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Available online: 27 Sep 2011

To cite this article: Meg Rincker & Martin Battle (2011): Dissatisfied with Decentralisation: Explaining Citizens' Evaluations of Poland's 1999 Health Care Reforms, Perspectives on European Politics and Society, 12:3, 340-357

To link to this article: http://dx.doi.org/10.1080/15705854.2011.596310

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Dissatisfied with Decentralisation: Explaining Citizens’ Evaluations of Poland’s 1999 Health Care Reforms

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ABSTRACT Decentralisation of public policy from national to sub-national governments occurs in 80% of developing and transitioning economies worldwide (Manor, 1999), and is advocated by the International Monetary Fund, World Bank, and European Union. Proponents argue that decentralisation disperses political power, involves citizens in the political process, and allows sub-national officials to craft efficient policies. After suffering under centralised state policymaking (1945–1989), citizens of Central and Eastern Europe should be avid supporters of decentralisation. Yet 80% of the Polish populace was dissatisfied with decentralisation of health care services by 2000. This article uses public opinion, interview, and elite survey data to examine the critical case of Poland’s 1999 health decentralisation, answering two questions about public opinion on decentralisation. First, why were Polish citizens displeased with decentralisation? Second, what factors make or break public evaluations of decentralisation? The article demonstrates that Poles were more dissatisfied with their health care during health decentralisation (1999–2001) than when it was centralised (1994–1998, and 2002–2007). Aggregate public opinion data suggests support for decentralisation dwindles when it becomes synonymous with offloading state responsibilities to private citizens. However, surveys of health care consumers, providers, and administrators in four Polish provinces show the important role political parties play in managing expectations and support for decentralisation.

KEY WORDS: Decentralisation, health care, Poland, political parties

Introduction

In August 1989, after almost 45 years of centralised communist rule, opposition Polish Solidarity activists sat down with communist leaders at the Round Table Talks to hammer out reforms to the communist system. In the short term, Solidarity acquired the right to represent the interests of union workers, a general agreement to convert Poland’s budgetary health system to a social insurance scheme (Bossert &
Włodarczyk, 2000; Regulski, 2003; Roberts, 2009) and the right of Solidarity to participate in elections in a re-opened Senat, as well as one-third of the seats in the lower house, or Sejm. After the founding elections, a central political debate in Poland in the 1990s was discussion over the division of power between the central government in Warsaw and provincial capitals. In 1972, Communist Party Secretary Edward Gierek increased the number of provinces to 49 in order to weaken the middle tier of government and strengthen the national government in Warsaw (Regulski, 2003; Kerlin, 2005; O'Dwyer, 2005). Post-1990, Solidarity activists pushed for a decentralised political system, featuring a ‘transfer of power to different sub-national levels of government by the central government’ (Oxhorn et al., 2004, p. 7). Whereas Solidarity activists supported the idea of fewer, stronger provinces (12), reformed communists in the successor Democratic Left Alliance (SLD) party supported a larger number of regions (17). Some argue that the true motivation behind the SLD’s support for 17 provinces was, in effect, to weaken provincial authority; others claim that SLD leaders wanted to recognise important provincial centres left out by Solidarity Electoral Alliance’s (AWS) plans (Kerlin, 2005). By 1998, the AWS-led government achieved a compromise with SLD President Aleksander Kwaśniewski, passing a series of laws creating 16 new provinces. Each province would have a provincial governor appointed by the Prime Minister, but also a directly elected provincial legislature.

Concurrent with territorial and administrative reforms, Poles were refashioning their centralised Semashko-style health care system. From 1945 to 1990, Poland’s health system was based on a centrally defined percentage of the budget spent on health care, typically around 5.2% of GDP (Girouard & Imai, 2000). The National Minister for Health made key health policy decisions which were then administered by local officials. Under the Semashko system, local officials were punished for efficiency, as local budgets were determined by past spending and capacity. Additionally, the 1952 Constitution of the People’s Republic of Poland guaranteed Poles positive rights to health care, and the Polish health system offered little incentive for citizens to curtail health consumption. These policies contributed to increased deficit spending and misallocation of resources in the Polish health system. To this day in Poland, most doctors are public servants, receive relatively low wages, and take gratitude payments from patients. A recent study shows that doctors in Poland make as much in tips as their reported salary (Kornai & Eggleston, 2001).

