

GENDER MACHT ARBEIT

WIDE, Berne, 4 May, 2012

Financialization of public health care in
Poland

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Main sources for the presentation: Feminist Think Tank research and publications:

Julia Kubisa. Protests of nurses and midwives in the context of health care reforms. FTT report 2008

Anna Zachorowska. Reclaiming citizenship. Macroeconomic analysis of the situation of women in Poland. FTT report 2010

Ewa Charkiewicz. Feminist critique of health care reforms. FTT report 2007

Ewa Charkiewicz & Anna Zachorowska, eds. Gender and Care Economy. 2010

View from the ground

2006. Claudia, diagnosed with stomach cancer is refused life saving treatment. The treatment can be prescribed to grown-ups. She is 16. It is illegal to save her. One of the commentators on the Polish media website Onet compares the new health care procedures to selection in Auschwitz.

In 2007. 994 women in Wroclaw went through risky and unnecessary procedures (hysteroscopy, entailing womb puncture) that earned the hospital one million zlotych. The procedures were ordered by the head of the gynecology and neonatology clinic to earn money for the clinic and help pay hospital debt. The hospital went in debt because of providing health care on need basis, beyond contractual agreement with the National Health Fund

Hospital floor experience in many hospitals: doctors and nurses struggle with the system to ensure care

How health care/market for medical services is organized

- Pay roll & private household financed (86 %, 2009. In 2004 54 %) with contributions from state budget.
- National Health Fund manages the money and signs contracts with public and private providers who compete for contracts.
- Access for subscribing and registered population. „Registered poor” and “registered unemployed” - costs covered from public budget
- Predefined health care package (pending the provider signed the contract with NHF), and partial funding of medication costs available for entitled & registered population
- All other procedures on the basis of individual requests of the doctor to Medical Technologies Agency.

Health care reforms. How they were carried out

- First attempts at reforms in the 1980. Until the early 2000s discourse on health care as right, as commons, and as “basis for durable social and economic development” (National Health Care Strategy 2006 – 2015, draft). **Disjunction between rights discourse and politics of financial allocations.**
- Since the early 1990s liquidation of hospitals and local clinics. Health care at work place & schools dismantled. New private sector in the primary care. **(Destruction of existing organizations necessary to put new system in place).**
- **Decentralization of health care to local authorities without financial allocations.** Result: growing debt of hospitals. **Emergence of new markets in hospital debt** (securitization). To solve the problem of lack of resources hospitals shifted to employing nurses on civil contracts (labor code does not apply). Since 2011 legal guillotine. Local authorities forced to pay hospital debt or to commercialize hospitals.
- In the mid 1990s **a new discourse on health care as an issue of costs management emerged. The frame mediated political decisions on health care.** Investment in reports, engagement of neoliberal think tanks, scientists and media in production of new knowledge on financial aspects of health care. The main message is “we” (?) cannot afford the wasteful system. Discourse on costing health care provided toolkits for managing care (capitation, diagnostic related groups – DRG)
- **Persuasive marketing strategies, healthy budget frame, shock therapy model;** targeting specific groups (e.g. investment in persuading nurses to move to self-employment in the name of empowerment, reconciling private life and work)
- **Contractual system,** and extra-contractual treatment (life saving beyond contracts)) as debt trap.
- **Changes through the force of law.** The role of Constitutional Tribunal.

What has happened? From health care to medical services markets

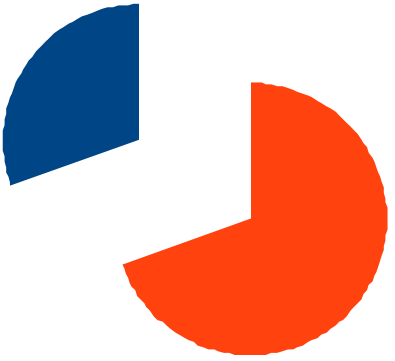
- Blanket concept of neoliberalism is not useful. Neoliberalising health care takes different and contingent forms (privatization with regulation; commercialization or marketization without privatization).
- (Foucault on neoliberalism as extension of markets and dissemination of entrepreneurial form. Ideal model of free market as permanent economic tribunal which constantly demands adjustment. Hence never ending reforms).
- Form of enterprise (efficiency imperative, management by financial allocations) disseminated at all levels of the system. Public hospitals and the state itself governed as financial firms. Treatment is commodified, it becomes a disembodied techno-financial product which is traded on medical services market between provider and insurer.
- Financialization of health care at micro-mezo and macro levels, enforced from inside and outside. Governing and self-governance through finance (including debt), financial valorization, by contracts and audits focussed on finance.
- Control of medical profession displaced. No longer doctors but financial managers decide who will live and who will die.
- Terminal care patients (valorised as economically useless populations) yield no profits. Hence total neglect, lowest staffing levels (work intensified), medications and food costs minimized. Hospitals forced to choose breast amputation rather than chemotherapy The choice is between two financial options: 7000 zlotys versus 37 000 zlotys.

