. They not only take an active part in managing the establishments, but also have a direct contact with patients. Moreover, the role of the interviews is related to the confirmation or rejection of information which are obtained from the secondary data. The answers may lead to reaching conclusions or gaining novel knowledge which may shed new light on the problem of the malfunctioning Polish health care system. Gathering diversified empirical data (including interviews) will allow to apply theoretical concepts in practice and consequently, find the explanation for the lack of systemic reforms in Polish health care nowadays as well as estimate the feasibility of Dutch reforms for Poland.

Table 4.4 The interview guide

Topics	Questions
Mechanisms of change	<p>1. The occurrence of which mechanisms of change can you recognize in Polish health care after the transformation in the 1990's? Can you elaborate on them?</p> <p>2. What is the level of discretion of actors when interpreting the rules and procedures of the National Health Fund?</p> <p>3. What is the mechanism of contracting between providers and the National Health Fund?</p>
Challenges & Solutions	<p>4. Which are the most burning challenges in Poland in respect to the health care provision</p>

	<p>and financing in your opinion?</p> <p>5. Which feasible institutional arrangements could be put in place in order to address such challenges as the underfunding of health care, dissatisfaction of citizens, privatization of health care, and long waiting times?</p>
Regulated competition	<p>6. To what extent are the preconditions of regulated competition currently fulfilled by the Polish health care system? Can you elaborate?</p> <p>7. Based on the level of fulfilment of the preconditions, how feasible is the introduction of regulated competition in Poland?</p>
Barriers for reform	<p>8. Which of the indicated barriers can you identify in case of reforming the Polish health care system - can you elaborate on your choice?</p> <p>9. Which of the specified barriers do you find the most crucial in respect of hampering achieving reforms?</p> <p>10. The 'oncological package' reform in 2015 was an abrupt reform and did not bring expected results. What is the reason for its failure according to you? Would a gradual institutional change be more proper and why/why not?</p>

There are not only various manners of collecting different data, but also ways of processing and analyzing such information. 'Qualitative research is typically geared towards the exploration and description of the research subject, which means that it is predominantly inductive in nature' (Van Thiel, 2014, p. 140). In the following study the method of content

analysis will be applied. Such an approach focuses on exploring the content of existing sources (Van Thiel, 2014). Hence, firstly the adequate material will be selected for the analysis and its interpretation. Next, its content in terms of facts and opinions regarding the Polish as well as the Dutch health care arrangements will be closely studied. The goal of such analysis is not only related to determining various facts and stands of relevant actors, but also reconstructing the debating points. Secondary analysis, such as statistical data, will not be used due to the character of the study – such a form is mostly suitable for hypothesis-testing sorts of study, and the latter is not the focus of the this research. The theoretical framework is not considered to be the form of content analysis due to another purpose, hence empirical research carried out in following chapters represents content analysis (Van Thiel, 2014).

4.4 Limitations – reliability and validity

The consistency, accuracy of the process of conducting studies, its stability over time and across various methods, explain the reliability (Meyer, 2001). The emphasis which has to be stressed concerning reliability, is the proper and exact measuring of variables. ‘In explanatory research, a high level of reliability means that the explanation offered is most certainly the right one’ (Van Thiel, 2014, p. 48). The aspect of consistency is more difficult to be achieved, and it is related with the concept of repeatability (Van Thiel, 2014).

Since the case study will be limited to Polish and Dutch health care (the latter being a benchmark), such a limitation is likely to endanger its reliability and external validity. In order to address such a problem application of triangulation is essential. It is a manner of gathering necessary information by taking into account various data sources, thus considering diversified techniques. Collecting large amounts of data will ensure greater validity of the study (Van Thiel, 2014).

Moreover, analyzed aspects, which account for the lack of systemic reforms in Polish health care will not be exactly the same as barriers hampering achieving changes in other countries. Hence, they cannot serve as a general explanation for certain challenges and problems, applicable for other cases. ‘Countries with different economic and social structures and with different policy legacies may differ greatly in their vulnerability and hence in problems that their policy system must deal with’ (Scharpf, 2000, p. 766). Nonetheless, the undeniable strength of a limited case study is its in-depth, detailed analysis (Van Thiel, 2014). Namely, the emphasis will be placed on challenges and barriers hampering the achievement of reforms in the Polish health care with respect to its provision and finance, as well as

feasibility of a regulated competition for Poland. When many aspects are taken into consideration, it may be difficult to elaborate sufficiently on all of them - that is why restricted focus allows for a more accurate and extensive approach. The case study strategy ensures that the gathered information is studied elaborately in a specific context – in this case, aspects of the financing and provision of the Polish health care system and the Dutch one as a benchmark. Hence, its internal validity remains high (Van Thiel, 2014).

Semi-structured interviews, which will be held during the data gathering phase, do not guarantee great reliability and validity. However, in contrast to an open interview, it is structured to a larger extent – and that ensures larger reliability and validity than the open type.

4.5 Conclusion

The aim of the chapter was connected with the overall explanation and justification of the manner in which the research will be conducted. By operationalizing theoretical constructs, the indication what variables will be examined and measured was provided. Moreover, the sources of acquiring relevant data as well as the manner of its interpretation were also presented. Lastly, the limitations of the study related to its validity and reliability were discussed, as well as ways to possibly counter them.

5. The Benchmark model

In this chapter, the focus will be placed on the Netherlands to create a reference point for the analysis of Polish health care. First, Dutch reforms, aimed at enhancing the efficiency as well as sustainability of health care will be explained. Moreover, the organizational structure and the current challenges faced by the Dutch health care system will be elaborated. Subsequently, the arrangements aiming at addressing elaborated challenges will be examined. Consequently, the analysis will not only create a mirror conceptualization for the Polish case, but will also contribute to distinguishing to what extent Dutch reforms are feasible for Poland, and in what aspects the system may differ.

5.1 Dutch reforms – towards regulated competition

Health care is a very complex area and ‘the system is constantly in motion: new organizations and institutional structures are layered over old ones; existing organizations and institutional structures are converted into new ones’ (Helderman, 2007, p. 177). Since the end of the Second World War, the health care system in the Netherlands has been a subject of continuous reforms as well as institutional adaptations. The changes were gradually introduced in succession in 1941, 1966, 1967, 1986 and 2006 (Helderman et al, 2014). The Dutch health care went through three health care policy programs, successively over recent sixty years: a corporatist (goal: needs based on universal accessibility), an etatist (restraint of costs), as well as market-oriented programs created to enhance efficiency of the health care provision (Helderman, 2007).

With the end of the World War II, two major systems have dominated the area of health care: the British Beveridge model and the Bismarckian insurance system. The Netherlands adopted the latter, not exactly voluntary, nonetheless it was highly likely the above mentioned model would have been chosen anyhow after the war (Helderman et al, 2014). The Sickness Fund Degree (1941) enforced an obligatory insurance via sickness funds for employees with determined amount of low earnings, and these funds were under the inspection of the state. The after-war benefit package was broader in its scope than the pre-war standards, and expanded the overall coverage of the population, while the ones who were not covered were obliged to obtain insurance in private schemes.

Repetitive conflicts among physicians as well as sickness funds were one of the barriers creating the difficulty for the government to introduce a novel legislation of the health

insurance for around twenty years. Conflicting interests may relate to the benefit barrier - physicians were afraid of losing income. Precisely, expanding obligatory insurance to a larger number the citizens would result in the loss of earnings for the physicians. Thus, they were benefiting from existing institutional arrangements and consequently, unwilling to resign from higher income in the name of novel legislation (Schafer et al, 2010).

The 1964 was eventually a beginning of new changes with the passage of the Sickness Fund Act (knowable as the Compulsory Health Insurance Act as well), coming into force in 1966. Thereafter, the Exceptional Medical Expenses Act was introduced in 1967 (in force in 1968), and this national insurance scheme expanded over the years (Helderman et al, 2014) – Primarily, it was designed to protect citizens from health-connected risks which were not covered by an actuarial health insurance program (Helderman, 2007).

After the World War II, responsibilities regarding such aspects as affordability or accessibility of health care were progressively coming in hands of the state government. Nonetheless, substantial arrangement as well as provision of insurance and health care stayed in the prerogatives of the non-public sector.

Eventually, the danger of drift appeared in the 1970s, with private insurers striving for profit (risk selection). The above-mentioned threat pushed policy makers to introduce the Access to Health Insurance Act (WTZ) in 1986, which ensured legal basis to the risk pool. The WTZ may be considered as one of the most important institutional layers which significantly contributed to the gradual alignment of both non-public insurers as well as sickness funds. Despite leading to the convergence of interests, the WTZ did not ensure the efficiency. More substantial reforms had to be introduced, and were launched by the Dekker and Simons (reformist actor) programs.

The Dekker Committee, created by the Lubbers Cabinet in the end of the 1980's was advising policy makers in terms of introducing reforms. It did not represent the interests of policy stakeholders, but consisted of independent experts. That is why finding the consensus when making proposals was easier. Hans Simons, the State Secretary of Public Health at that time, decided to accept the majority of the Dekker propositions. Thanks to finding backing for reforms (preliminary major political support in the Lubbers Cabinet), Simons predicted to achieve reforms by the end of 1995 (Helderman et al, 2014).

However, the Dekker Plan to introduce market principles in health care as well as its follower, the Simons Plan failed in the end. The barrier to introduce them was connected with the benefiting from existing structures of involved actors and consequently, major opposition to accept the plans in the end. Precisely, employers were afraid of losing costs effects, labor

unions would lose income, while insurers would have limited influence. Simon took a reformist approach, however in the end he did not find enough support from interests groups to pass the proposal in the Parliament (Schafer et al, 2010).

Despite its initial failure, it has to be stressed that some of the adjustments of the plans have been implemented (in the Health Insurance Act and general law on medical expenses). Consequently, the adjustments brought introducing a novel system closer. Therefore, the efforts of Decker committee and Simons did not go into oblivion, and eventually facilitated introducing market-oriented reforms in the long run (Helderman et al, 2014). Since the 1990s, the Dutch health care model went through a gradual process of conversion, changing the role of sickness funds to competing health insurers (Helderman & Stiller, 2014).

Increasing dissatisfaction of citizens related to the dualistic model (public as well as non-public coverage) became a facilitator for change, and finally led to the introduction of the Health Insurance Act, and reforming health care system profoundly in 2006 (Mossialos et al, 2014). Such problems as ‘structural unfairness in terms of contributions due to the income ceiling, a lack of transparency due to different regulations for social and private health insurance schemes and a high level of government interference’ (World Health Organization, 2007, p. 10) hampered the health care development, and caused inefficiency of the system. Long waiting times, lack of proper patient information, and an inefficient dualistic model caused a widespread disapproval with current health policies. In order to face above-mentioned challenges, the separation of mandatory sickness fund insurance as well as non-obligatory private insurance, which had been in existence in the country since the Second World War, was dissolved. One of the changes, brought by the reform, was the new role of health insurers. In accordance with the Health Insurance Act, private entities are responsible for the provision of statutory coverage and operate under public regulations. Their obligation is to enhance the efficiency of the health care system by buying health services in the name of their clients. Since 2006, every citizen is obliged to buy statutory insurance from non-public actors (Schafer et al, 2010; Helderman, 2007).

The Dutch health care experienced the process of gradual institutional change – the mechanisms of layering and conversion. Layering has contributed to lowering initial technical investments, which had to be made to create new institutions. The costs of transition to the novel health care system were predicted to be very high, which influenced the delay in implementation of regulated competition (Daley & Gubb, 2013b) The most recent and profound reform, introduced in 2006, was a result of long-standing planning and discussions for almost forty years. Hence changes were not the outcome of an exogenous, abrupt shock

(Helderman, 2007). In the following table (5.1), the summary of barriers and facilitators is presented.