In the early 1990s, the Polish government began allowing for private provision of health care. Poland began to move away from a system in which the state is the purchaser and provider of health care, to one in which citizens contribute to a social insurance fund, which, in turn, purchases health care services (Aksman, 2000; McMenamin & Timonen, 2002; Kerlin, 2005; Watson, 2006; Radin, 2009; Roberts, 2009). Politicians argued that a new system of decentralised health insurance funds, directed at the provincial level in Poland, would increase the efficiency of health care services, and allow Patient Funds to respond to the needs and resources of individual regions and populations. As a Deputy Head Nurse in Kraków put it:

I’m not in favour of centralisation [of health care] at all. Local government control (samorzad) is better. People know better what is going on, at least more so than in a centralised system. Still, we don’t know what the reforms will
bring. Generally though, local control is better. The contacts are more frequent, you have government offices in your town, unions, and others watching. The flow of information is simply better. When you try to communicate in the centre it is inefficient. ¹

In line with this point of view, the AWS government, on 1 January 1999, created 16 regional Kas Chorych, or Patient Funds, ² plus one additional Fund at the national level to serve members of the Police and Armed Services. The Patient Fund system would be financed by Polish citizens. Social insurance contributions were set at 7.5% of individual’s taxable income and employees were sole contributors to the fund, as employers did not contribute (Kornai & Eggleston, 2001, p. 149). Provinces were allowed to engage in deficit spending. Provinces could create a reserve fund, but local governments were also allowed to bail out Patient Funds. As of 1997 there were no co-payments for outpatient or inpatient care (Kornai & Eggleston, 2001, p. 154). Poland’s 1999 health decentralisation reforms, in place until mid-2002, made the costs of health care much more direct and real for many Poles, while also promising a measure of localised, provincial control over health care benefits and services.

This article examines two questions: first, whether or not Polish citizens were satisfied with decentralised health policymaking that began in 1999. Decentralisation writ large was seen as a natural remedy for 45 years of centralised communist rule, but the empirical question remains as to whether Poles were, in reality, happier with local control over health policy than national control over these matters. We report national public opinion on health from 1996 to 2006, the period before, during, and after decentralisation. We show that Poles were more dissatisfied with their health care when it was decentralised (effective 1999–2001) than before this period (1994–1998) or after (2002–2007), when health care policymaking was centralised. This finding is striking, given the arguments for decentralisation, and the fact that the most precipitous drop in overall health spending occurred in the early 1990s, years of Polish economic shock therapy. Second, we use original survey data to examine what factors explain Poles’ levels of satisfaction or dissatisfaction with decentralised health services. We examine how political party identification affects individual’s expectations of and evaluations of decentralisation, while controlling for respondent’s age, gender, region of residence, access to media, and attitudes on European Union integration. In particular, we find that party identification shapes the ways that voter’s anticipate decentralisation and perceive government decentralised services. Individuals who identify as supporters of the post-communist SLD were more likely to report dissatisfaction with decentralisation. Thus, our work sheds light on when decentralisation policies will be more readily embraced by the public: when the reforms are advocated by the majority party, and when these policies are perceived by the public as adequately funded and efficient, rather than underfunded or captured by local political interests.

**Origins of Health Decentralisation in Poland**

To evaluate decentralisation in Poland, it is important to examine the overall party system, party positions on decentralisation, and the compromise decentralisation reforms that were enacted. Since 1989, Poland has experienced tumultuous changes in its political party system (Bakke & Sitter, 2005). After the 1989 partially free
elections, in 1991 a record number of parties ran and won seats in the Polish national parliament or Sejm. Kitschelt et al. (1999) described Poland as having a roughly seven-party system. Poland had three parties on the Left: Labour Union (UP), a smaller communist successor party; Democratic Left Alliance, the largest communist successor party; and the agrarian Polish People’s Party (PPP). Poland had at least one party of the centre: Freedom Union (UW). Finally there were three parties on the Right: Solidarity Electoral Alliance; radical populist Self-Defence (SO); and the Catholic nationalist Polish Family League (LPR).3

In 1997, many of these rightist parties came back under the banner of the Solidarity Electoral Alliance. Central to AWS’ platform in the 1997 election was the introduction of administrative reform and decentralisation, as a way to promote Catholic anti-communist values (Szczerbiak, 1999a, 1999b; Gwiazda, 2009). AWS leaders wanted ‘competitive private insurance, private provision of health service, and separation of ambulatory and in-patient services’ (Bossert & Włodarczyk, 2000, p. 18). AWS leaders also wanted to see both competition for insurance including ‘Branch funds’ for different sectors and the direct election of Patient Fund board members. AWS coalition partner, the Freedom Union, was a party whose core supporters surrounded the political figure of Leszek Balcerowicz, father of Polish shock therapy, or rapid neoliberal economic reforms. Politicians from Freedom Union supported greater competition and choice in health insurance provision, but they also advocated for municipal, rather than provincial, control over health care. This aspect of Freedom Union’s health strategy would eventually put the party more in alignment with the SLD than its coalition partners, the AWS.

During the decentralising reforms of the mid-1990s, the SLD wanted to show that it was reformed and not trying to centralise power in Warsaw, and so agreed on a weaker form of decentralisation (Bossert & Włodarczyk, 2000; Kerlin, 2005; Yoder, 2007). In government (1993–1997), the SLD continued Solidarity reformers’ calls for decentralisation of administration and health care without publicising it. The SLD worked with Freedom Union to pass the Large Cities Act, giving control for outpatient health care and some hospitals to large cities, which were more sympathetic to SLD. When AWS won the 1997 elections, it began working on a package of reforms to decentralise aspects of four major policy areas: pensions, health care, education, and administration.4 However, AWS was bound to working within the health care deals that had been negotiated by the SLD and Freedom Union. The resulting Health Insurance Act passed in 1998 by the AWS government was largely agreed between the SLD government and the social democratic wing of the Freedom Union. The Health Insurance Act was not the competitive system the AWS wanted to pass, but the bill it was stuck with implementing (Bossert & Włodarczyk, 2000). The new system was financed by 7.5% of employees’ personal income, routed to 16 provincial Patient Funds, whose administrators were appointed by regional parliaments, rather than elected as AWS wanted.

