

Financial Resource Flows for Population Activities

Report of a case study in Poland

The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund

Table of contents

List of figures

List of tables

Preface

Map of Poland

1. Demography of Poland.....	1
2. Methodological issues	7
3. Official population policy and programs.....	11
3.1. Government population policy	11
3.2. Family planning.....	11
3.3. Reproductive health.....	13
3.4. Gender Issues/ Women’s promotion and development.....	14
3.5. HIV / AIDS and other STD activities.....	15
3.6. NGO sector in Poland	17
3.7. Donor coordination.....	17
4. Financial Flows.....	19
4.1. Institutional framework and budgeting system	19
4.2. Role of the Government of Poland	26
4.3. Role of national NGOs.....	36
4.4. Role of the Private Sector.....	42
4.5. The Role of the International Donor Community.....	42
4.5.1. Development of foreign donor funding in Poland	42
5. Concluding remarks.....	49
5.1. ICPD within the Polish context.....	49
5.2. Discussion: future data collection on resource flows.....	49
5.3. Recommendations	51
References	53
Annex 1.....	57
Annex 2.....	59
Annex 3.....	61

List of figures

Figure 2.1. Number of registered AIDS cases in Poland, 1985-2000	4
Figure 5.1. Schematic Overview of Financial Flows after the 1999 reforms	23
Figure 5.2. National Institute of Hygiene, income by source, 1992-2000	32
Figure 5.3. Structure of income, Institute of Mother and Child, Warsaw	33
Figure 5.4. KBN research grants by category, 1999-2001	35
Figure 5.5. Total donor expenditures for population activities, Poland 1990-1999	43
Figure 5.6. Donor funding by population activity category, Poland, 1996-1999	43
Figure 5.7. UNFPA expenditure in Poland by category, 1996-2000	46

List of tables

Table 1.1. Selected demographic indicators, Poland	2
Table 1.2. Use of contraceptive methods in Poland, 1996	3
Table 4.1. Poland, maternity and childbirth benefits, 1995, 1999, 2000	25
Table 4.2. Health budget, Poland, by administrative level, 2000 (Zloty's)	26
Table 4.3. Polish National Program for HIV Prevention and Care for people living with HIV/AIDS,	29
Table 4.4. UNDP budget, Poland, 1996-1999	46

List of abbreviations

ARV	Anti-retroviral drugs
HAART	Highly Active Anti-Retroviral Therapy
ICD	International Classification of Diseases
IMR	Infant mortality rate
KRUS	<i>Kasy Rolniczego Ubezpieczenia Społecznego</i> , Agricultural Social Insurance Fund
MMR	Maternal Mortality Rate
MOHWS	Ministry of Health and Social Welfare
MOND	Ministry of National Defence
PSL	Peasants' Party (formerly the ZSL party)
UFMR	Under-five mortality rate
UNUZ	<i>Urząd Nadzoru Ubezpieczeń Zdrowotnych</i> , Health Insurance Supervision Office (HISO)
ZOZ	<i>Zespół Opieki Zdrowotnej (ZOZ)</i> , autonomous health care administration units
ZUS	<i>Zakład Ubezpieczeń Społecznych</i> , Social Insurance Institution

Preface

In the Program of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Program of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities. The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Program of Action. This means four categories of population activities¹:

- Family planning services;
- Reproductive health services;
- STD and HIV/AIDS programs;
- Basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programs in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost \$ 17.0 billion in 2000, and increase to \$ 21.7 billion in 2015. The recipient countries should pay two-third and the international donor community one third.

In order to measure global financial resource flows for population activities, the UNFPA/NIDI Resource Flows project has sent questionnaires to public and private donor organizations in developed countries and to government departments and national NGOs in developing countries and countries in transition. Collecting all this information from a broad range of respondents is not without problems in terms of issues of definitions, classifications, response rates and time lines. To

¹ Basic reproductive health services given at primary health care level include: Information and routine services for prenatal care, normal and safe delivery, post-natal care; abortion (as specified in paragraph 8.25 of the ICPD document); information, education and communication (IEC) about reproductive health, human sexuality and responsible parenthood, and against harmful practices; adequate counselling; diagnosis and treatment for reproductive tract infections, as feasible; prevention of infertility and appropriate treatment, where feasible; and referrals, education and counselling services for pregnancy and delivery complications.

better understand and resolve these problems, country case studies are conducted. These case studies will complement our knowledge about financial flows for population activities, which was obtained through the mail enquiry.