Table 5.1: Barriers and facilitators of introducing market-oriented reforms in the Netherlands

Barriers	Facilitators
benefiting from existing structures (preferences) – physicians, employers, labour unions as well as insurers unwilling to give up the benefits (losing income and influence after introducing market oriented reforms)	Dissatisfaction of citizens with current health care policy due to lack of transparency, inefficient institutional arrangements of the dualistic system, long waiting times and lack of adequate patient information (in consequence, the concern that reform is unsettling diminished)
Technical costs of implementation (spending financial resources on the transition to the novel market- oriented organization of health care – costs of facilities, administration etc.)	Inefficient institutional arrangements – lack of institutional fit (the danger of drift - private insurance using risk selection) and crisis (the dualistic system malfunctioned and was not approved by the public); endangered sustainability of health care)
Unfavourable political context - decision making structures (opportunities) such as veto of Social Democrats and lack of consensus between Liberals and Social Democrats	Diminishment of the decision making structures barrier (the government was no longer dependent on the corporatist bodies' interests, new governmental coalition without Social Democrats, prior opposing reforms; merger of interests of sickness funds and insurers) and consequently favourable political context
	Reformist actors – Dekker and Simons launched a plan of reforms, which eventually facilitated introducing reforms gradually, step by step

At first sight, it might seem that the Dutch system was resistant to reforms since it took around a decade to implement a system of regulated competition. Physicians, insurers and

employers benefitting from existing structures, technical costs of implementation (related to costs of the transition to the novel system), unfavorable political context (veto rights barrier of Social Democrats and lack of consensus between Liberals and Social Democrats) hampered introducing reform.

However, regulated competition is a very intricate model, and its successful introduction would not be possible in a short time, without advancing such aspects as information for customers or risk adjustment first. Reforms were achieved gradually, without a major political attention. Moreover, another explanation for gradual introduction of the reform was related to conflicting policy aims in the field of health care, which hampered introducing changes as well (Helderman & Stiller, 2014).

The aspects, which facilitated introduction of the reform in 2006 were not only related to the dissatisfaction of citizens with the current health policies, but also inefficient institutional arrangements (Mosca, 2013) strengthen policy makers in belief, that the systemic reform had to be introduced. Additionally, corporatist bodies which represented partisan interests changed their status (did not represent political interests formally anymore) in the 1990s. Consequently, it led to diminishing of a decision making structures barrier – the government was no longer depended to such a major extent on partisan interests when making the decisions regarding reforming the country. Moreover, conflicting interests of sickness funds and private insurers started to concur, and the merger of their organizations into one was launched (Helderman & Stiller, 2014).

Furthermore, in 2002 a new governmental coalition was created (without Social Democrats), which led to the diminishment of the decision making structures, and paved the way to introducing solutions, previously unaccepted for the Social Democrats. The window of opportunity to push for change opened because of political developments – precisely, changing coalition and weakening political influence of Social Democrats. The Minister of Health – Hans Hoogervost acted on the moment to push for changes, and established a new legislation program, which finally succeeded. The eventual replacement of the furcated system in 2006 by the new health insurance system may be called a systemic reform, and has been facilitated mostly by an encouraging political context (Helderman & Stiller, 2014)

In conclusion, the transformation of the health system in the Netherlands is characterized by the absence of substantial shocks (with the exception of introducing obligatory sickness fund scheme, enforced by German government), but by the institutional adjustment and gradual change. In general, radical and abrupt reforms were impossible to achieve. The three waves which were visible during the evolution of the Dutch system were

firstly reforms until 1968 (with the introduction of the Exceptional Medical Expenses Act), then a second wave with the focus on addressing cost restraint matter (until the middle of the 1980s), and eventually the last wave which started about 1986, and related to the introduction of the Access to Health Insurance Act (Helderman, 2007).

In order to grasp proper comprehension of these gradual changes, it is essential to understand the importance of interrelatedness of public and private actors and their interests, also knowable as ‘corporatist’ orderliness (Helderman, 2007). All involved actors had a major impact on the development of the path of the Dutch health care system, which ‘is marked by deeply institutionalized interdependency between the state, private providers and insurers, which could only be made effective through a practice of negotiated agreements and co-governance’ (Helderman, 2007, p.191-192). Hence, not only the national government, but also non-public actors share common responsibilities with respect to the governance of the Dutch health care arrangements.

One might ask, what was the effect of above-mentioned institutional arrangements? Regulated competition fundamentally altered the relations of the actors in health care. The negotiations regarding price, volume, as well as quality of treatment may be negotiated among health insurers and providers on a purchasing market. The offers regarding treatment are presented by providers on a health provision market (Schafer et al, 2010). Moreover, the introduction of the reform led to shortening of the waiting times, improving accessibility and patient information (Mosca, 2013).

It is probably too early to judge the real efficiency of the Dutch reforms in health care, where the success would prove that competition driven alterations increase the efficiency and sustainability of health care. Nonetheless, there are certainly already positive implications of the reform. According to the Dutch Healthcare Performance Report, the accessibility of services, as well as the satisfaction of citizens with the received care has improved substantially since the reform was introduced (Hady & Leśniowska, 2011). It took over a decade for the Netherlands to implement the reform in 2006, which led to the decrease of costs and enhanced efficiency. One may only hope that the successful introduction of gradual institutional changes in the Polish health care system, which would lead to its improvement, will not take such a great deal of time (Pajewska, 2010).

5.2 Characteristics of the Dutch model - regulated competition

The Dutch health care system belongs to the Bismarckian model, with a social health

insurance system, however it differs from German arrangements to some extent (Helderman, 2007). The system consists of the three following compartments: long-term care, basic care, as well as complementary care, and is characterized by the universal coverage (Daley & Gubb, 2013b).

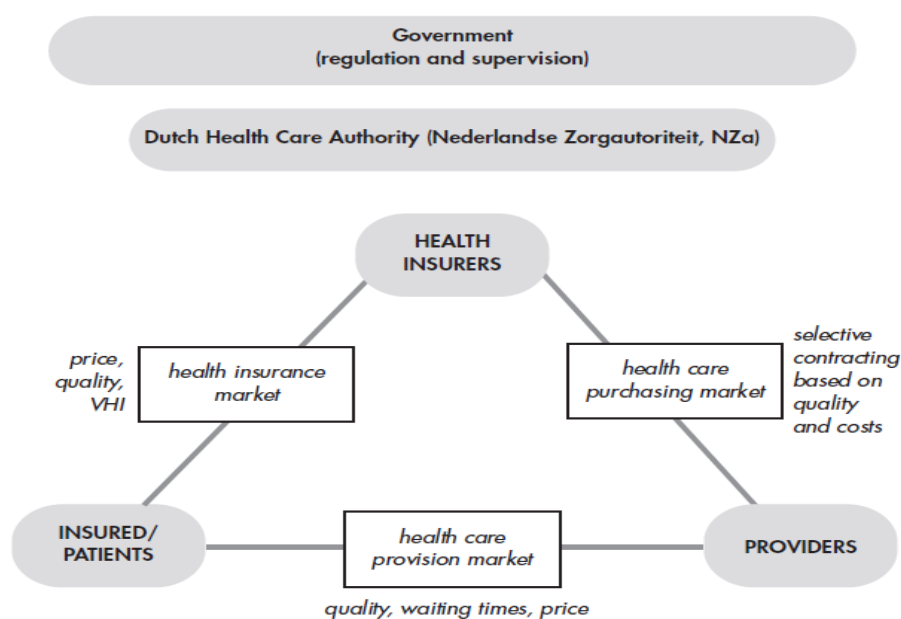
The universal health care coverage has been introduced over insurance market, aiming at competitiveness and the focus placed on patients, instead of a mainly government-guided system (as for instance in the United Kingdom). Hence, despite the government having a regulatory role in the system, which comprises monitoring as well as assuring the proper quality and safeguarding the universal health care provision, the government has no more prerogatives in terms of managing the superiority of funds. In addition, it does not keep control over volumes, rates, as well as production capacities, but oversees the processes from the distance (Daley & Gubb, 2013b). 'Instead of central command therefore, it is patient demand that is designed to drive quality of care, the end result being a health care system based on the principles of durability, solidarity, choice, quality and efficiency' (Daley & Gubb, 2013b, p.2). Hence, in terms of institutional context and level of discretion, the government stays in the distance and relies on non-public actors regarding the provision of service and insurance. A corporatist decision-making structure characterizes the Dutch system, where various actors (such as insurers and providers) have a say in the legislation of health care policies and the implementation procedure (Helderman & Stiller, 2014).

Regarding the Dutch political context, it is characterized by a multiparty system and it is practically impossible for one party to have an absolute majority. Therefore, the government is composed of the coalition of multiple parties. Expect the veto possibilities, reaching the consensus inwards the coalition is of great importance. Thus, the feasibility of reforms is influenced not only by veto possibilities, but also intra-coalitional, dynamic relations (Helderman & Stiller, 2014).

With regard to the relationship between purchasers and health care providers, it is managed by contracting. Thus, providers are characterized by their independence, while insurers bind them with the contract. Regulated competition has been gradually implemented on the purchasing market since the reform in 2006, with the insurers slowly building their experience in roles of purchasers. The negotiation tools in hands of insurers, with respect to remedial care, are large. Prices, volumes, quality of care, as well as selective contracting are one of them. The goal of such negotiations is to provide not only efficient service and care, but also to eliminate providers with poor quality care (Scharpf et al, 2010). Moreover, complete transparency during negotiation is a requirement, as well as every actor taking part

in negotiations is obliged to obey the same terms with respect to made arrangements (World Health Organization, 2007). With the involvement of citizens, above-mentioned actors have become market players, operating on three sub-markets – insurance, provision, as well as purchasing market, while the purchasing process and its principles are determined in the Health Insurance Act (van Ginneken, Schafer & Kroneman, 2010). Figure 5.1 reflects the relations on above-mentioned health care markets.

Figure 5.1: Health care markets in the Dutch model



Source: Van Ginneken, E., Schafer, W., Kroneman, M. (2010). Managed competition in the Netherlands: an example for others? *Eurohealth*.

With respect to the health care provision market, there have been no drastic alterations between 1990 and 2009. A physician is the first instance to which the patient is supposed to go in case of health problems, and if necessary, directed to secondary or another primary care. A number of minor alterations with respect to provision of health care, introduced in above mentioned period, include such examples as the appearance of independent treatment centers as well as multidisciplinary outpatient centers (Schafer et al, 2010).

The obligatory primary health insurance is financed in the following manners – firstly, individually - every citizen is obliged to pay income-connected contributions, transmitted to the Health Insurance Fund. Additionally, citizens with low earnings may receive tax credits. The primary health insurance is delivered by fourteen large, competitive, and non-public profit firms together with a number of subsidiaries (Browne, 2012).

The reform of the Dutch health insurance is, from a comparative view, an interesting

case of a policy learning. Examples of practices introduced in the Netherlands (for instance obligatory coverage for every citizen) are also visible in the Swiss health insurance model.

Moreover, soon after the establishment of the reform, German scholars and policy makers started having an interest in the novel arrangement of the Dutch model. In order to clarify the conception of the reform, various Dutch experts (among others, the Minister of Health) were sent to Germany and consequently, certain aspects introduced by the German reform in 2007 were parallel to Dutch solutions (amongst others, emergence of a central fund in order to accommodate resources to insurers). Nonetheless, there is one significant difference between those two models. In contrast to Switzerland as well as the Netherlands, the German system has kept a discretionary division between social and private insurance (Greß, Manouguian & Wasem, 2007).