The parties’ positions on the involvement of the state in economic matters and decentralisation are supported by Benoit and Laver (2006). Notwithstanding challenges to the traditional left–right party distinction in Polish politics, Figure 1 shows Benoit and Laver’s placement of Polish political parties on the left–right political spectrum. The party furthest to the left is the Labour Union and the party furthest to the right is the Union for Real Politics. Note that the Alliance of
Democratic Left, the third from the left, is the major communist successor party in Poland. Also note that Freedom Union and Solidarity Electoral Action fall in the centre. Benoit and Laver also classified Poland’s political parties according to their stances on decentralisation, writ large. They did not specifically categorise parties by position on health decentralisation, so the measure is not as precise since it includes parties’ positions on decentralisation of education as well, but Figure 2 makes three important points for our argument. First, most centre and rightist parties support decentralisation, excepting the League of Polish Families. Second, and related, Freedom Union and Solidarity Electoral Alliance strongly support decentralisation.

**Figure 1.** Ideological position of Polish parties on left–right spectrum. *Source:* Benoit and Laver (2006).

**Figure 2.** Ideological position of Polish parties on decentralisation. *Source:* Benoit and Laver (2006).
Third, the Alliance of the Democratic Left is less supportive of decentralisation than Freedom Union and Solidarity Electoral Alliance. Particularly on decentralisation of health care and administration, the SLD grew increasingly critical of decentralising politics from 1999 until the SLD’s electoral victory in 2001. In late 2000, the SLD campaigned against the AWS in large part on the need to recentralise and rationalise health care. After taking control of government, SLD minister Mariusz Łapinśki recentralised health care toward the end of 2002, using the infrastructure of the special Brażowa Patient Fund created for police, military and fire-fighters across the country, which existed alongside the 16 regional Patient Funds from 1999 to 2002.

National Public Opinion on Health Care in Poland

National public opinion surveys conducted by the Polish Statistical Centre CBOS (Centrum Badania Opinii Społecznej) provide context for overall satisfaction with health care since Poland’s transition to democracy, including during periods of decentralisation (1999–2001) and centralisation (1994–1998; 2002–2006). Examining Table 1, we gauge national levels of dissatisfaction with health policy over time by combining the percentage ranking of health care as rather bad and very bad. Table 1 shows us that Poles were very dissatisfied with their health system in 1994. At the peak of Poland’s shock therapy, and the period in which total health care spending decreases most precipitously, this low level of satisfaction with health care is readily understood. Dissatisfaction is relatively low when decentralisation laws are passed in 1998. However, dissatisfaction peaked at 79% in 2000. Dissatisfaction with decentralised health care services stemmed from a few main sources, including rampant problems with the Social Insurance system (ZUS) in collecting premiums from citizens and disbursing the money to the Patient Funds, inadequate resources for regional health funds, and political intervention in provincial health care decisions (McMenamin & Timonen, 2002; Finlinson et al., 2003; Watson, 2006). There were also medical corruption scandals, including the ‘Cash for Corpses’ scandal in Lodz, undermining citizen trust in doctors and health services all around (Walton, 2002). In large part because of the perceived failure of decentralisation, AWS failed to win any seats whatsoever in the Sejm in the 2001 parliamentary election.

Table 1. Percentage of Poles dissatisfied with health care, 1994–2007

<table>
<thead>
<tr>
<th></th>
<th>June 94</th>
<th>Sept. 95</th>
<th>Nov. 96</th>
<th>Mar. 98</th>
<th>June 99</th>
<th>Jan 00</th>
<th>Jan 01</th>
<th>Sept. 02</th>
<th>Nov. 03</th>
<th>Nov. 05</th>
<th>Sept. 06</th>
<th>Feb. 07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Rather good</td>
<td>20</td>
<td>18</td>
<td>26</td>
<td>39</td>
<td>24</td>
<td>15</td>
<td>23</td>
<td>34</td>
<td>26</td>
<td>36</td>
<td>30</td>
<td>32</td>
</tr>
<tr>
<td>Rather bad</td>
<td>33</td>
<td>32</td>
<td>36</td>
<td>42</td>
<td>44</td>
<td>41</td>
<td>35</td>
<td>39</td>
<td>42</td>
<td>42</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Very bad</td>
<td>44</td>
<td>47</td>
<td>31</td>
<td>10</td>
<td>22</td>
<td>38</td>
<td>37</td>
<td>17</td>
<td>21</td>
<td>17</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Dissatisfied*</td>
<td>77</td>
<td>79</td>
<td>67</td>
<td>52</td>
<td>66</td>
<td>79</td>
<td>72</td>
<td>56</td>
<td>63</td>
<td>51</td>
<td>62</td>
<td>59</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>10</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Mean % Dissatisfied</td>
<td>68.7</td>
<td>72.3</td>
<td>58.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Notes: A: For a given column, Dissatisfied equals the sum of ‘Rather bad’ and ‘Very bad’.
The most comparable indicator over the time period is a survey question asking about the respondent’s overall satisfaction with health care.
In later years the question was specifically about public health care.
elections. The key communist successor, Alliance for the Democratic Left, positioned itself as a competent, credible, western European style social democratic party. With the 2001 parliamentary elections, incoming Minister of Health Mariusz Łapinski quickly advocated a recentralisation of health policy to bring order and competency back into the health care system. Dissatisfaction with health care decreased to 56% in 2002, which may reflect public belief that SLD recentralisation would rationalise health care in Poland again. On average, levels of dissatisfaction with health care in Poland were higher during years of decentralisation (73%) than centralisation before (68%) or after the reforms (58%).

