

Opportunities for and constraints to integration of health services in Poland[☆]

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Abstract

At the beginning of the article the typologies, expected outcomes and forces aiming at health care integration are discussed. Integration is recognised as a multidimensional concept. The suggested typologies of integration are based on structural configurations, co-ordination mechanisms (including clinical co-ordination), and driving forces.

A review of the Polish experience in integration/disintegration of health care systems is the main part of the article. Creation of integrated health care management units (ZOZs) in the beginning of the 1970s serves as an example of structural vertical integration missing co-ordination mechanisms. ZOZs as huge, costly and inflexible organisations became subjects of public criticism and discredited the idea of health care integration.

At the end of the 1980s and in the decade of the 1990s, management of public health care was decentralised, the majority of ZOZs dismantled, and many health care public providers got the status of independent entities. The private sector developed rapidly. Sickness funds, which in 1999 replaced the previous state system, introduced “quasi-market” conditions where health providers have to compete for contracts. Some providers developed strategies of vertical and horizontal integration to get a competitive advantage. Consolidation of private ambulatory clinics, the idea of “integrated care” as a “contracting package”, development of primary health care and ambulatory specialist clinics in hospitals are the examples of such strategies. The new health policy declared in 2002 has recognised integration as a priority. It stresses the development of payment mechanisms and information base (Register of Health Services – RUM) that promote integration. The Ministry of Health is involved directly in integrated emergency system designing.

It seems that after years of disintegration and deregulation the need for effective integration has become obvious.

Keywords

integration, disintegration, co-ordination, consolidation, integrated health care management unit (ZOZ), integrated health care package, Register of Health Services (RUM)

Theoretical introduction

Confusion of terms and approaches

Integration can be considered from several perspectives and it can serve as a means to achieve several goals. Speaking about integration we frequently use such terms as collaboration, co-operation, co-ordination, concentration, consolidation, joint ventures, programs and projects, interdependence, adjustment, continuity, etc. Disintegration also refers to a set of similar but slightly different notions: decomposition,

fragmentation, deregulation, lack of relations and lack of co-operation, autonomy, etc. Therefore integration and disintegration are associated with many other not quite exact concepts and terms. The lack of precise definitions contributes to divergences over aims, goals and means of both integration and disintegration. Although ‘integration’ has a positive connotation, one can ask: do we really need integration, to what extent, what actions toward integration can be justified, whose interests should it serve, etc.?

It is easy to agree with T. Parsons that any social system has to integrate its constituent parts. “The parts of a social system must be brought together in contact with one another, interdependencies understood and organised, and the need for coordinated action resolved” (description of Parson’s AGIL con-

[☆] This article is a modified version of a paper prepared for the Workshop on Integrated Care, WHO European Office for Integrated Health Care Services, Barcelona 15-17 November, 2001; with WHO European Office for Integrated Health Care Services kind permission to publish it in International Journal of Integrated Care

cept in:) [7]. However, this general thesis does not point out the right degree of integration, nor the appropriate approaches and the methods for achieving it. The same author distinguished three basic “structuring” principles/forces forming complex systems [9]:

- bureaucracy,
- market,
- associations.

Bureaucracy stresses centralisation of power and unification of solutions as the easiest organisational devices for obtaining integration. Markets rely on free flow of capital, labour, goods and services by which demand meets supply. The market players want to satisfy their own particular needs. In market context integration is seen as a means to achieve better competitive advantage and economic gains. Associations are focused on promoting professional standards and values (effectiveness and quality of work, improvement of products/services, positive influence on the lives of others) as well as on securing professional interests (providing professional contacts, running conferences, developing skills, lobbying governments, improving job conditions, getting certificates and licences, etc.) [6]. Integration promoted by health professionals is oriented on patients’ needs (easy access to health care and continuity of care, the best possible results of treatment, quick clinical information flow, satisfaction) as well as on extending professional knowledge, improving professional skills, and creating job arrangements and technology that enhance health gains.

All three forces play an important role but there is no answer to what extent we should submit health care integration to strict bureaucratic regulations, how much we can rely on market “invisible” mechanisms, and how much on professional values, standards and attitudes.