In conclusion, a significant lesson drawn from the Dutch example is that the introduction of regulated competition is a very long-standing and intricate process, which has begun in the beginning of the 1990s, and is still going on nowadays (van Kleef, 2012). Achieving a ‘health care system in which incentives for efficiency are combined with universal access to good-quality care’ (van Kleef, 2012, p.171), demands not only a great deal of effort, but also a fulfillment of important preconditions, elaborated in this section – amongst others, effective market regulation, competitiveness of the market and freedom to negotiate.

The Dutch health organizational model seem to seem to be structured in an efficient manner. Nonetheless, the system did not escape from facing certain challenges, which will be elaborated in the following section.

5.3 Challenges and solutions

Despite its remarkable performance, the Dutch health care system is certainly not flawless. All European countries are facing similar challenges with respect to, on the one hand, providing effective, high quality care and on the other, keeping low costs (Perleth, Jakubowski & Busse, 2001). The achievements with respect to Dutch health care arrangements are without doubt acknowledged, however there are also urgent challenges, which need to be addressed.

Questions troubling policy makers in different countries are the same: What to do to control growing costs? (van den Berg et al, 2010), how to provide high quality health care as

well as long term services, and be cost-efficient at the same time? (Schut, Sorbe & Hoj, 2013). Hence, which institutional arrangements will be helpful in addressing burning problems (Scharpf, 2000). In order to counter above-described challenges, the Dutch government adopted a model of regulated competition aimed at increasing efficiency of health care, decreasing the side effects of market driven rules, as well as the protection of citizens against them (van den Berg, 2010).

The aspect of universal accessibility is reached via not only instructing every citizen to obtain private insurance and wide coverage (for instance primary care or inpatient as well as outpatient hospital treatment), but also through subsidies for citizens with low earnings and risk equalization. The latter relates to compensations for health insurers with respect to predictable loss (for instance, aged consumers) and benefits (for instance, young, healthy consumers). Moreover, such solutions as free selection of health care planning for customers, as well as selective contracting have been introduced. The presence of such arrangements resulted in enhancing the efficiency and consequently, creating a proper base for competition-driven market (Van Kleef, 2012).

The reform introduced in 2006 has not addressed all the burning challenges yet. A number of short term financial issues demanded attention at hand, such as the overfunding of hospitals, caused by overabundant tariff. According to the opinion of the government commission from 2010, the system was still settled in between centrally organized as well as market-oriented model, which resulted, on the one hand, in hampering the state to control the costs and on the other, insurers from becoming cost-efficient buyers of health care (Schut, Sorbe & Hoj, 2013). ‘Health insurers had insufficient incentives because of the still prevailing substantial ex post compensations and a lack of adequate instruments because of remaining government regulation of prices, supply and entry in various sectors’ (Schut, Sorbe & Hoj, 2013, p.21). Moreover, the absence of such arrangements as the proper system of product qualification as well as shortage of publicly accessible indicators of performance, caused by deficient information framework, only intensified the scale of problems (OECD, 2010; Schut, Sorbe & Hoj, 2013). In order to face these challenges, policy makers have been working on a number of reforms aimed at enhancing the strength of market forces with respect to provision of health care, and ensure cost restraint (in specific, regarding hospitals) (Schut, Sorbe & Hoj, 2013).

Introducing the risk equalization system helped to solve the challenge of risk selection, nonetheless it is still not sufficiently well designed. In order to increase effects of the above-mentioned arrangement, establishing new adjusters is needed. Its presence would decrease

motives for risk selection, and safeguard equal as well as universal access to high quality health care (Van Kleef, 2012).

Moreover, competition on the health care market may result in unwanted side effects. In order to prevent them, the authoritative body – the Dutch Healthcare Authority, created in 2006, has been given the right to inflict sanctions on entities which gained major power on the market as well as impose regulations (in terms of tariff and performance) (Van Ginneken, Schafer & Kroneman, 2010). The Health Care Inspectorate has an important role as well in monitoring and safeguarding the quality of health care. When it comes to the merger of health organizations, the decision has to be approved by the Competition Authority, which can also inflict financial sanctions on merged organizations with improper interests (such increasing prices). Hence, monopolization is one of the threats which cannot be neglected (Daley & Gub, 2013b; Van Ginneken, Schafer & Kroneman, 2010).

Another important challenge had to be faced by policy makers in order for regulated competition to function effectively, and was connected to the patient information. Citizens are thought to make informed decisions when it comes to choosing providers. It cannot be done without arranging adequate, credible, and widely available information. There have been a number of actions taken through internet websites, to improve the clarity and transparency of care. Nonetheless the system is still not complete (Van Ginneken, Schafer & Kroneman, 2010).

Recently, additional steps have been taken to enhance the competition between health providers as well as insurers. One of such initiatives was introduced in 2011, and related to the abolishment of the ex-post risk adjustments, aimed at limiting the fiscal risk of insurers. Moreover, under very rigid rules, some hospitals have a right to serve for profit (Daley & Gubb, 2013b).

The implementation of regulated competition in the Dutch health care system has brought major transnational attention, and became a source of inspiration as well as recommendation for other countries. Nonetheless, introducing the reform would not have been achieved without its price. Health care spending has significantly grown at the expense of obtaining positive results, and in 2012 the Dutch expenditure reached one of the highest levels among the OECD group (Browne, 2012). Constantly growing costs of health care (as in many other Western countries) are becoming a serious threat for the Dutch public finance.

The solution, which was considered by the government in order not to lose the support of electorate and avoid the decrease in the quality of health care, was to slow the pace of implementing reforms. However, it has not brought significant changes – recent analysis of

the Central Planning Office indicate that the costs are continuously growing, while health care is becoming a larger and larger bargain for the budget. The Central Planning Office is warning – if the pace of increasing costs is not slowed, the expenditure on health care will exceed thirty percentage GDB by the end of 2040. It means that the percentage which average household spends on health care will double. The reason for this increase of costs is believed to be related to, amongst others, the problem of the ageing Dutch society and an introduction of new technologies.

The above-described challenge has been a very topical subject in the Dutch public debate during recent years. Politicians are struggling to create a proper solution since 2010, which on the one hand would reduce health care expenses and on the other, keep the political stability and quality of care – which proved to be difficult to reconcile. Hence, political costs are high in this case. Such solutions as the gradual increase of pension age (till 67 years) to solve the problem turned out to be very controversial in the eyes of the public. According to experts, it will take a number of additional years before health care expenses will stop posing a threat for the stability of the Dutch national budget, while nowadays keeping political balance and quality of care becomes one of the highest priorities (Economist Intelligence Unit, 2013).

In conclusion, experience and time has shown that regulated competition reforms have not been only time-consuming and complex, but also that in order for successful implementation of regulated competition in health care to work, such aspects as consumer information, transparency, safeguarding of the market, as well as preventing risk selection is crucial. The arrangements, which have been introduced to solve the above-mentioned challenges have been majorly fulfilled. Hence, they were effective - however, not entirely. The most burning challenge of growing expenses on health care has yet to be addressed, and governmental proposed solutions have not been widely accepted. Moreover, additional developments are necessary in order to face such challenges as quality indications and cost-efficiency. Despite the fact that since the introduction of regulated competition in 2006 there have been positive results visible in the functioning of the Dutch health care system, some effort still has to be made for its improvement (van Kleef, 2012).

5.4 Conclusion

The Dutch health care model has been a pride for the country, while its model of regulated competition can provide a source of inspiration for others as the best practice in Europe

(Health Consumer Powerhouse, 2014). Transfer of experts' knowledge from the Dutch, benchmark practice would be certainly precious, nonetheless treating the practices as a blueprint and a perfect solution for the Polish system, is certainly incorrect. Poland, as a post-communistic country, has a completely different historical background than the Netherlands, which consequently results in not only the cultural and mental differences of the civil society (Catholicism, communism, corruption leading to lack of trust), but also in the wealth of the state. Hence, the direction of changes are conditioned by such factors as the political system, mentality of people, the economic conditions, as well financial situation (Pieprzyk, 2013).

The focus of this chapter was placed on the analysis of the Dutch health care system, and proved that the path to successful implementation of a model of regulated-competition is a long-standing process of gradual adjustment, not an abrupt reform. Moreover, the analysis not only provided insights of the Dutch organizational structure, challenges, and solutions introduced to counter them, but will also contribute as a reference point, during investigating the Polish health care arrangements in the following chapter.

6. The Polish system

The aim of the following chapter is first to elaborate on challenges in Polish health care and institutional arrangements introduced to counter them. Subsequently, in order to grasp how institutional legacy conditioned the present challenges, the historical background with different mechanisms of change will be analyzed. Furthermore, barriers hampering reforms in Polish health care nowadays will be discussed. Moreover, with the reference to the Dutch reform of regulated competition, the extent to which the preconditions of regulated competition are fulfilled currently in Poland will be examined. The last section will be focused on distinguishing potential facilitators that enable change.

6.1 Challenges and solutions

The balance of accessibility, efficiency, and sustainability is not only a priority for most countries, but also characterizes well-functioning health care systems (Euractiv, 2014). Unfortunately, it cannot be said about the Polish health care system, struggling with various challenges and problems to a much larger extent than the Dutch system. Without doubt, too long procrastination in regards to reforming health care has resulted in many negative consequences, and the changes in the system are necessary (Kubów, 2013). Nonetheless, changes do not guarantee achieving success, since all countries struggle with problems in the health care system nowadays (Kurowska, 2010).

The underfunding of health care in Poland is currently one of the most burning and topical challenges. The fulfillment of health care priorities demand bearing technical costs, related to, amongst others, taking financial investments. That is one of the reasons for the continuous increase of health spending in many European countries, including the Netherlands. On the contrary, constant lack of financial resources for health care in the Polish budget enforces taking various cost-restraint initiatives, which not only consequently negatively effects above-mentioned sector and does not diminish expectation costs, but also poses a barrier for its improvement (Kubów, 2013). There is a growing need for increasing expenditures for health care, due to ageing society and development of new technologies. Without addressing this challenge, further improvement of health care is hampered (Janczewska-Radwan, 2015).

According to T. Podsiadło (personal communication, May 27, 2015), in order to address the problem of underfunding of health care, one of the feasible solutions would entail

increasing the health care contribution rate which Polish citizens have to pay. The contribution rate equals nine percent, while for instance in Germany, it is over fifteen percent. The absence of such an arrangement causes a significantly smaller amount of money in the budget to be spend on health care, and provides the answer to the second question in the problem-oriented perspective. Furthermore, the reason for the arrangement in such a manner nowadays in Poland, is connected with the fact that citizens are not willing to pay a higher tax contribution and consequently, that effectively keeps politicians from increasing it. According to Marek Balicki, the former Minister of Health Care, the reason for unwillingness of citizens is interrelated with another problem – dissatisfaction with the functioning of health care, and the belief that the additional money would go to waste (Zadrożna et al, 2015). Moreover, because of communist roots (mentality of the nation), people are not willing to pay additionally for health care services, since during the communist regime health care “officially” was for free (Sagan et al, 2011).

Many public hospitals struggled with the challenge of ineffective financial management, causing building debts. The arrangements which were proposed to address it related to the privatization of hospitals – however, due to a heavy opposition, the process took place only partially (Sagan et al, 2011).

Not only satisfaction of Polish patients, but also their trust regarding doctors and the quality of treatment they receive, is very low. Decreasing trust is caused by various missteps, taken by professionals. A feasible solution to address this problem would be connected with improving the control system which would not only protect citizens, but also hold involved actors accountable. Its lack causes a malfunctioning coordination of the health care system (S. Manulik, personal communication, May 22, 2015).