Sources of financing health care. Life on private subscription

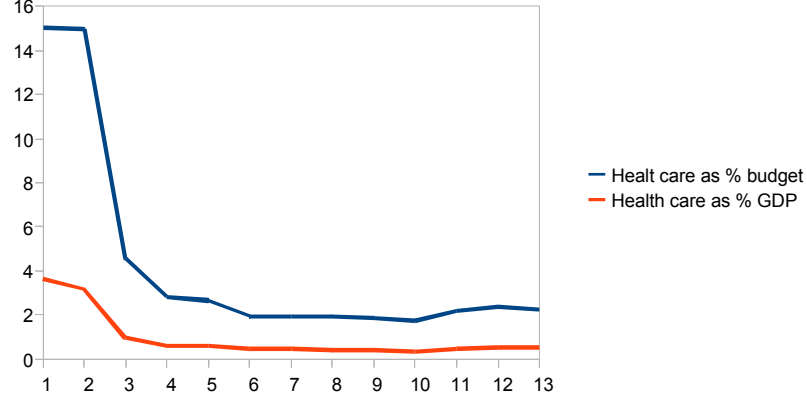
- Sources of financing 2006 - 2010

Health care budget 1997 – 2009
(Zachorowska, 2010)

In 2009 87 % from pay roll and private households. In 2004 57 %)



■ State & EU ■ Pay-roll & private



Public but hollowed out

- During the perpetual reforms, the health care system shifted to markets for medical services.
- Rights displaced. Universal access dismantled with financialization.
- High management costs. It would be cheaper to provide free health care to every citizen.
- Economic efficiency as regulatory framework in health care generates social inefficiency. Work does not disappear. It is transferred.
- Responsibility for care shifted to households and disproportionately to women. Affluent women can buy time of other women to provide care work. The burden falls in particular on women from poor and middle income households, and migrant women.

Mentalities of economic decision makers: patriarchy meets neoliberalism. Budget deficit (a whole in the budget) in a woman's abdomen. Women as devourers of budget



About the cartoon: patriarchy meets neoliberalism in public finance

- **CIVIC DEVELOPMENT FORUM (FOR), competition for economic education cartoons, 2009 theme: budget deficit.**
- **In Polish political discourse the deficit is addressed as “the hole in the budget”. The cartoon that won the 1st prize, represents the Republic of Poland as a simple country woman, and identifies the hole in the budget with her womb, and her voracious appetite for social provisioning, including health care.**
- **The judge in the competition, founder and director of FOR, is a former minister of finance, head of national bank and deputy prime minister, architect of “shock therapies” of the 1990s. prof. Leszek Balcerowicz.**
- **www.for.org.pl**
- **Health care expenditures for treating men exceed by 30 % expenditures on women. (Source: NFZ, 2010)**

Strategic role of nurses and midwives.

- Located between marketization of care and care as (unmutual) obligation.
- Nursing profession as strategic site for neoliberalization of care (following 1999 reforms 1/3 loss of employment; intensification of work, precarization)
- Political care – in the context of withdrawal of the state from responsibility for health care of citizens, nurses union activists took up this responsibility in their own unpaid time intervening in reform discourse from the perspectives of rights to health care
- Aging of the professional group. Young women do not choose to become nurses.

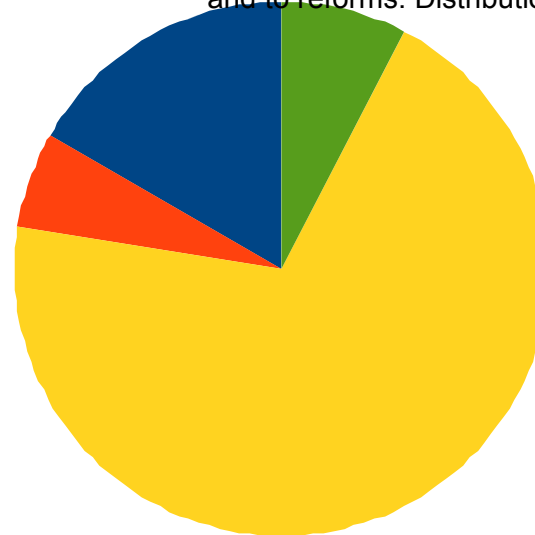
All Poland Nurses and Midwives Trade Union – response to reforms



- Protest actions since early 1990s, against liquidation of hospitals, pay and work conditions, casualization of work, intensification of work, impacts on quality of care.
- Hunger strikes, occupations, marches, media work, interventions in health care law making, critiques of health care reforms
- Reaction of the state: repressions of resistances and encouragement to neoliberalizing the profession (e.g. grants for professional associations to encourage nurses to shift to self-employment)
- New private hospitals do not employ union activists
- New polarization between different groups of nurses (e.g. specialised in anesthesiology, and nurses employed in terminal care)
- Invisible women: hospital cleaners and cooks – the first group to lose employment, work outsourced



65 m euro for adjustment of nurses and midwives to EU requirements, and to reforms. Distribution by beneficiaries



- Business & for profit NGOs
- Professional Corporations
- Government
- Universities

Care economy and public finance

- Increase in public income and expenditures, constant GDP growth since 1994
- Decline in the share of expenditures on care (education, child care, health care, social protection) in the budget, as corrected for inflation, and as share of GDP. (research by A.Zachorowska, 2010)
- Budget deficit growth
- Polish National Development Strategy to 2030 – main goal accumulation of capital. Assumption of trickle down effects
- Redistribution to private sector (private keynsism)

Feminist conclusions

- **Health care reforms as a new round of enclosures** - this time in the publicized domains of social reproduction/care economy, such as health care, pensions, childcare, education, protection of the poor and disabled, communal services – in parallel to privatizing nature
- **When the state governs through budgets the citizens are recategorized as assets or liabilities.** Care and care/reproductive work fall in the category of liabilities that have to be minimized for the sake of good management of the state.
- **De-democratization.** (No public debate, decisions shifted to unelected expert bodies and organizations). Centralization of decision making. New form given to former citizens: registered or unregistered. Rights, including women's social rights do not erode. They are displaced.
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- Feminist strategies for change have to relate to different forms and contexts of neoliberalizing health care, and to the financialization of public care sectors and the state.