The case study in Poland was conducted from 14/1/2002 to 30/1/2002, and forms part of the UNFPA-NIDI project, which measures global financial resource flows for population activities. Data for this report were gathered by Dr. Ernst Spaan, on the staff of NIDI and member of the UNFPA/NIDI Resource Flows team, Dr. Krzysztof T. Niemiec MD, the national consultant for this study based in Warsaw, and Ms. Beata Balinska of UNFPA-Warsaw. We like to extend our sincere gratitude to Mr. Destanne de Bernis, UNDP/UNFPA Representative for Poland, and his staff, for the warm welcome and excellent logistical and substantial support for this study. Thanks also to Ms. Sylvia Stomiczewska who translated documents from Polish to English. Last but not least, we like to extend our gratitude to the respondents, who kindly shared their time and information with us.

Poland is the first UNFPA/NIDI case study in an Eastern European country in transition. The health sector in Poland has been completely reformed. The former health system based on the Soviet Semashko model, with universal state subsidized health services, has been replaced by one characterized by decentralized health services, universal health insurance and free market principles. The case study took place shortly after an election took place, resulting in a change of government and positions in governmental institutions.

The change of system has resulted in a lack of comparable data and a lack in institutional memory. These factors, together with the short duration of this study, have complicated the measuring of resource flows for reproductive health and population to a certain degree, so that this report could contain some omissions and inaccuracies. However, the authors have striven at comprehensiveness and accuracy. They take full responsibility for any errors and welcome any comments and suggestions for the improvement of the information contained herein. We hope this report will help increase the knowledge of the health system in Poland and be of use to all stakeholders in health sector development.

Ernst Spaan, Krzysztof T. Niemiec and Beata Balinska
Warsaw, The Hague, November 2002

MAP OF POLAND



1. Demography of Poland

In 1999 Poland was ranked as a country with high human development.² The country is currently going through fundamental changes in the demographic, political, social and economic fields. Poland is currently preparing for EU Accession in 2003, which has implications for all economic sectors. The health and educational sectors and the physical infrastructure need modernization and large-scale improvements in order to meet EU standards. In addition, the upgrading of public administration and reforms of the legal system are needed in order to successfully implement social restructuring and privatization.

Although during recent years Poland has experienced economic growth, the transformation process from an agricultural economy to a service based economy has been accompanied with problems of unemployment (13 per cent in 1999) and (rural) poverty.³ The Russian economic crisis of 1998 and high costs associated with economic and social restructuring have contributed to balance of payment deficits and tight government budgets (UN, 2000).

Poland's GDP per capita increased from US\$ 3,293 in 1995 to US\$ 4,078 in 2000 (CSO, 2001a, p. 716).⁴ This is far above the GDP per capita of neighboring countries such as Belarus (US\$ 2,639 in 1999) and Ukraine (US\$ 770 in 1999), but still far below that of the EU countries.

The Polish government recognizes the linkage between socio-economic development and demographic processes. A government report submitted to the UN in 1998 stated that significant demographic changes were noted in the mid-1990s, particularly a decrease in marriages and fertility rates and an increase in illegitimate births. This was accompanied by deepening impoverishment, unemployment, growing social stratification, a deepening housing crisis and changing family values (Government of Poland, 1999). The ageing of the population points to the need for more employment creation and pension reform.

Poland's population stood at 38.6 million in 2000, up from 38.1 million in 1990 and 35.7 million in 1980. Poland is reaching an advanced stage in the demographic transition with relatively large age cohorts in the 10-49 years age range, with smaller proportions of young and elderly people. About

² In 1999, Poland ranked 38 with an HDI index of 0.828; in 2000 it ranked 44 with an HDI of 0.814 (UNDP, 2001).

³ Unemployment grew from 1.1 million persons in 1990 to 2 million in 1999. The percentage of people living under the official social-welfare minimum increased from 15 per cent in 1989 to 50 per cent in 1997. The monthly minimum was set at PLN 348 (head of household), PLN 245 (other adults) and PLN 175 (under fifteens), or US\$ 84, US\$ 59 and US\$ 42 respectively (UN, 2000, p. 30).

