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THE HEALTH CARE SYSTEM IN POLAND

1. Introduction

It would be difficult to find a country in the world where the inhabitants would be fully satisfied with their health care system, and therefore structural changes of the systems have been underway in recent years. The range of reforms undertaken was extensive, involving the improvement of health care efficiency, access and quality. This is a difficult and complicated process, mainly because of the often adverse interests of different institutions and bodies involved. Besides, the health care system protecting the health, safety and well-being of the citizens has been too often used for political game-playing. This is particularly the case in these countries where the health care system is largely financed from public resources. These resources should ensure an equal access for everybody to the best functioning, fairly shared, effective and modern national health care. From another point of view, public resources intended on the maintenance and the improvement of the health care can also be viewed as providing favourable social and economic benefits to the community.

The purpose of this paper is to provide some key background information on the functioning of the health care system in Poland over the period from 1999 till now.

2. Organisation of Health Care System in Poland before 1999

The Polish health care system was dominated by the financing of the national health care infrastructure by the state throughout the 1990s, and this meant that the only way to secure meaningful financing was, *e.g.*, via increasing the number of hospital beds. This phenomenon, along with a pressure

towards an expansion of the specialised health care services, had produced an oversupply of certain hospital services that have lasted until today in the Polish health care system [Włodarczyk, 2003].

Health care reforms were among the earliest to be taken up. The share of health care in the GNP was as low as 3–4%, investment in health care was scarce, and projects took exceptionally long time to be effected. Yet, at the same time, the health status of the population of Poland was not good. In spite of the development of many national programs (vaccinations, mother and child care projects, prevention and control of tuberculosis, sexually transmitted diseases, etc.), considerably improving the health situation of the society compared to the pre-war period, the commonly used health status indicators such as infant mortality, average life expectancy, incidence of the most common social diseases positioned Poland at the end of the ranking in Europe.

Till 1999, the Polish health care system had been financed mostly by centralized budgets. The income to the budget came from the following sources [Włodarczyk, 2003]:

- income taxes from state owned enterprises and business companies,
- income taxes from natural persons,
- import levies,
- other monetary contributions as prescribed by law.

The resources for health care were allocated mostly by a centrally-controlled budget-based system, and allocation of funds among hospitals and health care centres was based on the total previous year's budgetary spendings of particular facilities, and was subject each year to a political auction, where province governors were the main bidders. Budgets for the health care expenditures were part of total provincial budgets set each year under a specific parliamentary regulation, and the same provincial offices decided on the allocation of their own total budgets among the health care sector and other needs. Almost all funds on health care were distributed among the provinces on per capita enrolment formula (with no consideration of the demographic and epidemiological characteristics) and in function of the necessity for the financement of the existing public health care institutions called Integrated Health Care Units (BP ZOZ) from the State budget. In consequence, considerable inequities existed in this ex-ante distribution of the health care resources among the individual Integrated Health Care Units at the level of the Provinces [Czupryna, Poździoch, Ryś, Włodarczyk, 2001, 34].

Additional health care funding opportunities were also provided in connection with special health programs and planned investment expenditures.

Political and economic transformation in Poland that started in 1989 also brought changes in the health care system. Poland has moved from a highly centralized system towards the devolution of responsibility for health care, which exerted a significant influence on the health care system.

3. Reforming the system

The fundamental idea of the 1999 national health insurance reform was to improve [Niżankowski, 2003] the health care standards in the country, and:

– improve health status of society,

– strengthen protection of constitutional rights of Polish citizens to receive health care services,

– ensure a patient-oriented structure of care,

– address the inequities in health care access by different social groups,

– improve the effectiveness of financing of the health care (better utilization and management of available resources, slow down the snowball effect of growing liabilities),

– improve the working conditions of health care workers,

– improve the material and organizational structure of health care to suit social needs.

The structural transformation of the health care system was a complex process and therefore was divided in several steps:

Step I (till the end of 1998): it aimed at giving more autonomy to the health care institutions, to strengthen the structures of Health Funds; competition between service providers was encouraged with each Fund negotiating contractual agreements following a bidding procedure.