Desired outcomes and types of health care integration

There are at least three desired outcomes to be achieved through health care integration:

- cost control or expenditure regulation,
- increase in health provision efficiency,
- implementation of new patterns of health services, shifts in continuum of health care, i.e. improving patients satisfaction as well as quality of services and health gains.

The other goals for which integration may serve as means are a development of new technologies and an attempt to serve new needs in new ways.

In the economic literature there is a common distinction between vertical and horizontal integration. While vertical integration means creation of complex systems linking resources, production/provision, distribution and after-sales service, horizontal integration refers to concentration of many individual enterprises into one production/provision system. “In health care, vertical integration commonly refers to the ability of one provider system (i.e. owner or controlling entity) to provide all levels and intensities of service to patients and health care consumers from a geographically contiguous region when these clients present themselves to that system” [1]. There is also another meaning of vertical integration of health services – a link between production function and the sales function.... “Health maintenance organizations (HMOs), independent practitioner associations (IPAs), and preferred provider organizations (PPOs)... all of them shared one common theme: They integrated the producers of health care services, physicians and hospitals, with the health insurance policies that sold the producers’ services” [3]. Horizontal integration is enlargement of size and activity scope of a sector through acquisition or other forms of cooperation (cooperative chains) with the providers offering similar kind and range of services. “Lately, the horizontal integration, which dominated health care (in USA) during the 1970s, appears to be waning in popularity” [2].

Vertical as well as horizontal integration may allow:

- economies of scale effect,
- low cost of health services offered to buyers (public fund holders, private health insurance companies and individual patients),
- increased health care staff and resources flexibility,
- better services convenience for patients
- focus on service quality and patient satisfaction,
- focus on health provision efficiency and effectiveness.

With reference to the above typology we may distinguish structural and functional integration. The first one means creation of big and complex organisations or inter-organisational systems, which consist of many different parts and are able to perform various tasks. Structural integration may be reached not only under a single ownership and under one organisational/structural umbrella but also by many forms of inter-organisational interdependence, among them: joint ventures, partnerships, formal contracts, affiliation agreements, etc. [1]. However, putting together different elements is not enough to obtain a smooth performance and desirable results. We need to make these parts work together and achieve synergy. Func-

tional integration requires co-ordination of activities/ functions within a single complex organisation as well as within a network of organisations. Within a single organisation and in inter-organisational networks functional integration requires a set of co-ordinating mechanisms and devices such as [1]:

- programme management,
- liaison roles to link departments,
- co-ordinating committees,
- shared plans and budgets,
- shared medical standards, administrative policies and procedures,
- clinical co-ordinators,
- integrated clinical and financial data,
- communication systems,
- case management,
- interdisciplinary teams,
- training programmes, involving different medical professionals,
- quality monitoring and assurance projects,
- clear patient information and referral programme, etc.

The general conclusion is that integration may occur in different complex structural configurations and must be supported by various co-ordination mechanisms that link the parts and prevent them from concentrating on their own particular interests.

Health care integration may be beneficial to patients and health care providers. Therefore, taking under consideration on whose interests it is oriented, we can distinguish:

- clinical integration oriented on patients' gains,
- organisational integration oriented on health care providers' prosperity.

Both types of integration should be linked and should empower each other. In the list above clinical mechanisms for patient care integration as well as organisational (administrative) integration devices are included. They need to be applied together to achieve both organisational and clinical integration.

The ideal situation occurs when health providers offering integrated services become more effective, efficient and achieve sustainable financial gains. Very much depends on regulation. Inappropriate rules and incentives may ruin such empowerment and set clinical integration against organisational integration. For this reason the role of government and purchasers who design and apply regulation rules and mechanisms is so crucial for integration/disintegration issues.

To avoid confusion it has to be stressed again that the distinguished types of integration should not be

perceived in opposition. On the contrary, the bigger structures we create the more functional integration is needed, including mechanisms for both organisational and clinical integration.

To sum up we distinguish:

- a) structural integration, i.e. creation of complex organisations or inter-organisational networks in vertical or horizontal configuration,
- b) functional integration, i.e. co-ordination of clinical activities which contribute directly to effectiveness of health care and health gains as well as organisational/managerial actions which link different subsystems and contribute to organisational productivity and prosperity.