⁴ At purchasing power parity (current prices) it increased from US\$ 4,466 per capita in 1991 to US\$ 8,763 in 1999 (CSO, 2001a).

65 per cent of the population live in urban areas. The number of live births has been decreasing since the mid-1980s and since 1989 the total fertility rate has fallen below the replacement level (Government of Poland, 1999). The population growth rate (UN medium fertility variant) for the period 1995-2000 was 0.01 per annum. The UN projects a further decrease in population growth, namely — 0.09 for 2000-2005. The total fertility rate was 1.46 for the period 1995-2000 and was projected to decrease to 1.26 in 2000-2005 (UN Population Division, 2002).

In general the main health problems in Poland are similar to the rest of Europe: cardio-vascular diseases, malignant neoplasms and mental illnesses. However, the standardized death rates for cancer and cardiovascular diseases for the EU countries are significantly lower than those in Poland (WHO-EURO, 2001). In 2000, the female and male life expectancy at birth was 78 and 69.7 years respectively, up from 75.5 and 66.8 years in 1990 (Sito, 1995; UN, 2000). In 1996, the maternal mortality rate (MMR) was 4.9, a decrease from 11.8 in 1993 (OECD data in UN, 2000, p. 44). The main causes of death for Polish women are breast cancer, cardio-vascular diseases and cervical cancer (UN, 2000). Cancers account for about 20 per cent of deaths among women (personal communication, Institute of Oncology, Warsaw). For men cardio-vascular diseases and lung cancer are the main causes of death. The ingrained unhealthy lifestyles of the Polish population (in particular alcohol abuse, smoking and inactivity) and low efficiency of health care services have led the government to adopt a new health care policy in 1996 (see Chapter 3).

Infant mortality was 25.5 in 1980, 19.3 in 1990 but decreased to 8.1 in 2000 (CSO, 2001b), which is far below the ICPD targets (*table 1.1*). In the 1990s there was a rapid decrease in neo-natal mortality. In comparison with other Eastern European countries, Poland showed the largest decrease during the 1990s. The under-five mortality rate (deaths per 1,000 live births) decreased from 15.2 in 1993 to 11.7 in 1997. The risk of death in first year of life decreased two times. In 1990, 19.4 and in 1999 it was 8.9 (Szamotulska and Stankiewicz, 2000, p. 7). The main causes of neo-natal death in 1999 were congenital abnormalities (33 per cent), low-birth weight (21 per cent), hypoxia (seven per cent), neo-natal sepsis (five per cent) and respiratory distress syndrome (five per cent). These causes together were responsible for 76 per cent of all neo-natal deaths, and 85 per cent of newborn deaths (Szamotulska and Stankiewicz, 2000, p. 8).

The average number of children per woman decreased from 2.0 in 1990 to 1.4 in 1999 (Szamotulska and Stankiewicz, 2000, p. 4). However, there is a relative increase in the number of teenage pregnancies, particularly in the West of Poland (personal communication, NIH).

Table 1.1. Selected demographic indicators, Poland

	1993	1994	1995	1996	1997	1998
Life expectancy at birth	71.7	71.8	72.0	72.4	72.7	73.1
IMR per 1000 life births	13.4	15.1	13.6	12.2	10.1	9.6
UFMR per 1000 life births	15.2	17.1	15.3	13.8	11.7	N/A
MMR per 100,000 life births	11.8	11.0	9.9	9.4	8.6	7.6
AIDS incidence / 100,000	0.18	0.26	0.28	0.31	0.34	0.34
Syphilis incidence / 100,000	5.06	4.63	4.08	3.92	3.15	2.70

Source: UN 2000: 44 (HFA Database, WHO-EURO); WHO-EURO (2001).
Government of Poland (2002).

According to CSO data from 1980, 1990 and 2000 the number of live births to teenage mothers increased slightly from six per cent in 1980, to eight per cent in 1990 and seven per cent in 2000 (CSO, 2001, p. 244). In 1990 births to unmarried mothers was 9.5 per cent, but increased to 11.9 per cent in 1999 (Szamotulska and Stankiewicz, 2000, p. 4). According to Wróbleska (1995, p. 57) the number of births among teenagers remained relatively stable at 30 births per 1000 females aged 15-19. Considering the overall declining fertility rate this means that teenage births is a growing proportion in overall fertility. Moreover extramarital births shows a progressive trend. This points to an unmet need in family planning.