Step II (till the end of 1999): the purpose of the reforms was to develop and implement new patient-level information systems within the National Health Fund and to oversee and pay for health services, to enhance the health service accreditation, to provide means for checking the performance of the health service providers, to create opportunities for autonomous health care institutions to provide competitive offers for their services. Other goals were associated with the tendency to strengthen the role of the primary health care sector financed by Health Funds and the announcement of the call for proposals for health services in 2000;

Step III (till the end of 2001): the reform aimed at the consolidation of the system, bringing to the common usage of the standardized cost accounting system, developing the rules for a universal health insurance system driven by market and competitive pressures;

Step IV (from 1 January 2002 onwards): the health related business has been opened to organisations other than health funds to engage in.

Starting from 1999, a decentralised approach has been adopted, marking an important shift from a centrally-controlled, budget-based system to a decentralised insurance-based system. Almost all health care institutions, except for teaching hospitals, university hospitals, and locally-owned hospitals have ceased to be national institutions, while local communities were given a say in the management of the health service sector. The situation of freelance

professionals (medical doctors, nurses and midwives practising in primary health care) has been progressing to a better and better future. It had been expected that the assumption of responsibility for decisions would result in the rationalization of expenses, increased effectiveness, and better utilization of the collective resources, capacity, and skills.

The reforms, which allow health care providers to sign contractual agreements with health funds have accelerated market organisation for private health care providers. The government had announced its ownership transformation plans concerning the outpatient health care sector and the process of privatization of these institutions (particularly of primary health care ones) was started in mid-1998 and was welcomed by public health care institutions (the future Health Funds) willing to enter in contractual agreements with non-public health care providers. Private health care providers have developed creative hospital options for insured patients, although the growth in the number of private hospitals across the country has been minimal and usually these institutions have treated low-risk patients [Goetzen, 2000].

Of course, all these changes in the health care sector were associated with the effect of the health care policy on the extent of transformation. With this in mind, this paper will seek to ask what decisions had been made concerning the health care system, how the decision making process had taken place and how it had been linked with the whole political process. Here, importance will be given both to the content of the assumed goals and to the instruments for achieving them. In fact, health policy has been widely used, as part of the political process, at the preparatory stages of the health care reform, the main objective of which was the implementation of the health insurance reform.

Poland's political breakthrough in 1989 had basically restored the health care system as a potentially influential factor at all levels of social organization. This meant that the decisions relating to the health status of the population become an integral part of the political process. All matters regarding health could be discussed and decided upon by communities themselves.

The health insurance system, membership of which is compulsory, began operating on 1 January, 1999, in virtue of the new Act on Health Care Institutions, and was characterised by the following key points:

– separation of the payer from the service provider (competition),
– new insurance-related policies; limited obligations of communes and districts,
– primary source of financing: setting the income-based health insurance premiums, payable to Sick Funds, from the eligible population or from the state for those unable to make such contributions.
– secondary sources of financing: the state budget, limited co-financing,
– arrangements concerning the payer: large regional Health Funds,
– transfer of resources: individually negotiated contractual agreements,

– devolving the ownership of health service facilities: State-owned, communal-owned, privatized,

– structured network of health service providers: shifting to a decentralised outpatient and hospital care system; all public institutions operating independently.

An essential feature of the new Act on Health Care Institutions was the introduction of the name "Sickness Fund", harking back to the pre-war tradition. The fundamental principles were adopted, which since then have been applied to and related to the patient's right to choose freely both the payer and the health service provider. Competition between service providers was encouraged. The compulsory character of the insurance premium remained in force, but key responsibility for the health insurance coverage of poor families continued to rest with specific public authorities. A compulsory health care insurance payable by the working population remained in force, whilst in terms of resource mobilization, a means was provided to raise funds for health care through mandating earmarked contributions from the eligible population or from the state for those unable to make such contributions. The Social Insurance Office (ZUS in Polish) was now the institution to collect insurance premiums. A concept of limited co-financing by patients was adopted.