Three main forces aiming at health care integration:

- health care professionals,
- managers/administrators of health care organisations/providers,
- governments and other institutions regulating health care systems,

may also serve as criteria for distinguishing the types of health care integration processes.

This way the typologies of health care integration are developed in three main dimensions:

- structures,
- co-ordination mechanisms,
- driving forces.

Each one of the above dimensions can be subdivided according to the other criteria. For example structural vertical integration can include the whole range of health care referral levels or only some of them. Regulations can shape directly the structures and activities of health care providers or establish general requirements/conditions to be met by providers in their own way, etc.

Such a holistic approach seems to be helpful in identifying the types of integration, which take place in health care systems. Furthermore, it helps to realise what is (was) missing and why a certain case of integration does (did) not bring desirable results.

The complexity of any health care system and so many conditions influencing integration make it very difficult to achieve and sustain.

A review of Polish experience in health system integration/dis-integration

Health care reforms have a long tradition in Poland. After "...the first set of reforms aimed to develop free

and universal public health care.... The second set of reforms aimed to bring together comprehensive health and social services in each district” [4]. Strong trends toward decentralisation and diversification of providers occurred in the end of the 1980s and in the 1990s. “Quasi-market” conditions, set up in the middle of the 1990s for a limited number of independent public health care providers, became universal under the compulsory health insurance from 1999.

In the text below integration/disintegration processes and arrangements are discussed in the background of the reforms.

Back to the 1970s—Integrated Health Care Management Units (Zespoły Opieki Zdrowotnej-ZOZs) and lessons from structural integration of health services in Poland

In the period of so-called “real socialism” the importance of integration and planned co-ordinated activities was stressed in every socio-economic domain, including health care. Creation of complex organisations was easy to do and the ideology lying behind structural consolidation was very convincing. In 1973 the government started health care reform, which can serve as an excellent illustration of a vertical structural integration without necessary co-ordination mechanisms [11]. So called ZOZs, i.e. Integrated Health Care Management Units, consisted of many providers of health and social services, including hospital(s) of first referral level, ambulatory clinics, diagnostic centres, emergency station, community nurses, social assistance units, etc., previously acting as independent budgetary units. ZOZs served a population of 50,000–250,000 inhabitants. The reformers underlined that creation of such complex organisations (still being state-owned budgetary units) would bring advantages as follows:

- improving efficiency by concentration of administrative and auxiliary staff and achieving “economy of scale” effect for functions like finance, personnel, supply, maintenance etc.,
- savings by avoiding duplication of medical tests,
- smooth “flow” of patients between outpatient and inpatient health care providers,
- co-operation of ambulatory and hospital care, including exchange of doctors,
- integration of health and social services.

What sounds good in theory does not always happen in practice. The results were undesirable and unexpected:

- development of a huge management structure (deputy directors for primary health care, specialist

health care and social assistance, personnel, administration, investment, etc.), with their administrative staff and many hierarchical levels in separate functional areas,

- duplication of patients files in primary health care, specialist ambulatory care and hospital,
- repetition of tests,
- maintained barriers for patients between primary health care and specialist care,
- no real connections between health and social assistance,
- limited exchange between doctors from ambulatory clinics and hospital,
- a slowdown of activities and lack of elasticity of administration and auxiliary services caused by their concentration and long distances to some providers.

It was evident that structural consolidation itself, imposed by central administration, without corresponding co-ordination mechanisms, brought more harm than profit. Lack of integrated clinical information systems, lack of procedures aimed toward integration of services, financing the activities according to strict budgetary rules within separate paragraphs which could not be combined, etc. resulted in a total failure: huge, inflexible, costly and functionally disintegrated organisation.

The transition period of the 1990s—toward differentiation and disintegration

A strong tension to dismantle ZOZs, which occurred in 1989, as a spontaneous response to the situation described above, led to disintegration of ZOZs, especially in big cities and urbanised areas. Hospitals separated themselves from ambulatory clinics. Social care, under separate administration, lost its links with health care. Traditionally integrated ZOZs (without social care component) remained in rural areas, relatively poor in terms of medical staff and infrastructure, where one first referral level hospital was dominant.