Poland does not collect official data on contraceptive prevalence and method mix. However, there are limited survey data available. A study using data from Fertility and Family Survey 1991 (FFS, 1991) and the 1996 survey on 'Sexual Attitudes of Adolescents' indicates that in 1980 about a fifth of men and women used no method at all, while 16 per cent of men and 29 per cent of women used traditional methods. Condoms were by far the most used modern method (Wroblewska, 2002). According to a recent report of the Polish Federation for Women and Family Planning (2000), up-to-date data and research concerning this issue are very scarce. This is also true of the registration of contraceptive counseling. A 1996 survey among 1000 women and 960 men showed that modern contraception is the exception rather than the norm (Izdebski, 1997, p. 59). About 30 per cent did not use any form of contraception, while 27 per cent used traditional methods. Of the modern methods, condoms were the most popular (*table 1.2*).

STDs and HIV/AIDS

The first AIDS case in Poland was registered in 1985. Since then, up to 2002, official figures indicate that HIV has infected 7,307 Polish citizens and 1,116 have developed AIDS. In 555 cases it was lethal (NIH 2001). However, the unofficial estimate is that the total number of infected people could be as high as 20,000. The incidence of AIDS per 100,000 persons increased from 0.06 in 1990 to 0.34 in 1998 (UN, 2000, p. 45). Those affected are young people between 20-39 years of age. The Polish National AIDS Center estimates that, from the late 1980s on, the number of registered HIV infected people varied between 500 and 800 a year (NAC, 2002). The large majority of those infected were between 20-29 year of age (53 per cent), followed by the age group 30-39 (24 per cent). The major mode of transmission in the period 1985-1999 was through the

Table 1.2. Use of contraceptive methods in Poland, 1996

	Total	Women	Men
No contraception	30.1	28.3	32.1
Calendar method	9.8	11.1	8.4
Temperature method	1.8	2.4	1.2
Withdrawal	15.1	16.2	13.9
Oral pills	8.3	9	7.6
IUD	4.8	5.6	3.9
Foams, gels, creams	0.3	0.4	0.3
Condoms	20.8	18.2	23.6
Other methods	1.4	1.8	1
No data	7.6	7.1	8

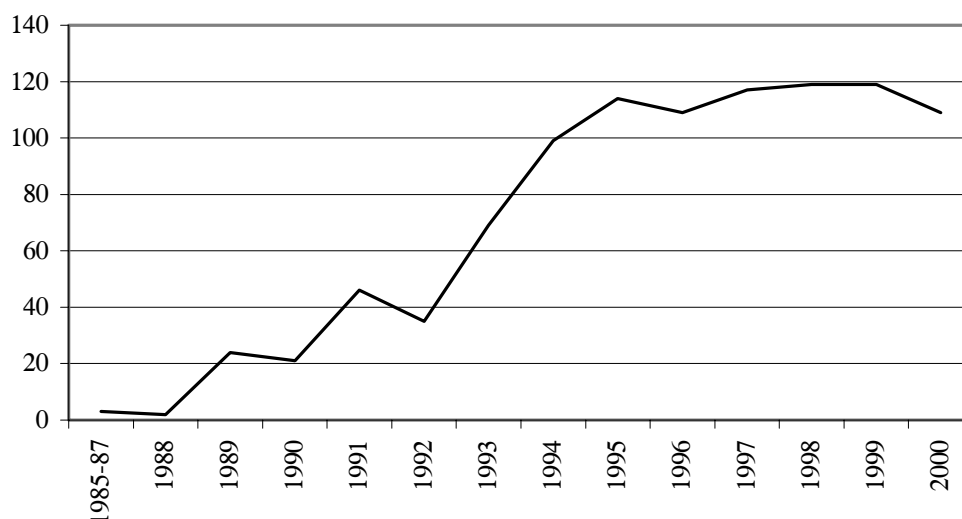
Source: Izdebski (1997, p. 59, table 4.25).