The 1998 process of reforms was characterised by a series of settings exerting the influence on the functioning of the health care system.

One of them was the institutional separation of the payer from the service provider, through the establishment of regional health funds. The health insurance was based on the following particular principles: social solidarity, self-government, self-financing, right to the free choice of the service provider and sickness fund, management and relevance of activities. The basic health insurance budget was set as a percentage of taxable income, deductible from personal income tax.

Another issue was associated with the envisaged accession of Poland to the European Union, although not the EU accession itself, but, *e.g.*, the settings concerning the employment matters, equalities in the access to the services and the manner of implementation of further changes have a large influence on the existing health care system.

Another intention of the new system was to create opportunities for many businesses to enter the growing market of health services to ensure equal access to public resources. A base for the provision of services were contractual agreements stipulated between a payer and an eligible provider. What was important, that patients were left free to choose among many service providers (public and not public) financed from public resources.

Changes were made in the management of health care institutions: integrated strategic and operational planning was introduced to replace budget plan-

ning. The development of such a strategy for health care institutions meant a new approach to the functioning of the system through the introduction of the market game rules. The major importance was attached to the changes in the system of health care management aiming at the enhancement of the availability, effectiveness and quality of health care services and at exacting responsibility for decisions.

Unfortunately, the four years of functioning of the Health Funds were marked by growing availability of health care services, whilst too much autonomy given to the Health Funds resulted in the shift towards their own independent health policies.

However, numerous amendments have been made to the regulations regarding the Health Funds, thus confirming their legislative imperfection. The continuing disintegration of the health care system was the reason to develop a new healthcare solution that would enforce the constitutional rights of equal access to health care.

4. The National Health Fund

Bad experience with decentralisation of the public healthcare service caused the Parliament to pass a new healthcare solution – the Act of Social Insurance in the National Health Fund of January 23, 2003. The regional sickness funds were amalgamated to create a National Health Fund (Narodowy Fundusz Zdrowia, NFZ in Polish) that [Włodarczyk, 2003]:

– was a public organizational body and had a legal status,

– was intended to enter in contractual agreements with service providers and to receive the health insurance contributions collected through the ZUS and Agricultural Social Insurance Fund (KRUS in Polish)

– financed health services from the resources assigned by the respective authorities.

The changes introduced by the National Health Fund consisted in:

– paying for health services from the resources assigned by the respective authorities.

– introduction of equal rules for contracting health services,

– adoption of uniform procedures and standards governing the contractual agreements for health services,

– equal opportunities to all health care providers by creating conditions of fair competition related to the process of contracting health services,

– unification of the definition of health services, the reporting system and accounting,

– providing equal access to health services for patients without the requirement of the so-called letters of promise (patient-centred model of care),

– elimination of inconsistencies in the allocation of financial resources (centralized distribution model),

– key responsibilities of the NFZ resting with the Minister of Health.

The intention of this system was to guarantee transparency both for patients and for health service providers.

Yet, once again, reality was different. The Polish Constitutional Tribunal declared the form of organization of the NFZ as unconstitutional, in terms of the basic regulations regarding the structure and form of functioning, provision of health services, financial management, and supervision and control over the realization of the assignments of the National Health Fund.

Every concept of reforms and the implementation of changes in the functioning of the health care system face a specific political and social context. The organisation of the health care system in Poland since 2003 has experienced some changes and improvements, including the Act of 27 August, 2004 (began operating in October 1, 2004), concerning the provision of health care services financed from public resources. The legislators who had supported the new law, intended to improve the health care system, particularly to create a patient-friendly organization and to ensure the rigorous stewardship of public resources, *i.e.* to avoid common improvement pitfalls that cost money. Given scarce resources, one should have to concentrate on the effective utilization of them through the implementation of optimal solutions.