Until 1999 the public health sector in Poland retained its state character: it was financed mainly from state budget and most of the providers had the status of budgetary units. In the second half of the decade several interesting processes were initiated, which changed the health system a lot. Firstly, public providers started to change their formal status to so-called “independent public health care providers”, i.e. they lost their budgetary status. Independence meant much more autonomy for the management over number, structure and remuneration of staff, internal organisational structure, finance, scope of activity and (to a

certain degree) even over property, but it also transformed the way of financing from safe stable budgetary donations to yearly negotiated contracts between providers and state/local authorities—public money holders. At the same time the private sector in the health system arose: many relatively small private ambulatory clinics and diagnostic centres as well as some specialist hospitals were established. Many public ambulatory clinics but only a few public hospitals were privatised. All these processes took place in a certain political and social ambience stressing the need for replacement of the state health care model by a statutory health insurance model. For medical professions and many politicians, as well as for the public, this reform was the only way for a fast and effective health system improvement. The first version of Universal Health Insurance Act of February 1997 was changed after the Parliament election by the new right-wing government in 1998. The new model was introduced in January of 1999.

The decade of the 1990s generally can be viewed as the period of disintegration of health care resulting from the trends—described above—towards the winding up of ZOZs and the development of a private sector. More differentiated providers have been established in the public as well as in the private health sector and most of them showed strong tensions to function independently.

Information base for health care coordination

At the same time we can observe some initiatives from health care managers at local levels toward integration of health services. An especially significant foundation for integration was the creation of so-called RUM (Register of Medical Services) information system [5]. This system was invented in 1993 in a traditional rural ZOZ in Czarnkow and served as an information base for managing an integrated health system, consisting of primary health care, specialist ambulatory care, first referral level hospital care, and emergency and community health services for a population of circa 60,000 inhabitants. The managers of this system were able to get out of traditional budgetary rules, dividing financial resources between different health care providers. They got a global budget for all types of activities covered by the system. The RUM registered every health service and allowed analysis of services provision by patients, providers, administrative units (communities), etc. It also gave information on cost of health provision at every point. A strong position of primary health care doctors, acting as “gate-keepers” (about 25 phc doctors), facilitated

control over access and effectiveness of all elements separately and the whole integrated health system. The system remained integrated despite privatisation of specialist ambulatory care and finally primary care. The logic of its functioning was very similar to the idea of American MHO.

Spreading out the idea of RUM by the Ministry of Health Ordinance did not bring desirable results. In a configuration of many independent providers where there was no management centre for co-ordination and integration nor any consolidated financial resources for integrated health care, RUM documentation brought only more confusion. But in traditional ZOZs the idea was developed and constantly improved. Paper documents were replaced by chip cards. Some sickness funds are also interested in introducing a comprehensive information system showing all the health services done by providers. Last summer every person insured in Regional Silesian Sickness Fund got a chip card.

Reasons for and symptoms of integration of health services and/or health providers under universal health insurance system

As mentioned above, a new health insurance system was introduced in the beginning of 1999. By the end of 1998 all public providers were forced to change their status from budgetary units into independent public health institutions (providers) otherwise they could not be able to contract health services with newly created sickness funds (16 regional sickness funds and 1 sickness fund for army and police), which became main public money holders. The state budget (through the Ministry of Health budget) remained responsible for contracting highly specialised medical procedures. The mechanism of financing changed dramatically: budgetary donations for public health providers were replaced by contracts for health services with independent public or private providers. Health care providers had to compete for contracts. The number and prices of services, and other contract conditions were established during negotiations between cash and every provider separately. Only in the first year of the new system sickness funds were obliged to contract with every applying provider (under certain conditions), but often contracts imposed by a cash were unsatisfactory for a provider. In the next years the funds could simply refuse to contract all or chosen health services with a certain public or private provider due to over provision of health services, high prices or poor quality/access standards, etc.

Integration of health providers as a response to new “quasi-market” conditions

The regional sickness fund as the only purchaser in the region, lack of universal regulation of prices, lack of the appropriate financing mechanisms, separate negotiations with providers, limited health insurance resources, significantly weaken the position of health services providers, who try to strengthen their power by different means. Application of these means may lead to health care integration. Even by the end of 1998 some of the independent public hospitals included primary health services and emergency units in the range of their activities because they wanted to attract patients offering them a whole set of services. This way they obtained contracts for emergency, primary and specialist care, and also multiplied resources and spread out financial risk covering many areas of activity. This was a smart move, because patients appreciated a provider who guaranteed continuity of health care and high standards of diagnostic services. After opting out to small private clinics we can observe patients come back to big public providers.