Long waiting times and consequently, limited accessibility of service, is another very important challenge for policy makers, and as the above-mentioned challenge, it has not been addressed by the Polish government successfully. The absence of efficient arrangements, which would solve the issue, is related to deficient funding of the health care system as well as weak coordination of citizens’ treatment (Boulhol et al, 2012). Due to the lack of proper computerized database of patients, citizens sign up for the same health procedure in a number of facilitates and consequently, not only take spots for others, but also deepen the problem of long-waiting times. Moreover, patients do not suffer any consequences concerning cancelling visits, and therefore there are no financial incentives, enhancing patient responsibility for their actions (B. Hawro, personal communication, June 2, 2015).

However, some of the challenges have been tackled and with a positive effect. In order

to improve transparency of the system, a number of initiatives have been taken concerning such aspects as the provision of adequate information or corruption. The NFZ has started to provide more comprehensive information regarding, for instance service provision or insurance. Gradually, the development of information system for patients has been going in the good direction during recent years (B. Hawro, personal communication, June 2, 2015). Moreover, a number of measures against corruption were implemented, mainly with respect to financing matters such as out of pocket payments (Sagan et al, 2011).

In conclusion, initiatives and institutional arrangements have been launched to address certain challenges such as transparency, patient information, or corruption. Regulations and informatization had a positive effect on addressing them – increased transparency, more adequate information and more limited corruption. Nonetheless, there is still a substantial number of challenges, which were either addressed ineffectively or not addressed at all, due to various barriers.

Without doubt, there are many challenges faced by the Polish health care system nowadays, and it seems that the most burning one is the underfunding of health care. It not only prevents achieving high quality of health care, but also negatively influences citizens' attitudes (Sagan et al, 2011). It is an extremely difficult problem to tackle, since the economy of the country conditions the development of health care (Janczewska-Radwan, 2015). It is necessary to increase financial resources in order to address also other problems, for instance long-waiting times or indebtedness of health care institutions. However, a feasible solution is yet to be found.

Table 6.1: Challenges of Polish health care system in comparison to the challenges faced by the Dutch system

Similarities	Unique challenges for Poland
Sustainability and efficiency of health care at affordable costs	Underfunding of health care – Lack of financial resources
Transparency of the system and patient information	Dissatisfaction of patients; lack of trust
The demand for increasing health expenditures	Long waiting times; accessibility of service
Effective market regulation & coordination	Corruption
	Low assessment of the quality and effectiveness of treatment

Compared to the Dutch system, there are some similarities and differences between challenges faced by both models, which are presented in the above table (6.1). The effect of arrangements introduced by the Netherlands – regulated competition with market-driven instruments had a positive effect on keeping the sustainability and increasing the efficiency of health care. For Poland, except underfunding of health care, it has been one of the largest struggles nowadays. The following table, provides not only knowledge of disparities and commonalities in terms of faced challenges, but also compels to reflection about the (lack of) efficiency of the Polish institutional arrangements.

6.2 Historical background

In order to grasp the source of challenges elaborated in the previous section, institutional legacy and historical background, conditioning policy challenges, have to be introduced. Over the years, scholars from various areas of science (including law, economics, and psychology) have been conducting research on the Polish health care system. The reason for such a large interest relates to the fact that the above-mentioned system has been a subject of major changes, as a result of the political transformation of the country in the 1990s (Szelemej, 2009; Pieprzyk, 2013).

Under the communist regime, policy inheritance as well as decision making structures, were one of the main barriers hampering introducing any changes. The government was supposed to follow a specific policy, imposed by communists, holding power in their hands, and actively blocking any political or social initiatives. The system was called ‘democratic centralism’ to create the illusion of democracy in Poland, however in reality the full legislative power was held in hands of the Communist Party. Despite official changes in the government, in practice there was one ruling party imposing policies, which consequently created policy inheritance barrier. Precisely, The *Sejm* was forced to follow Soviet health care policy (heavily centralized model of health care) for over 50 years (from 1948 till 1989), and consequently there was no leeway to push for changes for a half century (Davis, 1996). Until 1990s, there were few prospects for institutional reforms, while without proper facilitators, systemic transformation would not be possible to achieve. The events that triggered the opening of the window of opportunity and reforming amongst others, the health care system, were not only related to the transformation of a political system, but also subsequent

deepening integration with the European Community (Sowa, 2001; Karpińska, 2002; Hejnicka-Bezewińska, 2000; Domowicz 2014).

Precisely, the window of opportunity has opened in this case due to two major political developments. Firstly, with the introduction of pluralism on the political arena, the barrier of decision making structures and policy inheritance has diminished. The political system has been transformed into a democratic multiparty state, hence the Communist Party had no longer possibility to veto any legislative initiative, while the new government was no longer enforced to follow Soviet policies (Sowa, 2001). In addition, forthcoming alliance with the EU and NATO has created a major incentive to introduce reforms in diverse sectors. After the fall of communism, Poland strived for joining the Western elite, but the fulfillment of certain conditions was required. Therefore, in order to meet the European standards and consequently, join the alliance, the motivation for reforming the country was justified in the eyes of public and politicians. Both of above-mentioned political and international oriented developments led to the diminishment of decision-making structures, and opened the window of opportunity to push for systemic reforms (Domowicz, 2014; Sowa, 2001).

Systemic transformation has had a great impact on all structures of the Republic of Poland, amongst others health care. The events, which enabled the transformation of the political system and consequently, gradual changes in health care, have contributed to opening a macro window for change.

The reform strategy contained four significant systems – administration, pension, education, and health care. The governmental decision to transform above-mentioned areas was circumstantiated by systems' inefficiency, and a burning desire to meet international standards (Szelemej, 2009; Pieprzyk, 2013). The transformation of the health care system and other sectors in 1999 was also possible thanks to the empowerment mandate, which was used by Jerzy Buzek after winning the elections and becoming the Prime Minister of Poland (Szalkiewicz, 2013). Precisely, Solidarity Electoral Action (AWS) won the elections, and received over 200 mandates in the *Sejm* as well as over 50 in the *Senat*- hence, received the majority in the Parliament. That event resulted in the creation of the new cabinet, at the forefront of Jerzy Buzek, and opened the opportunity to act (window opened by elections). Thus, Jerzy Buzek was an entrepreneur who was able to push for reforms when the window of opportunity opened – without the elections and consequently the mandate to act, he would not have pushed reform proposals through (Sowa, 2001). His reformist approach led, in consequence, to the introduction of the package of reforms, and could not be achieved without public and political support – henceforth, creating allies on political arena as well as the

approval of electorate were very significant in the whole process of reforming the country in the 1990'.

The research on the subject reflects that before the outbreak of the Second World War, Eastern health care systems were based on the Bismarck model, similar to the Netherlands. Nonetheless, during the communist regime, Polish health care became an example of the Semashko model – titled after the Russian Commissioner of Health (Marree & Groenwegen, 1997; Pieprzyk, 2013; Kulesher & Forrestal, 2014). It was characterized by strict control of all health care arrangements, exercised by the central government. With respect to the provision of health care, citizens had practically no choice when looking for service. The expenditure on health care was very low and neglected in comparison with Western countries, which consequently resulted in the creation of an extremely inefficient and ossified health care system (Kulesher & Forrestal, 2014; Pieprzyk, 2013).

Along changes in the 1990's, the above-mentioned model of management was abandoned and 'the public health infrastructure was rebuilt according to international standards' (Bell, 2014, p.1). After the collapse of communism, Eastern countries were considered to have a Bismarckian social insurance arrangement. The collapse of communism and systemic transformation altered, amongst others, the manner of financing of health care.

Instead of the budget planning, an obligatory health insurance was introduced, subtracted from salaries of employees and employers. The mechanism of displacement became visible, while, before implementing gradual changes in 1989, the central government was responsible for funding largely hierarchic model. A common characteristic for displacement is adopting foreign traditions and practices (Streeck & Thelen, 2005), which has also been taken into account, while creating four sectors' reform plans - to meet international standards (Pieprzyk, 2013).

The critical juncture perspective is an unarguable frame of reference in terms of the transformation from the communist regime to a democratic state, nonetheless it reflects an oversimplified understanding of institutional change. Change in the manner of financing of Polish health care can be considered as radical, but other kinds of gradual change may be determined in the process as well (Sitek, 2010).

The ossified Semashko model has been reestablished as a decentralized structure with an obligatory health insurance, supplemented with local as well central budget funds. The main goal of reforms implemented between 1991 and 1998 was related to decentralization of the system, development of non-public medical practice, as well as improving the framework of national health providers.

In the end of 1999, local self-government units (*gminy, powiaty* and *województwa*) were restored, and given a large share of ownership of the majority of health care facilities which initially belonged to the Ministry of Health (Sagal et al, 2011; Taberning & Schanckenberg, 2011). Hence, conversion has been visible after the reform, and was mainly connected to the attachment of new goals as well as redirecting functions of self-local government units (S. Manulik, personal communication, May 22, 2015). To be precise, given responsibilities connected with creating strategic plans regarding health policies on the given territory, promotion of health care, as well as instituting, and controlling public health care centers. Due to changed circumstances (systemic transformation), existing regulations were redirected (Dercz, 2012).

The policy drift could be found in post-communist Poland as well. Informal payments were a very popular form to receive services, and supported the creation of informal institutions. The reason for its survival, even after the systemic transformation in the 1990s', was mainly related to a very low and neglected enforcement of laws. Such a manner of informal advancement resulted in a 'change without reform' (Sitek, 2010), revealed in an intense growth of private financing of health care (Sitek, 2010).

One of the most visible examples of displacement is the dismantling of Sickness Funds, and its replacement with a completely new institution. (Sagan et al, 2010). To be precise, the system decentralization was based on the principle of devolution and creation of sixteen regional Sickness Funds, which in 2003 were replaced by the National Health Fund (Boulhol et al, 2012).

In conclusion, from chronological view, gradual changes which have fundamentally altered Polish health care arrangements may be distinguished by three periods of time: before the outbreak of World War Two, after its end, as well as afterwards the systemic transformation in the 1990s (Pieprzyk, 2013). The mechanism of radical displacement was put in place in 1999, when the major, systemic reform was introduced in the country that led to the transformation of not only the whole political system, but changes in the health care system. New structural arrangements in four sectors – public administration, pension, education, and health care system were established. The political transformation in Poland is an example of major change, which represents the classical punctuated equilibrium perspective. Nonetheless, reforming Polish health care has been a long-standing and gradual process with some episodes of large, legal alterations, instead of a single and abrupt phenomenon (Sitek, 2008). The inherited, ossified institutional settings have been majorly

rebuilt, based on the careful selection of international reform logics and ideas, for instance a partial implementation of market instruments in the health care sector (Sitek, 2010).

6.3 Organizational structure

In consequence, the current state of the Polish health care has been established as an outcome of a number of gradual reforms which took place between 1989 and 2004 (Boulhol et al, 2012). In compliance with article 68 of the Constitution of the Republic of Poland (1997), everybody has equal right to health services independently from their financial status. Other statutes and ordinances which regulate the arrangements of the Polish health care system with respect to its provision are: the Act On Health Care Services financed from public funds (regulating such aspects as conditions, range of service provision and the legal rules how the National Health Fund is supposed to function), the Health Care Institutions Act (regulations regarding establishing and functioning of health care bodies), as well as regional government legislation, which dictates the functioning of subnational (local as well as regional) health care structure (Magda & Szczypiński, 2011).

Extensive regulation is an aspect which characterizes the above-mentioned sector. Such matters as the conditions of service delivery, financing of health care, or a functioning of providers are firstly determined by the Ministry of Health, which submits a draft of proposal to consultations of various experts and eventually to the Parliament. After the approval of a draft, the Ministry of Health issues proper executive regulations determining which institutions are liable to implement the law. The aspect of a monitoring as well as an assessment is poorly advanced in the system. There are different supervisory institutions (for instance, the Chief Sanitary Inspectorate), nonetheless its coordination is insufficiently organized (Sagan et al, 2011).