From the technical point of view, the most important concept within the model was connected with the coexistence of three tiers of services, differing in the content, and the rules of access and financing. The first tier is the service financed from public resources. The whole population is covered with primary health care and receives guaranteed free health services within that system, whilst in case of other levels (out-patient specialist care), a form of rationing of services is utilized when demand overwhelms supply (a referral of the doctor, queuing rationing mechanism, except for emergency cases. Focus was given to ensure the quality standard of the services provided.

The second tier regards the so-called recommended health care services *i.e.* these with proven, evidence-based effectiveness and financed partly from public resources.

The third tier of services is these non-standard or supplementary services that are considered safe according to the recognized standards, but playing a secondary role in meeting the health needs. The decisions related to the use of these services are treated as private decisions and may require co-payment.

Health services are financed from public resources composed of [Chwieruta, Kulis, Stylo, Wójcik, 2003]:

– the collections of health insurance premiums managed by the National Health Fund,

– the budgets of communes that cover the uninsured population,
– the budget financed by the Minister of Health, covering eligible beneficiaries of both above-mentioned groups.

This system, although differentiated in the scope of the services, is subordinated to the fixed rules. The principle of solidarity and equal access applies to the guaranteed services, not to the recommended services. Public resources are built through the mechanisms of insurance premiums at the level set by the Parliament. Queuing may be needed as a prerequisite.

The National Health Fund is a public payer for health care, acting through the regional branches. Provision of health services is financed based upon contractual agreements between the payer and the service provider.

These changes to the health care system cannot be implemented in a single phase but require multi-step evolutionary rearrangements to achieve complete stabilization. But here political decisions are inevitable.

A properly arranged health care system should provide a fair access to the services, based on real needs. The current scope of it depends upon the available financial resources.

The utmost importance should be attached to ensuring the effectiveness of the system in the real circumstances. The potential of the system should be translated in its optimal performance in pursuing continued improvement of the status of health of the society using the available resources.

Another factor is connected with the meeting of the needs and social expectations related to the function and the structure of the system and with the satisfaction of service providers. The available health care services and the level of their financing should reflect the social needs that in turn should be established on the basis of reliable information.

Financial limitations create the essential barrier in the access to the services, but it should not mean, however, that higher resources could resolve the problem of rationing of health care services. It could be said with a high dose of certainty, that a tangible improvement of the availability of health services is inevitably connected with the strategy of their financing and with the well-developed methodology of their allocation that could meet the health needs. It is of key importance, particularly due to the fact that the health and life of people is the utmost goal to be achieved by an efficient health care system, and considering that the resources intended to accomplish this goal are allocated by all society with the hope of their better utilization.

The reasons for limitation of the availability of health services are complex and are related to the payer, the health service providers and the patients. The access to health services is an important performance factor characterizing the health care system as a whole, as referred to the demand-supply ratio, to the individuals or to the social group, although it can be stated that in the view of observations and analyses of the health care system there are still the

health needs to be defined and met. The health needs of a society should be seen as a large area to be considered and more awareness is required here to meet them fully and to take responsibility for them. Otherwise, restrictions and limitations may be a solution resulting from the given epidemiological and demographic situation of a specific region, being a solution away from the current expectations and the supply of health services. The most narrow attempt although essential, would be the definition of health needs that could be satisfied through the available system resources.

The definition of real health needs and the reasons for access limitation are differentiated and have different basis, because such limitations could result from the fact that the objectives outlined by the accepted by the health care reform have not been attained or that improper instruments have been used to accomplish them, or, finally, that these objectives are simply unachievable.

5. The criteria of medical services effectiveness – the structure of expenditures on health services

In the health protection sector the criteria of medical services effectiveness are extremely important because they refer to such values as life and health. The way of health services financing considerably influences the choice of treatment methods; in a longer perspective, it is the strongest factor determining the behaviour of service providers. However, apart from the financial aspect, the quality and availability of health services are also important criteria. Accreditation, which undoubtedly contributes to the popularization of the notion of an institution's mission, should also serve this purpose.