Deteriorating financial condition of health insurance and a need for protection induces sometimes agreements between providers. For example in Warsaw 6 big public ZOZs integrating primary, specialist ambulatory, diagnostic and community health services, serving about 150,000 inhabitants each, in autumn 2000 set the agreement on co-operation in negotiating profitable contracts to guarantee themselves similar prices and scope of activity.

An idea of “integrated health care” as a “contracting package”

In big cities some ideas of offering “integrated health service” have recently emerged. This idea was invented by the managers of one big public ZOZ in Warsaw, providing outpatient care—primary and specialist, community care and palliative care together with the manager of a big hospital (the authors: U. Rogalska, M. Stachurska-Turos, J. Rosłon—“Integrated health care”, project design – in progress, MBA in Health Care, L. Kozminski Higher School of Business and Management, Warsaw 2001). As it was mentioned above, under the new health insurance system sickness funds contract individually with health providers a specific set of services: primary health care, specialist ambulatory care, emergency, hospital care by different wards and referral levels, etc, using different payment mechanisms and different prices. Diagnostic services, which are important cost-carriers for all these types of health care, are not paid separately. Despite the ideology of rationalisation the whole treatment process is not fully controlled, many procedures, main-

ly diagnostic, are repeated by different providers, generating the rise of global health care cost not related with the quality of care. Integrated health, including primary health, specialist ambulatory services, hospital care as one complex, combines financial responsibility together with quality control. This kind of integration allows:

- avoiding of duplication of some organisational units and staff (administration, labs, transportation, specialist ambulatory units),
- flexible allocation of financial resources for the whole treatment process,
- decreasing cost of treatment, better use of resources and infrastructure,
- standardisation of treatment processes.

For the authors of this idea, proposing the new “product” called “integrated health care” should be profitable for all sides:

- providers included in the integrated system—by pulling together all the resources for health care and getting more possibilities for rationalisation and savings,
- patients—by better access, elimination of tests/visits repetition,
- sickness funds—by simplification of contracting process, avoiding double payments and cost inflation,
- health system as a whole—by cost control, better access of patients and improved quality of health.

The idea is not fully elaborated now, but the offer of “integrated health care” is being prepared for next year’s contract negotiation with Mazovia Sickness Fund. The integrated health system should be paid by per capita mechanism.

It represents a vertical integration in a network of autonomous health care providers and stresses well-balanced interests of providers, purchasers and patients.

Consolidation of private ambulatory clinics

For the last five years the number of private ambulatory clinics has been growing rapidly. In the middle of the year 2001, 10,664 ambulatory clinics out of all 13,000 were private. The consolidation process started last year [13]. In autumn 2000 the twenty best clinics in Poland, together with 80 other co-operating clinics, established Medical Centres Consortium (KCM). The aim of this consolidation was to give patients opportunities for high-quality treatment at the same prices throughout the country. All the clinics included in the system use the same logo, tend to establish the same prices and integrated information system. Such integration allows decreasing of cost in

the whole system by strengthening the position of the Consortium against suppliers. It also creates an opportunity for rational allocation of medical equipment and staff, for example by grouping the most expensive diagnostic equipment in one place. This is the way the private health sector is going to prepare itself for future conditions: foreign competition and legal framework allowing private health insurance in Poland. There are some predictions that the consolidation process in the private sector, which has already started, will lead to the situation that only a few consolidated groups of clinics will operate on the market.

Consolidation of private ambulatory clinics is a good example of horizontal integration driven by market forces.

Future changes in the Polish health system and their influence on health care integration

The New Polish social-democratic government is going to introduce some major changes in the health sector. In the election program the winning coalition—Union of Democratic Left-wing and Labour Union—claimed for:

- replacement of 17 sickness funds by one health insurance fund with 16 branches (one for each voivodship),
- involvement of local authorities and administration—owners of public health providers—in managing and financing health services,
- continuous improvement of contracts for health services, especially payment mechanisms.

These were the main strategic directions for changes. How the planned changes will affect integration?