The role of the Ministry of Health has been gradually growing since the end of the 1980s, ‘from health care funder and organizer of health care provision to health policy-maker and regulator’ (Sagan et al, 2011, p.19). The institutions, except the Ministry of Health, which hold decision making prerogatives as well management and financing roles, are the National Health Fund and territorial self-government units (Taberning & Schnackenberg, 2011).

The Polish health care system is, similar to the Netherlands, characterized by mixed financing – including public and private funds. Obligatory insurance contributions constitute a large resource of the financing of health care (it is impossible to resign from it) and are gathered by two intercessory institutions – The Agriculture Social Insurance Fund and The

Social Insurance Institution. It is in The National Health Fund's hands to generally plan and allocate financial means. The state-owned budget, local governmental units' sources, and private funds contribute to financing the health care system as well. This applies mainly to the sector of public hospitals, contrary to non-public entities operating under market conditions (Hady & Leśniowska, 2013; Sagan et al, 2011).

Private additional health insurance is functioning on a much smaller scale. According to reports prepared by the Polish Chamber of Insurance in 2013, merely 400 000 Polish citizens obtained private health insurance. This constitutes less than a half percent of total expenditure on health care. Individuals obtaining private health insurance are characterized by a high level of income (Balicki, 2013).

The National Health Fund (NFZ) is responsible for making contracts with health service providers, and financing the service from social contributions scheme (Taberning & Schnackenberg, 2011). Hence, it has the possibility to conclude agreements with providers, relating to such aspects as range of services and prices. In reality, instead of negotiating agreements, the Fund as monopolist enforces the scope of the contract as well as the price with providers. That is why, despite the freedom for providers to make agreements, in practice they are forced to contract with NFZ as it is the sole third-party payer (Więckowska, 2010).

There is a number of institutions responsible for the supervision of health care providers, including the Minister of Health (general) and the NFZ (contracts) (Sagan et al, 2011). 'A primary care physician is usually the entry point to health care services in Poland and a referral from a primary care physician is needed to access specialist care' (Sagan et al, 2011, p.122), which is also organized in a similar manner in the Netherlands.

In terms of health care provision, it is also significant to mention that health care services may be obtained in the commercial manner as well. The main difference is that such services are not financed by the state budget, but voluntary and direct payment of patients or supplementary private insurance, which particular patients possess (Pastusiak & Krzeczewski, 2012).

In conclusion, despite the fact that the Netherlands is considered to have the best health care system in Europe, while the Polish one is assessed as one of the worst in the ranking, the Polish system shares some similarities in its organizational structure with the above-mentioned benchmark model. It is difficult in case of both systems to give a strict label to which fundamental models they belong. The differences become blurry when various types of solutions, drawn from other countries (Pastusiak & Krzeczewski, 2012), are introduced and

lead to creating so called ‘hybrid health care systems’ (Schmid et al, 2010). Mixed financing is one of the similarities shared with Dutch exemplary model as well. Furthermore, universal coverage is a principle acknowledged by both models (Pastusiak & Krzeczewski, 2012). ‘However, the limited financial resources of the NFZ mean that broad entitlements guaranteed on paper are not always available’ (Sagan et al, 2011).

Except above-mentioned limited financial capacity, the Polish model also significantly differs from the Dutch organizational structure. Firstly, there is a fundamental difference in the manner in which the institution of the payer is organized. In Poland, the sole and monopolist payer is the National Health Fund, while in the Dutch benchmark case, there is also a competition between a number of payers. Moreover, Dutch patients have a possibility to choose the payer, while in Poland such a choice does not exist – the choice of the NFZ is enforced (Pastusiak & Krzeczewski, 2012).

Table 6.2: Polish health care organizational structure compared to the Dutch model

Similarities	Differences
<p>Universal coverage</p> <p>Mixed financing</p> <p>Provision of health care - primary care physician as the general entry point to health care treatment</p> <p>No strict label of the model</p>	<p>Accessibility of health care</p> <p>Organization of the institution of the payer</p> <p>The degree of competition and negotiation on the market</p> <p>(Lack of) freedom to choose the payer</p> <p>Historical conditioning of the model</p> <p>(Low/ high) expenditures for health care</p> <p>(Lack of) adequate financial incentives</p>

The above table (6.2) summarizes both similarities and differences between the Polish and the Dutch model. As we can see, there are substantially more disparities which divide Polish and Dutch health care. This summation also clearly reflects some sources of the inefficient functioning of the Polish model – for instance, low expenditures for health care and a historical conditioning of the health care system.

In the following section, the extent to which the preconditions for the successful implementation of regulated competition are currently fulfilled in the Polish system will be elaborated. The analysis will not only help to distinguish in which aspects the Polish system fall behind in reference to the Dutch one, but it will also reveal more disparities between the two models. As a result, it contributes to the understanding of reasons for an indubitable difference with respect to efficiency and performance of both health care systems (Pastusiak & Krzeczewski, 2012).

6.4 Preconditions for regulated competition – feasibility of Dutch reforms for Poland

In order for the Dutch market-oriented reforms of regulated competition to be feasible for Poland (or other countries), essential preconditions have to be fulfilled. Looking at the benchmark model, we can come to the following technical preconditions: efficient regulation of the market, transparency, insurers' freedom to negotiation/contracting, freedom of consumers' choice regarding insurers, financial incentives, contestableness of the market, and risk equalization (Van Kleef, 2012). Its recent degree of fulfillment will be analyzed in the Polish health care system with a reference to the Dutch model.

Above-mentioned aspects are necessary, nonetheless not sufficient for a successful and effective implementation of regulated competition. Thereupon, other facilitators or barriers may wield influence on achieving above-mentioned goal, and will be taken into consideration during analysis in the next section as well (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010).

Firstly, in order to ensure such matters as a proper degree of competition, protection of consumers, quality of health care, as well as financial soundness of insurers, adequate regulation of the market is crucial. In case of the Netherlands, such bodies as the Competition Authority, the Quality Authority, the Solvency, or the Consumer Protection Authorities uphold the duties with respect to safeguarding above-mentioned matters. In Poland, the bodies which are supposed to fulfill similar responsibilities are, amongst others, the Office of Competition and Consumer Protection, the Financial Supervisory Body, the Ombudsman of Insurance, or the Health Technology Evaluation Authority. Nonetheless, the feasibility of that condition is not fulfilled. Except the Health Technology Assessment Authority, other bodies do not possess adequate experience in addressing health care problems (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010). According to S. Manulik (personal communication, May 22, 2015), even the Health Technology Assessment Authority does not function very well - there is a lack of the effective measurement in practice regarding the costs of technological inputs and its possible effects.

Secondly, transparency in terms of products is essential for consumers to make comparisons between various insurance offerings. Moreover, transparency of medical products ensures the possibility for providers and insurers to negotiate and agree on a proper price as well as quality indication. Improvements in the Dutch model regarding above-

mentioned aspects were introduced, for instance by the Diagnostic Treatment Combinations (DTC) classifications. Nonetheless its revised version was necessary further on, due to drawbacks of its primary design. In case of the Polish health care system, the legislator holds responsibility for determining the spectrum of cover, while the Health Technology Assessment Body deals with the procedure with regards to qualifying health benefits. Nonetheless, statutory determination of the scope of benefits, as well as establishment of the Assessment Authority is not enough to state that the transparency condition is fully feasible in the Polish health care model (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010).

Moreover, in order for consumers to be appreciative and aware of their claims, availability of adequate and sufficient information has to be guaranteed as well. In comparison with the Dutch model, the Polish consumer information system is insufficiently developed and majorly incomplete. Not only do patients have a limited access to information regarding quality of offerings of service suppliers, but also quality indicators are missing – such as safety or accessibility. It is recommended by experts to create a proper computerized platform or take an example from the Dutch model (a consumer quality index), which would help to meet the above-mentioned precondition (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010).

Consumers' choice of health insurers drives the incentives for the latter to improve, compete, negotiate, and contract selectively with providers. With the introduction of the 2006 reform, Dutch consumers may change insurers every year (Schafer et al, 2010). Polish citizens are assigned to a regional branch of the NFZ according to the region they live in. Hence, they have no choice regarding public insurance due to the monopoly of the payer. However, the plan of introducing the Act On Voluntary Additional Health Insurance has been launched to address this problem (Więckowska, 2010; S. Manulik, personal communication, May 22, 2015).

A system of regulated competition is impossible to function without financial incentives and responsibility. Since the 1990s, financial responsibility has been progressively enhanced in the Dutch system in order to ensure the efficiency for the market players, while in Poland a system of incentives is practically absent. The monopolist tax payer possesses information about contracted benefits, while access of exterior institutions that could give an evaluation is very narrowed. Patients lack financial incentives with regards to seeking efficiency as well, since the information about price and supplied benefits is not provided (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010). Incentives are not

verified and despite the fact, that it would certainly improve the quality of service and performance, the government is not willing to provide them and pay for the effects due to cost restraint policies (S. Manulik, personal communication, May 22, 2015).

Not only a large number of insurers and health providers is significant, but also contestableness of the market – without these aspects, efficient competition is likely to be limited. This precondition has been fulfilled by the Dutch system, while the Competition Authority upholds the law regarding anti-competitive behavior (for instance creating cartels). The feasibility of the above-mentioned precondition in the Polish model is not satisfactory at all. Due to the monopoly of NFZ and lack of low entry barriers for service providers, proper contestability is not possible to be achieved in the Polish health care (Van Kleef, 2012; Bevan & Van den Ven, 2010; Więckowska, 2010).

According to S. Manulik (personal communication, May 22, 2015), competition practically never existed in the Polish health care, even with sickness funds in the previous system, which in reality became regional monopolists. Recently, changes regarding displacement of the NFZ by Sickness Funds have been proposed by the government, which would theoretically ensure contestableness of the market, but would be fiction in reality (S. Manulik, personal communication, May 22, 2015).

The last necessary precondition is the aspect of risk equalization, related to a compensation for insurers in terms of predictable costs. Without risk equalization, there is a larger threat of risk selection and rules violation by insurers. Despite the fact that the Dutch risk equalization model is found to be one of the most elaborate in the world, it is not flawless - undercompensating some ill citizens and demanding risk adjusters. In the Polish health care system, there is a lack of experience regarding risk equalization system, hence it practically does not function (Bevan & Van den Ven, 2010; Więckowska, 2010; Van Kleef, 2012).

The conclusion which can be drawn from the above conducted analysis is that the preconditions, necessary (but not automatically sufficient) for the implementation of regulated competition in the Polish health care system, are practically not fulfilled in most cases. There is a lack of proper consumer information system, only partial transparency, undeveloped system of a risk equalization and the lack of financial incentives, which all together hamper efficient competition on the health care market (Więckowska, 2010; Van Kleef, 2012; Bevan & Van den Ven, 2010).

At the moment, leaving the Polish health care system to market forces would not be proper. It is not only due to lack of an adequate consumer information (hence, taking rational choices and decisions), and other above-mentioned aspects, but also the process could 'lead in

consequence to negative social phenomena. Namely, market mechanisms could rid poorer part of the Polish society of the possibility to embrace high quality health benefits' (Kubów, 2013, p.50; Samuelson & Nordhaus, 1995).

The question which compels to reflection is: how long would it actually take for the Polish system to achieve a similar model of health care as the Dutch one? The predictions are not very promising. According to experts, a decade may not be enough to reach the goal because of many barriers standing in the way (Kurowska, 2010). Hence, there are several other factors which contribute to the discussion of feasibility of Dutch reforms for Poland, as well as the explanation of lack of systemic reforms in the Polish health care system nowadays, and will be analyzed in the following section.