The achievement of accreditation and a satisfied patient are tangible proofs of good quality and availability of health services for the service provider and for the payer. These are arguments which a health insurance institution must always have in mind as far as the planning and financing of medical care is concerned. At present, about 60% of the service providers in the Opolskie Province have a quality certificate or ISO system. Hence, all comments, patients' opinions and CMJ or ISO systems achieved by the service providers, as well as the implemented spectacular programs for quality and availability of services are a significant element in the negotiations for bigger financial resources conducted with the National Health Fund Centre for the accomplishment of medical services in the region.

It should be remembered that it is the media that very often create an image of health protection which motivates the patients' attitude to the providers and payers of health services. Therefore the feelings of our service recipients are very important, because they choose a physician, health centre or hospital following the principle of a qualitative choice. So it is a good idea to know their

opinions, to ask for such opinions and recommendations concerning the provision of services, and first of all, to pay attention to irregularities noticed by them. Patients' opinions constitute a source of valuable information on needs and expectations, they are a health indicator and a strong stimulus for the planning of the improvement process in health care for both service providers and payers. The methods of surveying patients' opinions and the use of comparative analysis are used in the assessment of the effectiveness criteria, *e.g.* the quality and availability of health services.

The results of surveys conducted in the Opolskie Province have shown that also in the Polish conditions, in the region without any big clinical hospitals or institutions, it is possible to achieve health services of good quality and oriented towards patients' needs. The following health care programs carried out in our province should be mentioned in this context [Kamiński, Łukowiecki, Idzikowski, Marek, 2003]:

- a strategy for the treatment of myocardial infarction,
- implants,
- the already implemented program of the early treatment of strokes,

as well as other initiatives oriented towards the rational management of available financial means, *e.g.* the MEDICINE system or the Internet portal called the MEDICAL AND FINANCIAL ANALYZER. An assessment of the availability of health service carried out on the basis of the analysis of such key documents as health services provision plans, financial plans, monitoring of service provision on the basis of concluded agreements, presents factual problems related to health needs in the Opolskie Province.

The proper provision of health services depends to a considerable degree on the financing process, *i.e.* the collection of health insurance premiums, the coverage of financial differences, the preparation and execution of financial plans and payers' financial management.

The true identification of society's health needs, which are reflected in demand for health services expressed, among others, by the level of health services utilization, constitutes an indispensable condition for the optimization of the allocation and utilization of resources spent on health care. Expenditures on health services provision constitute the most important and at the same time the largest type of costs incurred by the payer within the framework of health insurance. It should be remembered that such costs are related to the fundamental task, *i.e.* providing the insured with access to health services.

The planning process is an important factor in the financing of health services. The implementation of general health insurance in 1999 changed, although not completely, the previous effects of the planning philosophy. In the process of planning health needs, elements determining the availability of health services for the insured were used to various degrees.

These elements in the planning process are the following:

– determining objectives resulting from the needs of local communities and agreeing preliminarily on required health services;

– developing a plan guaranteeing the availability of services and agreeing finally on its scope;

– executing the plan by concluding agreements with service providers for particular types and scopes of medical services;

– identifying areas requiring improvement in health care;

– establishing a hierarchy of problems and determining priorities with respect to activities improving the quality, availability, organization and provision of health care.

In order to determine the health needs of the insured and the conditions of their proper fulfilment, health services provision plans are drawn up, taking also into consideration the analyses of statistical information on the provision of health services in a particular province in the previous years, as well as their number and scope corresponding to health needs within the framework of possessed financial resources.

In developed health plans for the Opolskie Province for particular years, apart from the financing area, the strategic objective has been oriented towards the equal access to health services for the insured according to epidemiological needs, the improvement of the quality of such services and the improvement of the effectiveness of diagnostics and treatment, whose goal is to lower the mortality rate and improve the quality of life of the region's inhabitants.