In the government's document "National Health Care. The Strategic Directions of the Ministry of Health for the Years 2002–2003" we can find several specific arrangements relating directly or indirectly to the integration issue. "Functional or structural integration of providers will be preferred, [...] and will allow to offer a complex health services package for big populations" [8]. The authors especially advocate integration of primary health care, ambulatory specialist care, health promotion, prophylactics and home care. A special task force will elaborate purchasing methods for those areas of care. "Night health assistance" (between 8 p.m. and 8 a.m.), in forms of doctors or outpatient clinics "on duty" and home visits, will belong to the primary health care. "Night health assistance" together with hospitals of two referral levels will be included into so-called integrated medical emergency

services. The emergency information centre will be in the core of this system, taking responsibility for "allocation" of patients in need either of "night assistance" or of emergency ambulance. In case of "a life threat" a patient will be transferred to a hospital emergency department or directly to a specialist referral centre. There will be 270 hospital emergency departments in Poland by the end of 2005. Up to now there are 110. The set of specialist referral centres for treating the most complicated cases will be established. These changes relate directly to clinical integration improvement by creating organisational interdependencies as well as clinical rules and standards.

Other changes may influence indirectly both types of integration by developing a comprehensive information system, supporting health needs-oriented local plans and extending comprehensive health programmes.

The Ministry of Health advocate development of RUM (Register of Medical Services) at local levels as well as at the central level. The unified rules for medical data collecting, transferring and processing are needed for integration of the local systems into the central database. RUM, by registering in electronic form the data on demography, health services provision (including consumption of pharmaceuticals) and costs, will serve many subjects and purposes by giving:

- full health records for patients,
- information necessary for elaborating health needs assessments and plans by local authorities,
- identification of patients, easy access to patients' records and easy transfer of these records for health providers,
- information on number, cost and quality of services provided for sickness funds/national health fund which facilitate monitoring of contracts, more effective control over health care provision and costs,
- complex information of health provision and its cost as well as demographic and epidemiological situation of the entire population for the Ministry of Health which gives good arguments for health policy aims and goals.

Local authorities will be responsible for the preparation of the health needs' plans. The involvement of local authorities as the third part of the health planning process should provide a broader and more population-oriented perspective. Therefore the opportunity for long-term cost/effective contracts arise. Local authorities should also stress continuity of care from patients perspective.

Summary and conclusions

In the decade of the 1990s a strong trend toward diversification and deregulation in the Polish health care system occurred. In 1999 a compulsory health insurance system replaced the previous state model. The sharp split between purchasing agencies, i.e. sickness funds and health care providers (both public and private) set quasi-market conditions, in which providers had to compete over health care contracts and had to attract patients due to their freedom of choice. The lack of unified financing/reimbursement mechanisms led to a wide variation of different agreements between sickness funds and individual providers.

Many factors and forces contributed to the disintegration of Polish health care in the 1990s. The first one was increasing the number of providers and substantial changes in ownership structure of health care institutions. By the end of 2001 the overall number of health care institutions reached approximately 13,500. Only 2000 of them remained public. For comparison at the beginning of the 1990s there were about 700 integrated health care institutions (ZOZs), about 50 university hospitals and countrywide health institutes of the third referral level. They represented the public health sector. The non-public sector consisted of 365 ambulatory clinics in health co-operatives. Therefore Poland experienced a huge restructuring process within the health care providers sector. As a result it became bigger and much more diversified in terms of ownership, legal status and scope of activities. There is a commonly agreed thesis in management theory that the more complex and more diversified the system, the greater is the need for integration which can be achieved by using a set of multiple and different integrating mechanisms. "Paradox. Increased differentiation creates the need for greater integration. However, integration becomes more difficult to achieve as differentiation increased" [10]. But in the 1990s the focus was much more on institutional diversification, including privatisation, than on integration issues. The mechanisms for integration were not prepared and even the need for integration was not enlightened or treated as priority.

In 1999 the new health-insurance model introduced "quasi-market" logic, i.e. financing health care institutions was replaced by financing health care services provided in both public and private health institutions. The new purchasing agencies (sickness funds) as well as health institutions were not fully prepared for effective contracting. There were not countrywide regulations. In individual contracts between providers and sickness funds different payment mechanisms,

different tariffs and clauses were applied. Such an approach led to different financial results of health care providers and also to significant differences in health care provision and access to health care among regions.