6.5 Barriers for reform and potential facilitators

The Polish health care system invariably struggles with many unaddressed problems and challenges, such as long-waiting times, low assessment of the quality of treatment, low salaries of medical representatives, underfunding of health care, and dissatisfaction of citizens with its current condition (Krajewski-Siuda & Romaniuk, 2011). In face of these problems, the question arises if it is even possible to introduce significant, market-driven reforms in Polish health care nowadays.

In case of the Dutch market-driven reforms, it has been a gradual process of layering and conversion. The higher the costs, the more difficult it becomes to introduce changes. In a situation of too high costs, the mechanism of change, which could be put in place in Poland, in order to achieve above-mentioned goal, is layering. It would result in decreasing support for old institutional settings, and consequently, costs of change may incrementally diminish in time.

Characteristics of institutional as well as political context are crucial for distinguishing mechanisms of gradual institutional change and their possible occurrence. Depending on veto possibilities or the degree of discretion, particular mechanisms are likely to appear (Helderman & Stiller, 2014).

In case of the Polish political context, the political arena is characterized by frequent divisions and changing relations between coalitions. Often, the goal of the parties is related to increasing their electoral advantage and maintenance of power, rather than national interests. Contradictory interests of involved actors and shifts in coalitions result in strengthening the fragmentation of the political arena and consequently, the decision making process is

hampered (Krajewski-Siuda & Romaniuk, 2011). Hence, veto possibilities are high during long-standing legislative process (including three readings), and in order for the draft to be passed, the consent of the *Sejm*, Senate, as well as the President has to be reached. The President has the right to either sign and accept the draft, or reject it by using veto. It is conditional – the *Sejm* with the majority (3/5) of votes, and with the attendance of at least half of the representatives may accept the draft after all. Notwithstanding, in 2008, the former president of Poland, Lech Kaczyński, vetoed three health care reform drafts which were eventually not adopted (Rzeczpospolita, 2008).

Except the possibility for the President to veto drafts, the consensus between parties in terms of reforming health care is extremely difficult to reach. Precisely, there are five biggest political parties in Poland, and their stances on health care considerably differ. For instance, *Platforma Obywatelska* strives for creating competitive funds against the National Health Fund, while *Prawo I Sprawiedliwość* favors liquidation of the National Health Fund itself. For *Polska Razem* the expenditures on health care have to be majorly increased, while *Sojusz Lewicy Demokratycznej* opts for its rational containment (Wierciński, 2011). Since the legislative process in Poland is very complex and long-standing, representatives have an opportunity during three readings to vote against each other's propositions and block unfavorable proposals (Krajewski-Siuda & Romaniuk, 2011).

Moreover, according to President Bronisław Komorowski, in recent years “antireform” parties have been increasing with politicians striving to receive the electoral support. Their claims has referred to a belief that reforms are not needed and consequently, the status quo should be preserved (Szuldrzyński & Stankiewicz, 2013). Hence, political context in the Polish case instead of facilitating legislative process, creates a decision-making structure barrier which effectively blocks introducing reforms, and may serve as one of the factors explaining its lack.

High veto possibilities indicate the likelihood of layering and drift. Nonetheless, another explanatory dimension has to be taken into consideration as well, when determining a particular mechanism – the level of discretion in terms of interpreting and enforcing rules. In case of health care, it concerns such actors as insurers, doctors, or providers of targeted institutions who possess a certain leverage to interpret or enforce the rules (Helderman & Stiller, 2014). In case of Poland, the National Health Institute imposes very particular and rigorist demands to medical facilities regarding such aspects as, for example, medical services, while the contracting is in form of specific procedures. Hence, there is no place for high level of discretion. In order for medical facilities to receive payment, the hospitals have

to perform specific procedures. The rules are very strictly abided and its improper enforcement entails financial consequences (T. Podsiadło, personal communication, May 27, 2015). When there are high veto possibilities and low level of discretion, the mechanism of change which has the most potential to appear in the Polish health care is layering. In order to elaborate barriers and facilitators of reform in a more exact manner, it is necessary to take a closer look at costs of change, as well as opportunities and preferences.

Since the communism collapsed in 1989, the issue of reforming the Polish health care structure has been invincibly on the political agenda, as well as became a subject of many public debates. Despite the fact that the Polish health care is a very topical and burning matter, the issue of how the organizational target model should look like, has not been resolved yet (Krajewski-Siuda & Romaniuk, 2011).

However, it has to be mentioned that between the end of systemic transformations in the 1990' and 2001, circa twenty regulations were introduced, which enhanced the development of health care provision with respect to the private sector. Additional acts progressively transmitted the responsibilities of ownership of medical facilities to local governmental units (*Województwa*), which gained a right to transform them into non-public institutions (amongst others, the law of March 8, 1990 on local self-government and on district self-government in 1998) . Nonetheless, none of these statutes have precisely and consistently determined the rules of privatization of medical facilities (Kaczmarek et al, 2013). 'This has resulted in a process that is complicated, legally unclear, and vulnerable to abuses, particularly in the case of hospitals that are the most controversial in terms of their privatization' (Kaczmarek et al, 2013, p.307).

Decision making structures (belonging to opportunities) was one of the barriers successfully hampering the establishment of such a regulation – there have been three attempts taken over last decade. Nonetheless, they were every time stopped by opposed politicians, voting against it at the legislation or preparation process. For instance, the Ministry of Health attempted to introduce one of the mechanisms of change – conversion, with respect to health care organizations being converted into commercial law firms in 2001.

Nonetheless, a disadvantageous political context (not only veto possibilities, but also heavy political disparity, and a collapse of governing coalition), resulted in a reform plan being cancelled. Analysis prepared by experts show that there is a large disparity in various health care sectors with respect to its degree of privatization (Kaczmarek et al, 2013).

The desirable direction, in which the Polish health care system should move towards was a subject of recent debate, which gathered a number of significant experts, and related to

amongst others, financial resources and human capital. Among the participants of the discussion, such crucial actors as the Vice-minister of Health care and the Chairman of the National Health Fund were present. The conclusion, which was drawn from a heated discussion related to the need of creating broad, over departmental and complex program, which would help to resolve burning challenges of lacking financial resources and consequential problems. Unfortunately, no specified solution for a problem has been suggested (Żylińska, 2014).

Hence, the lack of a concrete idea of key actors regarding the question how to reform the malfunctioning system poses one of the barriers to reform. It is difficult to place into one of the categories distinguished in the theoretical framework, but the lack of expertise may relate to technical costs of change. Lack of a proper expertise is a result of an ineffective education system, insufficient investment in training experts and consequently, the migration of specialists to Western countries (Mądrala, 2013).

Over recent years, there have been various propositions and plans of reforming the Polish health care system. Without doubt, meeting all the demands and expectations of different groups is not possible. Not only because of conflicting interests and reform postulates, but also because postulates generally had a form of desideratum, rather than seriously and extensively elaborated strategies (Kolwicz, 2010).

One of the most important barriers to reform the malfunctioning health care system in Poland have been costs – except political ones, financial costs are of great importance. They cannot be specifically classified in the costs distinguished in the theoretical framework, nonetheless they relate to technical costs – in order for an institutional structure to change, various investments are required, which the state budget cannot often afford. In terms of reforming health care, only hospitals within coming fifteen years would need 58 billion *złoty* of investments including staff, training and facilities. Hence, reforming the whole structure of health care would mean giant costs for the state budget, which currently cannot bear such a burden (Stodolak, 2013). The development and consequently improvement of health care, is dependent on the Polish' economy - that is why additional sources first need to be found to introduce other gradual changes in the system. Lack of financial recourses hampers diminishing expectation costs (coming from the society and private actors) in Polish health care as well (Janczewska-Radwan, 2015).

Moreover, taking unpopular decisions and introducing market-driven reforms, entails taking political costs, which significantly influence policy makers' willingness to take a reformist approach. The introduction of regulated competition entails obtaining insurance

from private entities, while for Polish citizens (even though commercial insurance exists) is still widely unaccepted and unpopular (S. Manulik, personal communication, May 22, 2015).

Moreover, during communism, the idea was rooted that health care is supposed to be a social kind of service and should not be a subject of efficiency and other similar measures. Hence, there is still a widespread opposition of introducing the above-mentioned aspect of marketization of health care. The unwillingness relates to such assumptions, as that privatized facilities would be expensive for patients, and would not provide high quality service for them (risk for hospitals to lose profit) (Kaczmarek et al, 2013). Unfortunately, there are cases nowadays with private hospitals proving such an assumption - the emphasis is often placed on the professional look of the facility, while the expenses are retrenched regarding the quality of treatment or equipment (T. Podsiadło, personal communication, May 27, 2015).

Another aspect confirming that market-driven reforms are unsettling for individuals is a common opinion that hospitals should not be profit-driven. Privatized health care facilities is still a suspicious concept for major amount of the public. Politicians are not willing to bear such a political costs at the expense of losing public support (vested interests connected with the fear to lose power and influence on the political arena). The number of private hospitals has been gradually growing over the years, and its number constitutes more than 25 % of the total number of hospitals. Nonetheless, legal base for its privatization is still not comprehensive (Krajewski-Siuda & Romaniuk, 2011; Kaczmarek et al, 2013).

The above mentioned aspects which influence citizens' dissatisfaction towards market-oriented reforms, withholds the willingness of politicians to act in this direction. The threat of losing votes in coming parliamentary elections in October 2015 (and consequently, losing the position in the Parliament) keeps the policy makers from making risky decisions. The candidate of the biggest political party in the country (*Platforma Obywatelska*), Bronisław Komorowski (and the President since 2005) has already lost the presidential elections in May 2015 (Zielazna, 2015). In face of coming parliamentary elections in October, *Platforma Obywatelska* is very reluctant to introduce novel and risky reforms. Especially that the most recent oncological reform created by the party, turned out to be a failure. The dissatisfaction with the results of the reform have led to strikes of doctors and medical staff in 12 regions of the country, and influenced the resistance of *Platforma Obywatelska* to launch novel health care reforms (Watoła, 2015).

An opinion shared by many scholars is that 'a free health care market does not exist in Poland, nor is it planned to be one' (Kaczmarek et al, 2013, p. 310). Nonetheless, the step toward privatization of some sectors has been taken - for instance, the sector of

pharmaceutical industry has been fully privatized, while ambulatory sector is on its way to be. According to T. Podsiadło (personal communication, May 27, 2015) in order for the privatization of health care to succeed and be efficient, the problem of underfunding of health care has to be solved in the first place.

Another barrier to reach favorable conditions for regulated competition is the monopoly of the NFZ. As a sole payer, the institution is very successful in hampering the development of regulated competition in Poland, and despite widespread dissatisfaction of citizens with such an arrangement, its functioning has not been changed (Kurowska, 2010). There have been already reform plans regarding the decentralization of the NFZ. However, again because of contradictory postulates and a lack of specified strategy, the reform plans were unsuccessful.

According to S. Manulik (personal communication, May 22, 2015), current politicians will not dare to take unpopular decisions regarding introducing systemic, market-driven reforms and avoid responsibility for potential failure, which will result in loss of support and power. Hence, politicians have vested interests in keeping the position they have gained in the parliament. One of the most recent reforms, called the oncological package, has been introduced because of mainly electoral reasons – political costs were very small in this case, since cancer disease has been present in every family and consequently, electoral support toward above-mentioned reform has been large (S. Manulik, personal communication, May 22, 2015).