sharing of needles by intravenous drug users (50 per cent), followed by homo/bi-sexual intercourse (26 per cent) and heterosexual intercourse (15 per cent) (Szata, 2001, p. 166). Poland stands out from other Eastern European countries in that intravenous drugs users represent over 50 per cent of all AIDS cases in the period 1990-2000. However, since 1989 other modes of transmission are increasing (National AIDS Centre, 2002). In 1999, 20 per cent of infections resulted from homo-bisexual contacts and 12 per cent from heterosexual contact. As to vertical transmission, a recent government report indicated that due to the application of anti-retrovirus prophylactics the vertical infection rate has dropped from 23 per cent before 1989 to 0.5 per cent at the end of 2001 (Government of Poland, 2002) (*figure 1.1*).

Poland has managed to keep the epidemic under control thanks to a well developed national plan and the establishment of the National Programme for HIV/AIDS prevention, and the establishment of a network of institutions involved in monitoring and treatment. These include the National AIDS Centre, overseen by the Ministry of Health and Social Welfare (MOHSW), and at the voivoidship (province) levels, the Sanitary & Epidemiological Stations (Sanepids), AIDS diagnosis centers and dermatology clinics (overseen by the National Institute of Venereology).⁵

Between 1990 and 1997 around 9.5 million HIV tests were conducted, which uncovered more than 4,300 cases of HIV infections. Most of the tests were done in the blood centers. However, most positive cases were obtained from people who took a test for reasons of their own risky behavior (MOHSW, 1999, p. 9). The HIV infected cases are registered at the National Institute of Hygiene,

Figure 1.1. Number of registered AIDS cases in Poland, 1985-2000



Source: National AIDS Center, Warsaw, Poland.

⁵ See paragraph 4.1. for more details on the organization of health care in Poland.

but many cases are diagnosed at the Institute of Veneorology in Warsaw. In the period up to 1999 most cases were detected in three voivoidships, namely Warsaw, Gdansk and Katowice (MOHSW 1999, p. 10). However, there are signs that the disease is spreading across the country. In particular the eastern border regions are areas of concern, because prostitution is rife. There is concern that the number of cases of STDs, including HIV, will increase due to increasing cross-border traffic with neighboring countries where the STD and HIV incidence is higher (Chodynicka *et al.*, 2000).

The only STDs that are currently screened in Poland are syphilis and gonorrhoea. The incidence of syphilis is higher than HIV in Poland. Between 1993 and 1998 the incidence of syphilis decreased from 5.06 per 100,000 population to 2.7, the latter figure which is still a factor eight higher than HIV incidence (UN, 2000, p. 45). In 1999, a total of 872 cases of syphilis were recorded in Poland. The incidence of gonorrhoea decreased from 21.3 per 100,000 population in 1988/89 to 3.1 in 1996/97. However, one of the reasons for the lower recorded incidence could be incomplete epidemiological data and reduced screening of sexually transmitted diseases and the figures should be treated as estimates (Pniewski and Majewski, 2000). The infections of foreigners in the eastern border region where prostitution is rife has increased by an estimated 50 per cent (*personal communication, Institute of Venereology*).

2. Methodological issues

The specific objectives of the case study in Poland were:

- To fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail enquiry;
- As benchmark for studying the quality of data gathered through the mail enquiry in other countries;
- To gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programs within the country? And how?
- to provide more information on how resource flows are directed towards population activities within the country and, how the ICPD Programme of Action is implemented;
- to investigate the roles of government agencies, NGOs, health insurance organizations, and foreign donor in the field of population activities;
- to study the health system reform and its implications for the financing of the health services and in particular those covered by the UNFPA/NIDI survey;
- to study the system of health service budgeting and coordination at central, regional and local levels;
- to assess the adequacy of the current methodology used in the UNFPA/NIDI survey and possible alternative, in particular the usefulness of NHA methods.

Next to geographical considerations, Poland was chosen as a case study for the following reasons: it is currently undergoing rapid political and socio-economic change. Furthermore, the health system is under reform, with important implications for the implementation of health and population policies on the one hand and the measurement of resource flows on the other.