Does the drop in public expenditure on health care drive Poles’ dissatisfaction with decentralisation? Citizens’ perceptions of lower government expenditure on health care during decentralisation are an important part of the story, but not the only explanation. The overall picture of Poland’s health expenditure since 1990 has been one of cuts in the early 1990s, a dip in spending associated with the 1998 reforms, followed by a moderate rise in spending by early 2000s (see Figure 3). The year in which our surveys were conducted (2002) health care spending was at 6.3% of GDP, up from 5.5% in 2000. While overall spending has averaged 5.7% of GDP in this period, the proportion of health expenditure that is public has declined markedly (see Figure 4). Major adjustment came in the early 1990s, when public expenditure on health, as a percentage of total spending on health, went from 91.7% to 75.6% in 1991. Percentage of public expenditure as a percentage of total health expenditure remained in the mid 70% range until the 1998 reforms, dropping to 65.4%. As of May 2002, the year in which our survey was conducted, 71.2% of health spending in Poland was public expenditure. So, citizen dissatisfaction with health care, if driven solely by levels of government expenditure, should be lower in Poland in early 2002 than it was in 1994, which it is not. Clearly, health decentralisation reforms are adding to citizen dissatisfaction with health care in Poland in early 2002.

In addition to government expenditures on health care, perhaps the speed of reforms influenced citizen’s evaluation of the health care system. In comparison with its Visegrad neighbours, Poland has undergone about the same level of health sector

privatisation as Hungary and Slovakia, but it did so earlier and more abruptly. Throughout the 1990s, Hungary pursued gradual reductions in public health expenditure as a percentage of total health expenditure, until it reached about the same level as Poland: 70.9%. Slovakia reduced public spending on health, but did so much more recently, from 88% in 2003 to 68% in 2006. Poland’s health care expenditure is far more privatised than that of the Czech Republic. For example, in the Czech Republic 88% of health expenditure is public expenditure, rather than the 70% we find in Poland, Slovakia, and Hungary (Mihalyi, 2000). Comparing public health expenditure levels in Poland with other Visegrad nations, we would expect strong dissatisfaction among Poles in the early 1990s, as they adjusted to cuts in health care spending associated with 1991 shock therapy. We expect a dip in public opinion on health associated with more private spending on health care in 1999/2000, but we also expect Polish public opinion on health to be relatively improved by 2002 with spending increases, if public opinion is driven solely by levels of government expenditure on health care. Since public dissatisfaction with health care in Poland peaks at 79% in 2002, amidst reforms but increased government spending, factors other than how much they are spending out of pocket must influence individual’s perceptions of health care in Poland.

Alternatively, Poles may have been upset that decentralisation did not successfully bring provincial needs and resources into the health care decision-making process. Poland’s 1998 health decentralisation was intended to give Polish regions substantial power in directing spending. In reality, Polish health decentralisation may have kept power in the hands of national ministers and municipal powerbrokers. Kornai and Eggleston (2001) report that the de jure intent of the 1998 Laws on Decentralisation and Health Care was to give real authority to the Patient Funds. ‘From January 1999, in Poland, budgets for operating costs are allocated by the territorial [Patient Funds]. Covering capital costs will remain the responsibility of the Ministry of Health’ (Kornai & Eggleston, 2001, p. 158). The territorial fund determined payment for outpatient care and inpatient care ‘according to the choice by the territorial fund’ (Kornai & Eggleston, 2001, p. 291). Moreover, secondary sources and interview data confirm that health decentralisation allowed provinces to pursue different policy.