Moreover, policy paradigm (preferences) plays its role in hampering introducing novel changes in Polish health care as well. The Civic Platform (*Platforma Obywatelska*) has been the political power wielding the largest influence in the Parliament since 2007. Hence, dominant goals, partisan routines, and values have been prevailing for a long time. Health has not been a priority in the program of the party (Mądrala, 2013), and the party is considered to have a conservative character. Thus, introducing controversial market-oriented reforms in health care, and liquidation of the NFZ is not a goal of the politicians (Kalita, 2011).

Moreover, the most conservative fraction of the party has proposed financial punishments for breaking the partisan discipline and voting against dominant values (Niesiołowski, 2012). Therefore, the policy paradigm barrier has kept the politicians for already eight years to act contrary to the given partisan paradigm.

In conclusion, various barriers have been effectively hampering the introduction of significant reforms in health care, and may explain its lack nowadays. The most important ones seem to belong to the political context – decision making structures, political costs and

vested interests of politicians, striving for keeping their power and avoiding responsibility. Limited financial capacity is of great importance as well. It is difficult to classify it, but it entails technical costs.

Without facilitators, achieving above-mentioned changes is not possible. However, potential facilitators which could lead to introducing gradual changes in the coming future may be distinguished.

Until recently, there was no charismatic entrepreneur on a political scene who would receive backing and push for changes, which is why a facilitator in such a form has been missing. However, recent presidential elections in Poland (held 24th of May, 2015) appointed a new head of the Polish state from the largest opposition party which can possibly be a turning point in the current politics of the country.

Winning presidential elections by Andrzej Duda opened the window of opportunity for him and his party to act. However, it is too early to determine if he will use it. He gained the majority of votes of Polish citizens, and that means that Andrzej Duda has the support of public. The society is clearly dissatisfied with the current governmental power, while forthcoming parliamentary elections may substantially revise governing parties, and most probably will (Gaweł, 2015). That would mean that *Platforma Obywatelska* would no longer be the largest power wielding influence on the political scene and consequently, lose the majority in the Parliament (Gaweł, 2015)

What it would entail is that the barrier of policy paradigm and decision making structures would be diminishing. In case of *Prawo i Sprawiedliwość* winning the elections and having Andrzej Duda as the President, the macro window of opportunity will open. It is a macro window, because presidential and parliamentary elections are two major political domestic events, which may completely reverse the powers on political arena of the country.

The new President already started announcing the need of introducing complex reforms, amongst others, in health care (Gazeta Prawna, 2015). Nonetheless, the direction of changes stays unclear at the moment, and it is difficult to predict if his reformist approach will succeed – without finding backing in the Parliament, the President does not have large prerogatives in this matter. Only if *Prawo i Sprawiedliwość* wins the parliamentary elections and gains the majority in the Parliament, the decision making structure barrier will diminish. Then, Andrzej Duda will have a chance to push his and partisan proposals through in the legislative process. Now, since *Platforma Obywatelska* (in the coalition with *Polskie Stronnictwo Ludowe*) still keeps the majority in the *Senat* and the *Sejm*, the oppositional *Prawo i Sprawiedliwość* has limited leeway to act.

Another potential facilitator of change is the constantly growing dissatisfaction of patients with the current functioning of health care system (Zadrożna et al, 2015). Consequently, this may lead to diminishing the barrier connected with the belief, that market-oriented reforms are disruptive and unsettling. Hence, unwillingness of the public will decrease and result in lowering political costs. 68% of citizens is extremely dissatisfied with the efficiency of the health care system and effectiveness of treatment, while the negative tendency is constantly growing. Moreover, 62 % of population agrees that reforms in health care are needed (Centre for Public Opinion Research, 2014).

When political costs are decreasing, while other costs still remain high, there is a likelihood of introducing frond-end changes. It would however entail symbolic policies, rather than reforming whole structure of health care.

Moreover, if the citizens are not satisfied with the current situation in the policy sector, crisis can occur. There is already a crisis in Polish health care nowadays, and because of growing negative media coverage, policy makers are forced to take stances on the matter and bring the issue on the political agenda. Over 30 % of the population blamed the Minister of Health Bartosz Arłukowicz, for the inefficiency of the system, and his subsequent resignation from the position has been loudly and negatively commented in the media. The new Minister of Health has been appointed (Polityka, 2015), but in order for changes to occur, an agreement must first be reached - despite ideological differences between parties (Gowin, 2015).

Above-mentioned aspects potentially may create a window of opportunity for change in the coming future and facilitate introducing gradual changes. However, there is a substantial number of previously elaborated barriers which have to be addressed first – especially the underfunding of health care. Nowadays, consultations are being held regarding committing over 3.5 billion *złoty* between 2016-2025, which will possibly boost functioning of Polish health care and decrease technical costs (Dobski, 2015).

Table 6.3: Barriers and potential facilitators of change in the Polish health care system

Barriers for change	Potential facilitators of change
Decision-making structures – long standing legislative process, veto rights, fragmentation, lack of agreement between oppositional parties	Change in political power due to coming elections – <i>Platforma Obywatelska</i> no longer would be the most influential power in the Parliament– in consequence, diminishing decision making structure barrier/policy paradigm

Policy paradigm – Civic Platform, as the largest political power in parliament for already eight years (strict party discipline and values, difficult to change)	Dissatisfaction of citizens with the current situation in health care sector - diminishing political costs (the majority of citizens in favor for reforming the system)
Vested interest of politicians, endeavoring to keep power and avoiding responsibility for a potential failure in face of coming parliamentary elections	Crisis in health care(inefficiency of the system) and two major political events (parliamentary and presidential elections) opening the macro window of opportunity
Unwillingness of citizens – market-oriented reforms are unsettling and disruptive; mental barriers – roots in communism	
costs of change – mainly political costs	
Limited financial capacity	

The above table (6.3) shows that the number of aspects hampering the introduction of reforms is larger than the aspects which may potentially facilitate changes, and explains lack of systemic changes nowadays. Moreover, the barriers which prevail, and consequently are the most important when explaining the lack of reforms in Polish health care relate to the political context. Decision-making structures belong to opportunities, while policy paradigm, benefits, vested interests, and unwillingness of citizens are in the group of preferences. Political costs relate to the political context.

One might ask why the introduction of market-oriented reforms eventually succeeded in the Netherlands, and why it did not happen yet in the Polish case. These countries are completely different in respect of their the economy, wealth and historical roots, but they shared some of the barriers. Technical costs (investing in health care) and decision making structures have been standing in the way of improving health care both in Poland and the Netherlands.

However, the difference is that the political context finally changed in the Dutch case (due to, for instance, new coalition). In consequence, decision making structure barrier diminished and allowed for change. In case of Poland, political context is still extremely unfavorable, and is explanatory for the lack of reforms to a great extent. Unless political context changes after coming elections, the chance to introduce significant market-oriented reforms in Poland is very unlikely.

Moreover, the Dutch budget is incomparably higher than the financial resources of Poland. The introduction of regulated competition demands great deal of spending, which

Polish budget cannot currently afford. Hence, technical costs in this context are a higher sacrifice to make than for the Netherlands.

Furthermore, mentality of the society significantly differs in both countries, and is explanatory for the strong unwillingness of Polish citizens towards market-oriented reforms. The communistic arrangement of health care deeply rooted the belief in the society that health care is free of charge with public, non-profit hospitals, and non-private insurance. Hence, the changes which introducing market-oriented reforms entails, are way more unsettling for the Polish society than it was for the Dutch population (and consequently, more difficult to diminish).

In the Dutch case more barriers diminished over time, since it took almost twenty years to introduce regulated competition. For Poland, market-oriented reforms in health care is still a fresh subject on political agenda, and became topical only recently.

The window of opportunity, which opened after the change of power (isolation of Social Democrats) in the Netherlands was used by Hans Hoogervorst, and eventually allowed for the introduction of the Health Insurance Act in 2006. In case of Poland, the parliamentary elections in October, may open major window of opportunity for Andrzej Duda and his party to push for changes in health care. However, if this will happen, is yet to be seen

6.6 Conclusion

The aim of the chapter was firstly to elaborate on challenges and illustrate the historical background which shaped current organizational structure of the Polish health care model. Analysis proved that the same as in case of the Netherlands, reforming health care is a very long process, paved with different mechanisms of gradual change, rather than abrupt and sudden transformations. Moreover, the extent to which the Polish health care system fulfills the necessary preconditions for successfully implementing regulated competition were analyzed, and results turned out to be unsatisfactory. Subsequently, barriers hampering substantial reforms were elaborated. The most important barriers seem to belong to a political context, related to decision making structures, political costs and vested interests of politicians. In order to examine general feasibility of market-oriented reforms nowadays, the potential facilitators were distinguished. If barriers diminish, potential facilitators may create a window of opportunity for a gradual, systemic change.

7. Conclusion

Based on the previous chapters, the main research question as well as sub-questions of the thesis may be answered. This chapter will discuss them, after a brief introduction. Subsequently, reflections will follow, and the thesis will be concluded with the future research agenda.

As indicated in the introduction of this thesis, the primary aim of this study has been related to answering the following research question: *How can we explain the lack of systemic reforms in Polish health care nowadays, and how feasible are the Dutch reforms for Poland?* Additional sub-questions have been analyzed as well, and will be discussed in the following section.

The functioning of the Polish health care system has been widely criticized nowadays, while the effective solution to enhance efficiency and sustainability has not been found yet. Analyzing the Polish system - its historical background, organizational structure, as well as challenges (in the reference to Dutch health care) revealed significant differences and some similarities with the Dutch, benchmark model. Examined aspects may not only condition the feasibility of Dutch reforms for Poland, but also expose the explanation for remarkable performance of the Dutch system, and poor quality of health care in Poland. Moreover, elaborating barriers and potential facilitators for change may shed new light on explaining the lack of reforms in Poland nowadays, and serve as a guideline for policy makers.

7.1 Answering sub-questions

How can we analyze institutional reforms?

In the theoretical chapter, two contradictory theories regarding understanding the occurrence and analysis of institutional change were distinguished. The first one, punctuated equilibrium theory, states that introducing major reforms is only possible at critical junctures and that incremental institutional alterations will not lead to significant reforms. It has been criticized due to an incomplete understanding of change – that is why the theory of institutional gradual change, which allows for a more sophisticated comprehension, has been chosen to analyze reforms in this thesis.

Moreover, changes in health care systems are characterized as being continuous processes of layering and conversion, spread over time – hence, not possible to achieve at once. The political as well as institutional context creates barriers and/or facilitators for different mechanisms of change – layering, conversion, displacement, and drift. By operationalizing and elaborating above-mentioned variables, one can analyze the possibility of introducing systemic reforms and specifically, particular mechanisms of change.

By analyzing costs of change, preferences, and opportunities in a detailed manner, different barriers can be distinguished. In order for the reform to be achieved, barriers have to start diminishing, due to various facilitators. To measure the possibility of introducing the Dutch regulated competition in Poland, the fulfillment of necessary conditions has been analyzed, such as effectiveness of the market regulation or the degree of its competitiveness.

What are the characteristics of the exemplary Dutch health care organizational structure, and how does the Polish model compare to it?

What characterizes the Dutch system, is a model of regulated competition which has been a result of an incremental and long-standing process, as discussed in the fifth chapter. Thanks to reforms initiated in the beginning of the twenty-first century, the Dutch system and its quality of care gradually became potentially the best system in Europe, and perhaps in the world.

A substantial amount of competing market players (purchasers and providers), effective market regulation, and financial incentives to enhance efficiency are one of the aspects of the Dutch model conditioning its success. Citizens are obliged to obtain the insurance from private actors and they are allowed to change the insurer once a year. The relationship between purchasers as well as providers is based on contracting, and its aim is related to not only providing effective health care, but also eliminating actors offering low quality services. The manner in which health care is financed is mixed, while the government does not possess a direct steering role in the system. Moreover, the accessibility of service is high and consequently, the patients' satisfaction with the functioning of the system.