The organization of the availability and financing of health services on the basis of concluded agreements constitutes one of the most important processes being the foundations of the system of general health insurance. During the contracting process, the basic issues concerning the provision of health services and fulfilment of health needs are dealt with. Service providers are also selected, the structure of services, *i.e.* their type, number, financing and availability, and the conditions for their provision are determined. The next phase is the factual provision of health services – it is very important from the point of view of both availability and financing, because it may turn out that arrangements made in the contracting processes do not fully correspond to the factual health needs and have to be corrected in order to ensure the proper availability of health services [Borkowska-Kawalas, Halik, Pączkowska, 2001].

The costs of health services incurred for the population of 1,057,000 people (as on 30 June, 2003) in the Opolskie Province in the years 1999–2005 resulting from the health insurance system are presented in Table 1.

The structure of expenditures on health services presented in the table shows that in 2004 there was an expenditure increase of PLN 188,727,800,

Table 1. Costs of health services in the Opolskie Province within the framework of health

No.	Type of service	1999		2000		2001	
		costs PLN thousand	% of total costs	costs PLN thousand	% of total costs	costs PLN thousand	% of total costs
1	Basic health care	72499.53	13.47%	65996.39	12.04%	74167.38	11.13%
2	Outpatient health care	29521.62	5.49%	31961.89	5.83%	42814.01	6.43%
3	Hospital health care	297175.54	55.22%	280088.86	51.09%	332381.70	49.89%
4	Psychiatric care and treatment of addictions						
5	Medical rehabilitation	1570.69	0.29%	5169.54	0.94%	8264.01	1.24%
6	Long-term care	7515.32	1.40%	8994.18	1.64%	13102.08	1.97%
7	Dental health care	15311.10	2.85%	12592.32	2.30%	15834.92	2.38%
8	Spa treatment	7323.42	1.36%	5141.70	0.94%	6424.95	0.96%
9	Emergency care	26572.17	4.94%	23261.68	4.24%	24598.87	3.69%
10	Prevention programs and health policy programs financed by NFZ			5415.02	0.99%	8673.55	1.30%
11	Health services contracted separately			8154.01	1.49%	19108.37	2.87%
12	Orthopaedic equipment, auxiliary means and medical technical equipment	4894.18	0.91%	6097.61	1.11%	7511.00	1.13%
13	Sanitary transport	754.36	0.14%				
14	Medicine reimbursement	74986.35	13.93%	95349.40	17.39%	113353.32	17.01%
	Total costs of health services	538124.28	100.00%	548222.60	100.00%	666234.16	100.00%

* Planned costs for 2005

Source: the database of the National Health Fund, Branch in Opole

i.e. 35.07% in comparison to 1999. Additionally, the analysis of expenditures on health services in this period indicates the following:

– the biggest increase in expenditures over the previous year occurred in 2001 and equalled 21.53%,

– in 2002, there was a 2.02% fall in the expenditures on health services in comparison to those in 2001,

– in 2003 expenditures rose by 6.22% over those in 2002,

insurance in the years 1999–2005

2002		2003		2004		2005* plan	
costs PLN thousand	% of total costs	costs PLN thousand	% of total costs	costs PLN thousand	% of total costs	costs PLN thousand	% of total costs
76125.71	11.66%	80425.85	11.60%	91088.85	12.53%	94141.00	12.44%
38358.72	5.88%	44776.67	6.46%	45366.21	6.24%	48500.00	6.41%
276716.24	42.39%	280992.77	40.53%	304879.74	41.95%	311308.00	41.12%
19950.02	3.06%	23436.31	3.38%	25724.08	3.55%	26553.83	3.51%
23495.25	3.60%	23775.81	3.43%	29891.90	4.11%	31100.00	4.11%
12876.66	1.97%	13124.31	1.89%	11429.99	1.58%	15498.17	2.05%
17878.42	2.74%	18963.47	2.74%	20148.77	2.77%	21500.00	2.84%
5852.84	0.90%	5454.55	0.79%	0.00	0.00%	0.00	0.00%
23121.64	3.54%	22999.89	3.32%	25178.12	3.46%	28000.00	3.70%
7457.75	1.14%	410.54	0.06%	0.00	0.00%	2322.00	0.31%
22963.81	3.52%	26135.52	3.77%	19407.40	2.67%	21625.00	2.86%
8717.65	1.34%	9659.18	1.39%	11319.61	1.56%	10000.00	1.32%
119241.07	18.27%	143207.27	20.65%	139850.88	19.24%	146460.00	19.35%
652755.78	100.00%	693362.14	100.00%	726852.16	100.00%	757008.00	100.00%

– in 2004 expenditures rose by 4.48% over those in 2003.