**Figure 4.** Polish public health expenditure in billion zlotys, 1990–2005. OECD (2011) OECD Stat Extracts, available at [stats.oecd.org].
strategies. Some Patient Funds were sites of provincial policy innovation, the likes of which we would expect to see under meaningful decentralisation. For example, Kocińska reports that the Śląskie Fund was pursuing unique programmes based on new regional autonomy over health care policy. The Śląskie Health Fund adopted a health identification card which stored information about individuals’ health status and health claims to streamline information and prevent fraud and abuse (Kocińska, 2002a, 2002b). The Śląskie Health Fund also created a rainy day fund to cover years with higher than expected costs. Granted, Ślaskie was endowed with very rich health resources in the provincial capital city of Katowice, but this evidence suggests Patient Funds can pursue innovative provincially conceived and implemented policies different from national directives, given the human and capital resources to do so.

Despite stories of successful decentralisation, there are also negative outcomes of decentralisation. These include inadequate capacity of some provincial administrators and ‘political meddling’ in Patient Fund contracting which made the system as inefficient and political as the one it replaced (Finlinson et al., 2003). National or regional officials, with little reason to support budgets being given to Patient Fund directors, could intervene in Patient Fund politics, and often tried to ensure that important providers or hospitals be given government contracts. In an interview with Rincker, a Patient Fund employee described how provincial political ties determined health care contracts rather than concern for efficiency:

There was a rural powiat [county] hospital outside of Limowa that was very badly in debt, and going to be liquidated. This public hospital was in danger of closing, and there were problems with the unions. The hospital building had been given to it by the county government. Then the powiat decided to rent out the property to a private owner. The owner of the private hospital was a member of the local government. After three years the hospital became private, but now the powiat official says he cannot rent out the building to a private hospital. So, a well-running private hospital will probably be closed to protect a public county hospital. The hospital will be re-publicized as an outlying department by the powiat leader, who essentially paid money to himself. There was pressure from the hospital director and unions to protect the public hospital.5

This example of health care services under Poland’s health decentralisation system shows that incentives for politicians to reward connections and public entities can undermine efforts to make decentralised systems competitive and transparent, and reduce public support for decentralisation. In this example, it is notable that powiat officials who choose to reward friends with political connections over efficient health providers should be removed through the electoral process, but the problem of citizen awareness and accountability may persist in provincial or lower-level politics as well as in national politics.

Hypotheses

Here we present four hypotheses derived from the literature on decentralisation, health policy, political party systems in transition, and voter expectations, as well as
from interviews with health officials and consumers in Poland. We expect to find that respondent’s age, party identification, positive anticipation of decentralisation, wealth, and region of residence will be significant predictors of a person’s positive or negative evaluation of health decentralisation. We also include control variables, such as gender, civic involvement, frequency of media consumption, and attitudes on European Union integration.

First, the decentralisation literature suggests citizens broadly support the notion that the most local level of government possible should be given authority over political decision-making. However, support for decentralisation is contingent upon the policy area in question. According to Tiebout (1956), decentralisation should lead to more efficient policymaking. Local officials have greater information about the needs and resources of their provinces, and should be able to craft more responsive, efficient policies. Additionally, as provinces compete with each other, they face incentives to innovate and retain their citizens. Organisations such as the World Bank and the International Monetary Fund have encouraged decentralisation as a key strategy for enhancing democratisation in new and developing democracies. Additionally, public opinion research on decentralisation in the United States suggests that America has gone through periods in which decentralisation has been a broadly popular strategy, such as the 1994 Republican ‘Contract for America’. Similarly, in post-communist Central and Eastern Europe, the 1990s were a time when decentralisation resonated with people. However, Shaw and Reinhardt (2001) show that support for decentralisation in the U.S. is contingent upon the policy area in question, and whether the lower level-government has the capacity and autonomy to makes its own decisions. For example, one Patient Fund director argued that a key problem with health decentralisation was that the AWS government did not ‘prepare the management properly. Many important positions, like Hospital Directors were filled by politicians’ friends who were not competent for the jobs. They would move from being a doctor to a local government official to a hospital director to a Sick Fund Director without proper training. And these positions are very different.’

Hypothesis 1: the majority of Poles will support decentralisation in principle, but not health care decentralisation in particular.

Second, there may be generational divides on the issues of health care decentralisation, with older generations preferring the centralised system. While, looking across the region, Kornai and Eggleston (2001, p. 337) find no region-wide trend of older generations against decentralisation, in some countries there is a generational divide. For example, in Bulgaria, older generations strongly preferred the Soviet-style system, while up to 20% of younger generations supported direct payment for health care. Therefore, we examine a second hypothesis. Hypothesis 2: older citizens will be less supportive of health care decentralisation.

We also expect to find that respondents’ party identification influences their evaluations of decentralised health care. Because prominent SLD politicians, including the 2001 incoming Health Minister Mariusz Łapinski, supported recentralisation of Polish health services in mid-2002, voters who identify as SLD supporters should negatively evaluate decentralisation as well as report longer waiting times, fewer resources for health services, and lower access to health care. Conversely, we expect AWS supporters, whose party was the strongest advocate of decentralisation, to expect greater efficiency of the system, to rate regions as the most
responsive level of government, to positively evaluate decentralisation and want to see continued regional control of health care. Therefore: Hypothesis 3: Poles’ support for health decentralisation in Poland is affected by party identification.