The present state of the Polish health care model is a result of introducing gradual reforms over almost a decade as well. Inefficient regulation, the institution of a sole payer, and the lack of freedom for citizens to choose the payer are the aspects which are different from the Dutch benchmark model. The degree of competition on the market is low since there is only one payer, while making contracts with the National Health Fund only means negotiating in theory – the sole payer usually enforces the conditions of contracts. Despite

universal coverage, the accessibility of service is often limited (due to financial restraints), and that is one of the main sources of patient's dissatisfaction with the malfunctioning system. Moreover, historical conditioning of the system is also different – Poland is a post-communistic country and its wealth and economy is not comparable to the Netherlands. The Semashko model was adopted under the communist regime and significantly hindered the development of Polish health care during that period.

Despite substantial differences between models, there are also some similarities in its organizational structure. Firstly, both Polish and Dutch health care are characterized by mixed financing. The principle of universal, obligatory coverage is shared as well – every citizen has to obtain the insurance, while a free riding is not acceptable. In terms of provision of health care, the primary care physician is the first instance in the process, determining further treatment. Although some analogy can be distinguished, the amount of disparities is considerably larger.

What are the main challenges in both countries with respect to health care and how do they differ?

Nowadays, all countries (including the Netherlands and Poland), struggle with similar challenges regarding health care – amongst others, maintaining sustainability and enhancing efficiency at minimal costs. Controlling growing costs and keeping high quality of health care at the same time has compelled many policy makers to reflections, while the solution is not simple to find.

In case of the Dutch benchmark model, growing expenditures for health care became one of the most burning and topical challenges. The Dutch spending is one of the highest in the OECD countries and it is constantly growing. Moreover, risk selection, proper market regulation, and adequate patient information system, have been a struggle for Dutch policy makers as well.

In contrast, one of the largest challenges faced by Poland is the underfunding of health care, which entails very serious consequences for the functioning and possible improvement of the health care system. Ineffective regulation and coordination, leading to the growing dissatisfaction of patients, poses a problem for politicians as well.

Similar challenges, shared by both models, are related to struggling with enhancing efficiency and sustainability, while simultaneously constraining costs. Moreover, transparency of the system and proper patient information has been bothering as well.

Furthermore, achieving effective market regulation and coordination of various institutions has been a subject of debates in both countries.

However, there are also disparities in faced challenges between above-mentioned systems – the lack of financial resources to sustain health care, the dissatisfaction of Polish citizens, and the lack of trust. Moreover, long waiting times and limited accessibility of health care is not a challenge in the Netherlands. Additionally, corruption and the low assessment of the health care performance characterizes only the challenges in the Polish system.

Distinguishing challenges in both models proves that the Dutch system, despite its remarkable performance, faces similar challenges as the Polish system. At the same time, analysis showed that the Netherlands has accommodated challenges better than Poland, and sheds light on disparities with respect to the encountered threats.

Which institutional arrangements are introduced in both countries in order to face elaborated challenges and what is the effect of these arrangements on addressing them?

In order to enhance efficiency and minimize costs, the model of regulated competition with market-oriented measures has been introduced in the Netherlands. It is difficult to assess its final effects already, since the process of its implementation is continuous. Nonetheless, some positive results of above-mentioned arrangements, can already be distinguished.

Thanks to such measures as financial incentives or competitiveness of the market, the efficiency and performance of health care has been improved. In the interest of preventing risk selecting, the risk equalization model has been introduced, which resulted in positive effects (however, improvements are still necessary for a better elimination of the discrimination). Various administrative bodies have been established to face the challenge of effective regulation and control, which had a positive effect on the proper functioning of the system as well. The challenge of transparency and patient information has been addressed by introducing internet systems, however the result is still not perfect – the system is not complete. The most burning challenge – growing expenditure, has not been effectively solved.

In contrast to the Netherlands, many challenges in the Polish health care system have either not been addressed, or the institutional arrangements have been ineffective. The most important one – the underfunding of health care, which also conditions solving other problems, has not been resolved. The feasible proposed arrangements encountered public disapproval.

Without increasing financial resources and consequently, improving the quality of care and long waiting times, the challenge of lack of trust and patients dissatisfaction cannot be alleviated. However, several arrangements were introduced which had a positive effect on such aspects as decreasing corruption (new regulations), improving the transparency, as well as patient information structure.

Polish policy makers may take an example from the Dutch arrangements to solve such challenges as increasing efficiency and creating a proper health care system management. However, the feasibility of Dutch market-oriented reforms for Poland is another question, which will be answered in the following section.

7.2 Answering the main research question

How can we explain the lack of systemic reforms in Polish health care nowadays, and how feasible are the Dutch reforms for Poland?

There are many factors which account for the lack of systemic reforms in the Polish health care system nowadays and consequently, hamper its development. Limited financial capacity is one of them. Moreover, the policy makers lack a concrete strategy due to not only insufficient expertise, but also conflicting interests of parties. They have vested interests in keeping their position, while making unpopular decisions entails political and technical costs (which are often too large to be taken).

Furthermore, political context, in specific decision-making structures (fragmentation of the political arena, veto, and a lack of agreement), hampers achieving a consensus as well. The Civic Platform has been the biggest power on the political arena for already eight years, and that consequently creates the policy paradigm barrier.

Furthermore, market-oriented reforms are unsettling for individuals, and create the unwillingness of citizens to change. The mentality of the civil society originates from the communism roots and considerably influences the belief how health care should be organized.

Additionally, unaddressed, above-elaborated challenges hamper a further development of health care and serves as an explanation for the lack of reforms nowadays as well. The most important barriers seem to belong to the political context, related to decision making structures, political costs and vested interests of politicians.

In order for the Dutch model of regulated competition to become achievable for Poland, certain preconditions need to be met. Unfortunately, in the Polish health care system, they are barely fulfilled. There are practically no financial incentives to improve efficiency, the system is insufficiently coordinated, and the monopoly of the sole payer excludes the contestability on the market. Moreover, not only Polish health care lacks sufficient transparency, but it also practically has no experience with the risk equalization system. The development of risk equalization is one of the most important preconditions for the implementation of market-oriented solutions. Additionally, there is no choice for a citizen to choose the payer.

It has to be mentioned that patient information and transparency have been recently improving. Hence, these conditions are fulfilled to a greater extent than the previously analyzed aspects (for instance, effective market regulation), but are still unsatisfactory.

Thus, for now, the feasibility of introducing Dutch market-oriented reforms for Poland is very low. Fulfilling above-mentioned preconditions is a time consuming process which requires introducing complex reforms in many areas of health care. The process should be laid down gradually, and not be a result of an abrupt reform. Without achieving these conditions and addressing challenges as well as diminishing barriers, the successful implementation of regulated competition in Poland is not possible.

However, it cannot be disregarded that there are also potential factors which could facilitate introducing gradually market-driven reforms. One of the biggest potential facilitators is the forthcoming parliamentary elections. They may result in a change of power and consequently, a new direction in the gradual development of the Polish health care system.

7.3 Reflections

In this section, the limitations and implications of this study will be discussed first. Subsequently, the usefulness of benchmark models as well as the theory used in the thesis will be reflected.

The main limitation of this study is related to the external validity. Hence, analyzed factors which explain the lack of systemic reforms in the Polish health care system nowadays are not identical as factors which hamper or facilitate changes in other countries. Therefore, the explanation of particular problems and the feasibility of Dutch reforms is not applicable in the same manner for other cases.

Another limitation of this thesis is related to the restricted number of conducted

interviews. Multiple invites were sent to various Polish experts in the field of health care, with a request to take part in an interview. However, only three recipients responded. Conducting more interviews may have possibly supplemented this thesis to a greater extent, but secondary sources are of great significance regarding validity as well. Therefore, in order to ensure the reliability and validity of this study, not only a substantial number of secondary data was analyzed, but also the sources were diversified – including newspaper articles, scientific journals, reports, documents issued by the Polish Parliament, and books.

One might ask what are the implications of this research for other countries and consequently, what is the usefulness of benchmark practices. Despite the limited external validity, there are challenges such as enhancing efficiency and sustainability of health care, which are common for all European countries. The Netherlands seems to accommodate faced challenges in a potentially best manner in comparison with other European health care systems, and is considered to be the most important exemplar. Other countries are advised to learn from best practices, but the usefulness of benchmark models depends on several factors.

Historical, geopolitical, and economic convergence may condition the success of the implementation of foreign practices. The Dutch model may become a potential benchmark for Poland, however it is essential to remember that policy learning cannot be a blueprint, implemented from one country to another without proper adjustments. As illustrated, there are significant differences in faced struggles and the organizational structure of both systems. Health care systems and its roots are related to the natural historical development, focused on meeting local needs and demands, and that is why adopting unchanged Dutch best practices to the Polish arrangements may be extremely difficult and consequently, useless. Without doubt, the Dutch reforms directed towards increasing efficiency, by introducing regulated competition, may exemplify for Poland and provide a source of inspiration, but they also have to be adjusted to Polish realities. Not only economy of the country, but also civil society in the Netherlands and Poland differ to a major extent, due to historical roots (Christian origins, communism, corruption and consequently, lack of trust). Moreover, it has to be taken into account that, despite the admirable performance of Dutch health care, the model is still not perfect. It faces the same challenges as Poland (to a smaller extent) and it did not manage to address all of the burning problems, including growing costs. Hence, there is no perfect model applicable to every health care system. What is also worth mentioning, is the fact that propagators of best practices neglect interaction oriented analysis, which is of great importance for determining barriers and facilitators of reforms.

The above-mentioned aspects compel to reflection about learning from benchmarks

and may question their usefulness. The answer is somewhere in the middle - we should not blindly copy the practices considered as benchmarks and follow rankings without questioning. However, if adequately adjusted and supported by a proper expertise, there may be a potential for Poland (or other countries) to learn from the Dutch regulated competition in the long run.

The combination of theories helped me to look at institutional change from different and critical angles and compelled to reflections about the policy transfer. Moreover, the whole idea of barriers and facilitators not only enabled me to find an explanation for the lack of systemic reforms in Polish health care nowadays, but also helped me discover potential factors which may enhance introducing changes in the future.

7.4 Future research agenda

The aim of this thesis has been to explain the lack of systemic reforms in Polish health care nowadays, and to investigate the feasibility of Dutch reforms for Poland. As a follow-up, there are some interesting aspects which could be additionally investigated.

This study specifically focused on Polish health care (with a reference to the Dutch model), while the uses of benchmarks in Europe has not been the main focus of this thesis. Hence, more elaborate exploration of the usefulness of benchmarks in the European Union may become an aspect of further research.

Moreover, the manner in which Dutch institutional arrangements should be adjusted to the Polish system in order to make them feasible is also a relevant topic as a follow-up. Subsequently, the consequences of an implementation of the Dutch regulated competition – hence, if it would actually improve the functioning of Polish health care may become a subject of another interesting research.

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Appendix A

S. Manulik is a CEO of one of the biggest clinics in Wrocław (*Przychodnia Kosmonautów*) and a teacher. He is an expert in the field of economy, management of health care institutions, and marketing of health services.

T. Podsiadło is a director of the office of public contracts in one of the hospitals in Wrocław (*Dolnośląskie Centrum Chorób Płuc*). She is an expert in law, management of health care, and logistics.

B. Hawro is a doctor and a radiology specialist in the oncological department in a hospital in Wrocław (*Dolnośląskie Centrum Onkologii*). She is an expert in the cancer treatment and management of health care.