From 14-1-2002 to 30-1-2002 interviews were held with representatives from government agencies (at central and local levels), international donors, national NGOs and private clinics in Warsaw and Krakow. In addition, interviews were held with leading academic specialists, knowledgeable on reproductive health, family planning, HIV/AIDS and health sector financing. Annex 1 provides a list of all persons and organizations contacted during the case study. In general, the respondents were very cooperative and shared their information without any reluctance.

To optimize the quality of the information, the team followed as much as possible a standard strategy:

- data were collected through the questionnaires;
- questionnaires were checked for quality and consistency;
- during the interviews with representatives from the organizations covered in the survey, inconsistencies in the data were clarified;
- if necessary, information was corrected and where needed, a second visit was made to the organization;
- written documentation or information on the Internet about activities and the organization's budgets were collected;
- in-depth oral information was gathered about various activities of the organization such as: historical overview of funding, implementation of the ICPD Program of Action, past and current priorities, future plans and activities, future financial outlook, cooperation and coordination with other NGOs or government agencies, donors *et cetera*.

As Poland has reformed and decentralized its health system special attention was paid to the implications of this process for tracking resource flows. In the study we collected information from public and private institutions, including public authorities at different levels in the administration, NGOs, private clinics, health insurance organizations and international donors. A full list of people interviewed can be found in the appendix.

The team is confident that the information obtained in the case study is of good quality. The fact that many of the organizations provided audited financial overviews for several years has certainly improved the quality of the data. In many cases respondents had to invest considerable amounts of time and effort to come up with exact figures on financial aspects of their operation.

Shortcomings

During the case studies it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years. Within the Resource Flows project the population categories as defined in paragraph 13.14 of the ICPD 'Program of Action' (United Nations, ICPD 94) are used. An important problem is formed by the fact that the four population activity groups, which are used to categorize financial flows, are often not used by the organizations concerned as budget lines. In Poland, the concept of reproductive health is still not commonplace and budget documents do not contain specific line items reflecting this concept. Furthermore family planning is a sensitive controversial subject under former and current governments and, as such, family planning does not show up in budget documents. Moreover, data on number of users of contraception and the method mix are hardly available. In the field of STDs only syphilis and gonorrhoea are systematically screened. This seriously complicates data collection on the ICPD costed package in Poland. The only subject on which more data are available is HIV/AIDS as this is considered a priority subject in national health programmes. Some budget information is available, as there is a separate governmental center for AIDS prevention and control.

Other complications are:

- Because the government health system is under reform, and its information systems are under revision or inadequate for the tracking of resource flows for population activities, the requested

information was often difficult to obtain. Some government departments or organizations could only provide allocations or global project budgets;

- The complexity and recent restructuring of the funding of government health services, makes it difficult to estimate exact expenditure figures. Precise figures on regional and district level expenditures could not be obtained because only aggregate figures for health were available at the central government agencies;
- Current health services are now purchased by sickness funds, which are not fully regulated and offer competitive contracts, so that there is a wide range of service provider contracts, health service packages and prices and reimbursements. It was very difficult to select out the costs for reproductive health interventions on the basis of hitherto used methodology;
- Indirect national expenditures on staff, housing, utilities and so forth are sometimes ignored, as well as other indirect financial mechanisms like for example television and radio broadcasting time for messages on population and family planning;
- Prior to the case study, elections took place and the former right-wing government made place for a leftist coalition consisting of the Social-Democratic party (SLD, Alliance of the Democratic Left) and PSL (Peasants party). As a result, many changes took place within the government bureaucracies and it was still unclear to what extent the (health) policies of the former government were being transformed. This obviously has had implications for institutional memory and, next to the fact that knowledge on reproductive health is rather scattered, makes that data are difficult to obtain;
- Due to the short duration of this study, a selection of organizations and government agencies to be visited had to be made, so that this report does not provide a comprehensive overview of all agencies active in population and reproductive health. However, the main institutional actors have been included.