Positive expectations about decentralisation may also affect how they evaluate it. Here we consider two competing schools of thought on positive expectations. Literature on the pain associated with economic shock therapy in Poland suggests that the higher citizen’s expectations for policy changes, the greater their discontent with policy outcomes. The J-Curve suggests that when individuals have rising expectations for their economic outcomes, coupled with sudden sharp declines in their economic well-being, they will negatively evaluate political officials in power (Davies, 1962). The pivotal point here is how can we predict, ex ante, the threshold at which the gap between citizen expectations and lived realities is just ‘acceptable’ and not unacceptable? According to Davies’ logic, those respondents who report high expectations for health decentralisation would report that they are very dissatisfied with decentralisation. Alternatively, political parties may shape voter’s perceptions of reality. Giovanni Sartori (1983) argued that societal cleavages do not divide the people on issues; rather, political parties create the cleavages. Parties are the ‘meaning-makers’ convincing citizens of which group identities matter and which groups and issues deserve representation in the political process. From Sartori’s point of view, party platforms, beliefs, and evaluations give citizens a filter through which they evaluate how well a policy worked. According to Sartori, higher expectations should be associated with more positive evaluations of health decentralisation. Hypothesis 4: Poles who anticipated positive effects from health decentralisation prior to 1998 will have positive evaluations of decentralisation in 2002.

Our statistical models, presented below, also control for the respondent’s gender, income level, region of residence, involvement in civil society organisations, sources of media consumption, and attitudes toward Poland’s accession to the European Union.

Data and Survey Methods

Our data consist of original surveys administered in four Polish provinces during May–July of 2002: Mazowieckie, Małopolskie, Lubelskie, and Śląskie. These four regions vary in terms of party control, percentage of region that is agricultural, and also original endowments in health care facilities. The survey was distributed by one author to health providers, health consumers, and national and regional political officials, including Provincial Patient Fund Administrators. The survey was distributed at a variety of settings including: Provincial Patient Fund offices in the four provincial capitals, academic hospitals, public hospitals, and ZOZs or non-public health clinics. The total number of individuals surveyed is 519. As the hospital setting is quite transitory, it was, therefore, difficult to calculate the potential number of respondents necessary to determine the response rate. Based on the variety of health settings in which the survey was administered and the general willingness of Poles to fill it out, we are quite satisfied with the representativeness of the sample, particularly so for these four Polish regions. Although some may counter that the focus is on urban centres of care, we note that many Poles would travel to the
provincial capital to receive health care, so the survey roughly approximates rural attitudes on health decentralisation.

Results

The results of Rincker’s (2002) Survey of Attitudes toward Health Decentralisation in Poland show that Poles were strongly dissatisfied with their country’s experiment with decentralised health services. As Table 2 shows, less than 30% of Poles involved in health care held a positive view of decentralisation. Respondents were asked which of five options motivated health decentralisation: improving health care, cutting spending, responding to EU pressure, putting friends in power, or counteracting losses in next national elections. Poles were fairly evenly split between the first two options. Fifty-two percent of respondents felt that decentralisation was introduced to improve health care, while 43% felt it was introduced to cut spending on health care (Table 3). Respondents negatively evaluated health care in the post-decentralisation era. Table 4 shows respondent’s views on the quality of health officials after the introduction of the Patient Funds. Just 10% believed that the quality of government health officials improved, while a striking 44% thought that the quality of health officials decreased during health decentralisation.

Table 2. Evaluations of quality of patient fund health services since 1998 health decentralisation

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Percentage</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better health care</td>
<td>26.06% (141)</td>
<td></td>
</tr>
<tr>
<td>Worse health care</td>
<td>37.71% (204)</td>
<td></td>
</tr>
<tr>
<td>No change</td>
<td>36.23% (196)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Rincker (2002).

Table 3. Reasons given for introduction of decentralisation

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve healthcare</td>
<td>48%</td>
</tr>
<tr>
<td>To cut spending</td>
<td>44%</td>
</tr>
<tr>
<td>To respond to EU pressure</td>
<td>29%</td>
</tr>
<tr>
<td>To put friends in power</td>
<td>33%</td>
</tr>
<tr>
<td>To counteract losses in next national elections</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: Rincker (2002).

Table 4. Respondent evaluations of health officials and health services, since 1998 health decentralisation

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Quality of health officials</th>
<th>Quality of health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has got worse</td>
<td>44%</td>
<td>38%</td>
</tr>
<tr>
<td>Has stayed the same</td>
<td>46%</td>
<td>36%</td>
</tr>
<tr>
<td>Has got better</td>
<td>10%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Source: Rincker (2002).
The dissatisfaction with decentralisation we found in our surveys is supported by other accounts of Polish health decentralisation (McMenamin & Timonen, 2002; Finlinson et al., 2003; Watson, 2006; Roberts, 2009). Finlinson et al. (2003) found only 29% of health insurance administrators believed quality improved under health decentralisation in Poland. Citizens’ negative views of decentralisation were apparent when we asked about Patient Fund performance. Table 4 shows just a quarter of respondents felt that the Patient Funds had improved health services; over a third reported health services worsened. Table 5 shows 40% of respondents reported that waiting times had increased and 53% stated that resources allocated to health had decreased. This result may be unsurprising, given the decrease in public expenditure on health after 1990. Even though the survey was administered in a period when public health expenditure was rising, it was still well below levels of health expenditure in Poland during state socialism.