A clear abrupt increase in expenditures in 2001 was related to pressure and expectations coming from public service providers, support offered by the founding authorities which demanded a rise in expenditures for the financing of the so-called "Act 203". The plan for 2005 provided for a 4.15% increase in expenditure on health services over those in 2004; in comparison to 1999, this is an increase of 40.68%.

As it can be seen, the major part of expenditures in particular years – from 55.22% in 1999 to 41.12% in the plan for 2005 – is made up of expenditures on stationary health service, medicine reimbursement – from 13.39% in 1999 to 19.35% in the plan for 2005, and basic health care – from 13.47% to 12.44%.

It should be noted that the cost structure of health services financed within the framework of health insurance in the years 1999–2004 and in the plan for 2005 is very diversified with respect to particular cost items. The identified changes corresponded to general trends on the health services market or reflected changes in the contracting and classification of particular scopes of services determined by the needs of particular regions.

A smaller share of basic health care in the total costs of health services in 2002 was caused by removing outpatient services from the range of specialist health care.

The dynamics of the increase in expenditures on health services within the framework of health insurance may prove a rise in their costs, but also an improvement in their availability. This dynamics is determined by the following factors:

a) the availability of services,

b) the number of hospitals and beds,

c) the development of diagnostic and therapeutic technologies,

d) characteristics defining pro-health attitudes: age, sex, education, income.

Changes in the costs of health services in the years 1999–2005 resulted from the following:

a) the tendencies on the health services market,

b) the reflection of changes in the contracting methods,

c) the classification of particular types of health services in accordance with the region's health needs.

The greatest increase in expenditures on health services in comparison to the previous year occurred in 2001 – it was 21.53%; in 2002 there was a 2.02% fall in expenditures over 2001, while in 2003, expenditures rose by 6.22% and in 2004 by 4.48% in comparison to their respective previous years.

The major part of expenditures in the years 1999–2005 is the cost of stationary health services and medicine cost reimbursement.

Expenditures on health services rise dynamically by the year, which may indicate not only a rise in their costs but also improvement in their availability. Besides the availability of physicians, number of hospitals and beds in them, number of other health care units, diagnostic and treatment technologies, it is such important characteristics determining pro-health attitudes as age, sex, education and income that influence the dynamics of the increase in expenditures on health services. For the elderly in the lowest income brackets and with more health problems stationary health care is more frequently the source of

health services than for others. The same problem concerns the use of outpatient basic and specialist health care systems, which are also used mostly by the elderly. An income level appears to be an obvious factor determining the use of paid services; this fact is also determined by non-economic factors such as education and greater social and health awareness. Thus, it can be assumed that the health conditions of this group are relatively better and that people belonging to this group are more rational in their use of health services.

6. Conclusions

1. The continuous monitoring of the provision of health services and opinions formulated by service providers and service recipients indicate a positive assessment of the quality and availability of health care in the Opolskie Province, even if one takes into consideration the subjective element in such patients' opinions. It means that the changes implemented in the health care system result in the absence of distinctive differences in the overall assessment of the quality and availability of health services.

2. The general assessment of the quality and availability of health care is "satisfactory". This "satisfactory" assessment with respect to the availability of health care concerned the availability of basic health care, specialist health care and stationary health care.

3. The analysis of the structure of expenditures on health services in the Opolskie Province has shown that the basic factor determining the availability and quality of health services is an effective structure of allocating financial resources oriented towards well diagnosed health needs, which can be confirmed, for example, by the availability of particular health programmes – "A strategy for the treatment of myocardial infarction" and other medical procedures such as haemodialysis or endoprosthesoplasty.

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