3. Official population policy and programs

3.1 | Government population policy

Poland has never formulated a specific population policy. However, the government does recognize the importance of population issues for socio-economic development. Poland has endorsed the Cairo and Beijing Programs of Action. The subject of population has always been strongly connected to the issues of family planning, sex education and abortion that remain highly sensitive subjects among policy makers and the general public. Although there has been a different approach among past left and right-wing governments, in general subjects like reproductive health and family planning are controversial in Poland. The Catholic Church (Episcopal Council) has a large influence on all matters concerning population and education. The parliament is divided over the issues concerned with reproductive health and family planning. There is still no real public debate on these subjects, some of which are taboo, particularly among policy-makers, politicians and religious groups. After the landslide victory of the leftist party during the 2002 election, many positions within government have changed hands and it is still uncertain what direction policy will take. It is a transitional period and new policy has to be developed and implemented on a step by step basis.

Due to this state of affairs there is a general lack of data on these issues and thus no solid basis for formulating population policy. The data that are available are very biased. For example, official abortion statistics only concern termination of pregnancies performed in public hospitals. Such data for the period 1994-1999 indicate annual number of abortions ranging from 150 to several thousands (FWFP, 2000a, p. 15). An official report for 2000 counted a total of 138 abortions (Government of Poland, 2001, p. 59). However, among civil society advocates it is a conviction that these data only show that access to legal abortion has become restricted and that the number of abortions performed underground has risen considerably (FWFP, 2000a, p. 15).

3.2 | Family planning

Demographic trends such as falling birth rates, smaller families, decreasing nuptiality and rising divorce rates were already apparent in the early 1970's. However, a traditional value system centering on the (nuclear) family remains predominant. In particular the Roman Catholic Church has a large influence on all matters concerning population and sexuality. In the period 1960-1980 government policy concerning these issues was one of 'increasing ignorance', resulting in a lack of information materials on family planning and a shortage of contraceptives (Okólski, 1983, p. 268). Government support for contraceptive development ceased in the mid-1970s and the

imports of pills and IUDs were very limited and expensive. Traditional contraceptive methods (calendar rhythm, withdrawal) were predominant. Those couples turning to modern methods mainly used condoms, the only contraceptives that were widely accessible at the time (sold in news-stands and pharmacies).

Family planning and contraception remain sensitive subjects in Poland. Under the former right-wing government policy was conservative, but even after the landslide elections in 2002 there are no clear signs family planning will be put on the political agenda. On 7 January 1993 the government endorsed the *Law on Family Planning, Protection of Human Fetus, and the Conditions Permitting Pregnancy Termination*. This law and later amendments thereof, is one of the main laws circumscribing women's reproductive rights. The law allows abortion only under strict preconditions (Nowakowska and Korzeniewska, 2000, p. 223). If medical tests indicate a high risk to the mother or the foetus or an incurable disease, then the pregnancy is allowed to be terminated up to the point that the baby can live outside the mother's body. In case a pregnancy results from rape or incest, termination is permitted up to the end of the 12th week. Furthermore, the pregnancy can only be terminated in a public hospital with the consent of another physician than the one performing the abortion. Written consent of the women, or of the legal representative in juvenile cases, is obligatory. Since 1997, abortion is only permitted when the mothers' life is in jeopardy, in cases of severe foetal impairment or when the pregnancy is the result of a criminal act, for example rape or incest. The termination of pregnancy is to be performed in a public hospital and in the latter case also in a private clinic. Undergoing or performing an abortion in unlawful circumstances can result to up to three years imprisonment (FWFP, 2000, p. 13-14).

In a similar vein, although male and female sterilization is permitted in Poland, causing damage to the body due to sterilization is heavily sanctioned by law. As a result sterilization is performed covertly, for example during caesarian sections and is not recorded.

In a pilot project, co-financed by UNFPA ('Mother and child health promotion, with emphasis on family planning'), fifteen family planning clinics were established with instructors and counselors. However, the choice of family planning methods is still restricted. Family planning counseling is integrated in MCH services, but it is insufficiently implemented and not obligatory (Sito, 1995, p. 87). There are few qualified counselors on modern contraceptive methods and counseling emphasizes traditional methods. The Polish government promotes 'natural family planning' methods, but State subsidies for modern methods are very limited. Hormonal contraception has been added to the official list of means causing cancer (FWFP, 2000, p. 26). In 1998 the government discontinued subsidies for five out of eight oral contraceptives.⁶

⁶ The brands (all with the same composition) that are now subsidized (30 per cent) are Stedizil (Wyeth-Lederle), Microgynon (Schering) and Rigevidon (Gideon Richter).