### Explaining Attitudes toward Decentralisation

In the second part of our analysis, we examine what explains Poles’ evaluations of health decentralisation. Three aspects of health care reforms were prominent in how Poles assessed health care decentralisation: health care quality, timeliness of service, and resources allocated to health care. Therefore, we created three models to explore each of these aspects of the Polish health care system. We expected to see roughly similar results across the three models. Model 1, our dependent variable of health care quality, shows the answer to the survey question: ‘How would you evaluate the overall quality of health services provided by the Patient Fund for your region since the Patient Fund opened?’, in which respondents indicated that health care had 1) improved, 2) stayed the same, or 3) got worse. Model 2, our dependent variable of timeliness of service, shows the answer to the survey question: ‘Since the creation of Patient Funds, waiting times for treatments have 1) decreased, 2) stayed the same, or 3) increased.’ Model 3, our dependent variable of resources allocated to health care, shows the answer to the survey question: ‘Since the creation of Patient Funds the amount of resources devoted to health care have 1) increased, 2) stayed the same, or 3) decreased.’ We estimated a series of three ordered logit models. Ordered logit models are the appropriate model to run with a dependent variable that has three possible outcomes. In each case the dependent variable is ordered, but without a cardinal variable. Therefore, regression is not the correct method. However, it should be noted that when the models are estimated using Ordinary Least Squares regression, there is very little substantive difference (Long, 1997). All three models were statistically significant, as shown in Table 6.

<table>
<thead>
<tr>
<th>Table 5. Respondent evaluations of waiting times and resources allocated to health care, since 1998 health decentralisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting times</td>
</tr>
<tr>
<td>Increased</td>
</tr>
<tr>
<td>Stayed the same</td>
</tr>
<tr>
<td>Decreased</td>
</tr>
</tbody>
</table>

*Source: Rincker (2002).*
Survey data analysis shows strong support for three of our four hypotheses about citizen attitudes towards decentralisation. As expected according to Hypothesis 1, we found that most Poles support decentralisation reforms in principle. Over 70% of Poles surveyed believe that the most local level of government possible should be responsible for any given policy. This finding supports the position that decentralisation is viewed by citizens in post-communist countries as a policy tool to be seriously considered for more responsive, fair, and effective governance.

However, some factors we expected to influence strongly a citizen’s evaluation of health decentralisation were not significant. The age of a respondent was not a statistically significant predictor of a person’s attitudes towards health care decentralisation. Rejecting our Hypothesis 2, we can see that in none of the three models was the age of the respondent statistically significant. Older citizens were not more likely to be dissatisfied with decentralisation as a risky or heartless reform. We expected individuals who believed decentralisation was a guise for reducing state responsibility for or involvement in health care would be more critical and rank decentralisation as bad. This was not uniformly the case. As was stated in an interview with the author, the best thing to come out of health decentralisation was...
that '[the] reforms made the hospitals economise.' Across two of three model specifications, the view that decentralisation is a cost-cutting exercise is not a statistically significant predictor of negative evaluation of decentralisation. Many other factors also turned out to be insignificant predictors of a person’s evaluation of health care decentralisation in Poland, including: gender, marital status, occupation, the number of organisations a respondent belongs to, or an individual’s views of the European Union.

Our most important finding supports our third hypothesis: party identification affects people’s evaluations of health decentralisation. In our models, we used support for one party to overcome problems of multicollinearity. The party affiliation we ran in the model was those individuals who supported the Democratic Left Alliance, which was lukewarm about decentralisation, and came to oppose it strongly in late 2001. As hypothesised, Poles who identified themselves with the SLD were much more likely to evaluate health decentralisation negatively, and to respond that waiting times for health services had increased. We think SLD affiliation matters because citizens look to party leaders and messages in the media to help them understand what is going on in politics, and citizens’ political ideologies shape who and what they listen to. While respondents from other political parties reported longer waiting times or lower quality in their health care as a result of decentralisation, they did not register the same predictably low level of satisfaction with decentralisation as their fellow citizens who aligned politically with the SLD. Therefore, party affiliation is shaping and reinforcing attitudes toward health decentralisation in Poland.

We also found strong support for Hypothesis 4: respondents with positive expectations of decentralisation also tended to evaluate decentralised Patient Funds positively. Respondents who reported believing things would go well with decentralisation evaluated decentralisation positively. Those who anticipated that decentralisation would not work well evaluated decentralisation negatively. These attitudes on health decentralisation held true across evaluations of health care quality, as well as waiting times and resources for health care. We note the possibility that respondents observed that things were bad, and then consciously or unconsciously re-evaluated their ‘original’ expectations, but believe it more likely that respondents did hold expectations, and these affected how successful they believed decentralisation to have been. For example, respondents living in the provinces of Lubelskie and Śląskie were more likely to evaluate decentralisation positively. These regions benefited from the decentralisation of health care decision-making and funds, and Warsaw and Kraków, the capital and ‘second city’ respectively, were more likely to expect negative outcomes of decentralisation and to evaluate it negatively, as they lost out when funds were redistributed to other provinces.