Sickness funds and health care providers were not prepared for contracting a "package" of integrated services and not interested in promoting networks of integrated providers. At the beginning every provider rather tended to apply autonomous contracting strategies with sickness funds.

In the year 2000 some sickness funds started to develop more sophisticated payment mechanisms for hospital care (based on DRG logic), but separate ones. Both public payers (i.e. sickness funds and the Ministry of Health responsible for contracting highly specialised medical procedures) and providers were concentrated much more on designing appropriate specific payment mechanisms for each type of health care service (especially acute hospitals) rather than on such financial and organisational mechanisms which could lead to integration of activities from health need/patients' perspective.

At the same time some tendencies toward inter-organisational and intra-organisational integration occurred, driven mainly by providers themselves. They expected financial as well as clinical gains as a result of integration processes.

We can observe an influence of market forces toward integration.

Both public and private providers understood quite early that an offer of broader range of health services was a good way to attract patients. The regulations gave free choice of patients in selecting providers. Some of the providers have decided to apply such types of market strategy, which offer a package of services. Ambulatory clinics have invited patients by extending their scope of activities: providing not only primary health care, but also specialist ambulatory care, many diagnosis services, emergency night services, rehabilitation. Hospitals have opened primary and specialist ambulatory clinics, developed diagnostic infrastructure serving both inpatient and outpatient activity.

Clinical functional integration within inter-organisational vertical networks not only attracts patients but also gives opportunities for savings, more rational allocation and use of resources. Such integration is of crucial significance in the circumstances in which the public purchasers, having monopoly's position, impose low prices.

Health care providers are aware of future problems. Feeling the threat of a new competition (commercial insurance firms and foreign providers), they try to undertake such organisational and managerial changes, which can give them a competitive advantage. The strategy is obvious—provision of high quality health services at lower costs. Organisational and clinical integration can serve as a tool for such a strategy.

Consolidation of many different health activities under one organisational umbrella may also serve as a means for risk sharing. A short-term contracting perspective (one year) as well as ever changing payment mechanisms, prices and limits imposed by sickness funds put health care institutions' management in a very difficult position. Having a package of different health services, managers give themselves room for equalising financial risk in the price-number negotiations with strong public purchasers. Organisational consolidation is not equal to clinical integration but gives foundations and good stimulus to it. The dynamic development of information technology and data bases created at different system's levels (the Ministry of Health, sickness funds, health care institutions) accompanied the legal, institutional and financial changes in the health care system during the 1990s. Much more information was obtained by decision-makers. Giving a reach and a more specific picture of the activities within health systems, databases set a solid fundamental for realising and facilitating health care integration. The idea of RUM (Register of Health Services), which was initially used to manage integrated local health system has been taken and applied by some sickness funds. The electronic cards have replaced traditional paper documentation. Recently the Ministry of Health has declared the introduction of a countrywide RUM information system for health data

management. Such a system will serve as a means for data collection on health providers, health provision and cost and replace paper medical documentation generated by general practitioners and other ambulatory doctors, hospitals, sickness funds, and future national fund with its branches. It can be used as a detector of double-reported services, of treatment paths in health system, thus such a system may be seen as a device for achieving cost control, economy of scale as well as ensuring more effective and efficient treatment. The opponents of the central RUM system claim that it will be a tool for unneeded centralisation of the whole public health sector. They also advocate a careful design of the central RUM system based on detailed specification of decision-makers' needs.

Nowadays the government and the opposition agree that in the course of the reforms in the 1990s the Polish health care system became decomposed and disintegrated. Responsibility and accountability of purchasers, providers and authorities has been unclear. However, both sides argue about the ways, mechanisms and tools for regaining integration and accountability. The government claims for national health system, unification of structures, networks, contracts, tariffs and standards designed by the Ministry of Health whilst the opposition advocates for the further development of the current health insurance model by evolutionary changes toward improved access to the health care, improved payment mechanisms, clarification of responsibilities, co-operation of providers aimed at clinical integration.

It seems that many people realise there is a need for integration in the Polish health care system and the debate on the methods of achieving it has been opened.

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