What about differences in findings across the three models? In Model 2, which asked people about waiting times, there was a similar party affiliation effect, and an effect of expectation on respondents’ evaluations of decentralised health care. There was also an effect based on where the respondent lives; however, there was not a positive effect from respondents from Lublin. The only major differences between Model 1 and Model 2 was the viewpoint that decentralisation was introduced to improve health care is no longer significant in explaining timeliness
of health care, and that support for the EU was significant (at the 0.1 level). Model 3, which asked about level of resources, was not as successful in capturing why respondents felt as they did. In Model 3, party has no effect. Only living in Warsaw affects one’s view of resources allocated, again in a negative way. Also, there is some expectation effect, with those who believe that Patient Funds were introduced for positive reasons believing there were more resources for Patient Funds, while those who felt Patient Funds were introduced under EU pressure, or to cut spending, viewed decentralisation as a cut in public health expenditures. Generally speaking, in two models which describe outcomes of the health system – quality and waiting times – SLD party affiliation is a strong and significant predictor; age is insignificant, and variables that account for expectations were significant as hypothesised.

Conclusions

This analysis suggests three important insights for policy decentralisation and party systems in Poland and the region of Central and Eastern Europe. First, Poles were satisfied with the general notion of local government, but were not satisfied with the implementation of decentralisation in their health services sector. As Regulski (2003, p. 218) noted, one necessary condition for the success of decentralisation reforms is ‘public support, [or] at least consent’ for the reforms. Public consent in Poland for decentralisation was high, but fell in accordance with the perception that implementation had failed. Second, this paper shows that citizens’ party affiliations and expectations strongly affect their evaluations of decentralisation. In Poland, the post-communist SLD enjoyed greater institutionalisation in the party system, was reluctant to decentralise, and came to criticise strongly the 1998 health decentralisation, as the AWS’s political fortunes were waning. In contrast with other political parties, the SLD therefore shaped and reinforced its supporters’ negative evaluations of health decentralisation in Poland.

Third, this analysis suggests that expectations help create a constituency for decentralisation. The results of our 2002 health decentralisation survey contrast with analysis of Poles in the early years of transition in the 1990s, where high hopes for political reforms led to drastic falls in citizen confidence with government. With health decentralisation, high hopes led to many satisfactory evaluations of the decentralised Polish patient funds, particularly in regions outside of Warsaw and Kraków. Respondents who expected good to come of creating provincial Patient Funds to administer health care evaluated them positively. But the message of improvements in health care was most likely lost in press coverage of rising private medical costs, medical scandals, and criticism of reforms by politicians within and outside the SLD. A longer decentralisation reform period, coupled with greater public expenditure on health and fewer medical scandals may have led to more positive evaluations of Poland’s decentralised Patient Funds. This analysis suggests that citizens in post-communist polities like Poland are receptive to policy decentralisation. To enjoy sustained high levels of public support, decentralisation requires a developed party system in which the pro-decentralisation party maintains majority support by promoting positive reform outcomes and endowing capable decentralised units with the resources to fulfil their mandates.
Acknowledgements

The authors would like to thank John Carey, Andrew Roberts, Saul Lerner, and panelists at Midwest Political Science Association for their comments on earlier drafts of this manuscript. Any errors are our own.

Notes

1 M. Rincker, July 2002. Interview with Deputy Head Nurse in Kraków, Poland.
2 'Kas Chorych' is also known as a Sick Fund but for clarity here is translated as a Patient Fund.
3 Responding to the 1993 elections, in which electoral thresholds were introduced, a number of Solidarity successor parties and parties on the political right of the spectrum received no representation in the Sejm. By 2006, Freedom Union's neoliberal position was replaced by Donald Tusk's Civic Platform PO and the further right Truth and Justice Party, led by the twin brothers: former President Lech Kaczyński (deceased) and former Prime Minister Jarosław Kaczyński. In the centre lie the agrarian Polish People's Party, and Poland Comes First, led by Joanna Kluzik-Rostkowska. On the left, the Democratic Party and Social Democracy of Poland have formed and hold seats in the Sejm, in addition to Labour Union and Democratic Left Alliance. Thus, in 2011, there are eight political parties active in the Polish national Sejm.
4 M. Rincker, June 2002. Interview with former Vice Minister of Health in Kraków, Poland.
5 M. Rincker, May 2002. Interview with Patient Fund employee, Poland.
6 M. Rincker, June 2002. Interview with Patient Fund Director, Poland.
7 The role of the respondent in the health care system (health care provider, consumer or administrator) was not a statistically significant predictor of respondent's evaluation of decentralised health care in Poland.

References