3.3 | Reproductive health

Since 1980, almost all deliveries have taken place in hospitals (CSO, 2001b, p. 275). Despite the decreasing number of births, according to data for 1994, one out of ten women in reproductive age were hospitalized. The main causes were birth complications, infections of the urinary and reproductive tracts, cancers and intestinal disorders (Brzezinski, 1998).

In 1992 the Baby-Friendly Hospital Initiative was launched as part of a national program for the Promotion of Breast-feeding. In this project the Ministry of Health and Social Welfare (MOHSW) worked together with the Institute of Mother and Child and UNICEF (Chazan *et al.*, 2001).

The Polish government adopted the National Action Plan for Women in 1995, by which it committed itself to 80 specific tasks (Women's Association for Gender Equality, 2000). Next to poverty reduction, advancing female education and reducing gender-based discrimination, the plan's health chapter mentions the following tasks:

- improve women's health through all phases of life;
- provide high quality medical services, client focused, especially for women in rural areas and small towns;
- reduce violence against women;
- supplement the National Health Program with family planning and reproductive health;
- create advisory centers for sexual health, STD/HIV/AIDS prevention and sexual education;
- promotion of WHO's definition of health, including sexual health.

Despite these goals, the MOHSW efforts' are biased towards improving mother and childcare, in particular medical care during pregnancy and childbirth. Other women's health issues such as menopausal disorders or infertility treatment deserve more attention (Women's Association for Gender Equality, 2000, p. 14). The Universal Health Protection law (6 February 1997), specifies that mothers have a right to prenatal care over the foetus, the care over women during pregnancy, childbirth and puerperium, and infant care (Government of Poland, 2001, p. 10).

During 1995-1999 government policy was basically pro-natalist and conservative and family planning and reproductive health remained a low priority issue. In light of decreasing fertility rates, family planning is no priority issue for government. The National Health Plan (NHP) 1996-2005 does not specifically address the issues of family planning or reproductive health, with the exception of cervical and breast cancer (MOHSW, 1996). One of the tasks set by government under the target 'Improvement of access to and efficiency of primary health care', is the training of nurses and midwives employed in primary health care.

As indicated above, breast and cervical cancers are among the main causes of death of Polish women. Thus, one of the targets of the National Health Program 1996-2005 was the improvement of early diagnosis and treatment of breast and cervical cancers. Measures to insure this target is fulfilled include awareness creation, establishment of screening units for breast cancer at the branches of the National Institute of Oncology, and the increase of the number of cytological tests and pap smears (MOHSW, 1996, p. 74). In the last five years the number of mammography units

has more that doubled from 172 to 500 at present. Moreover, about three million pap smears were made per annum (personal communication, Institute of Oncology, Warsaw).

The responsibility for the implementation of the National Health Plan 1996-2005 lies primarily with the local governments, local NGOs and communities. The central government bodies are responsible for establishing legislative mechanisms, setting targets and guidelines, monitoring, evaluation and fostering the development and financing of research which facilitates the achieving of specific targets (MOHSW, 1996, p. 85).

Health and sex education

One of the ways to achieve an overall improvement in health standards is the promotion of healthy lifestyles through mass media and health education at schools. In particular the government aimed at establishing a comprehensive health education program for primary and secondary schools, covering subjects such as responsible sexual behavior, HIV/AIDS and drug abuse. Although health and sex education has a long history in Poland, and was included in the school curriculum, it has remained a highly sensitive subject. However, after 1998, the limited initiatives in sex education at schools were suspended.

Since 1999 the Ministry of Education's has implemented a secondary school educational program on 'Upbringing to life in the family', of which the main goal is preparation for family life. Under the program thousands of teachers were trained on family life education and nine textbooks were produced (Government of Poland, 2001). The program has been criticized as advancing conservative, traditional moral values, while marginalizing topics such as modern contraception and prevention of STDs including HIV/AIDS (Nowicka and Tajak, 2000, p. 28; Women's Association for Gender Equality, 2000, p. 16).

3.4 | Gender Issues/Women's promotion and development

After the 1985 United Nations Conference on Women in Nairobi, the Polish government created the first institutional body for the advancement of women in the form of the Government Plenipotentiary for Women. This body remained operational until 1991, after which it changed its name into the Government Plenipotentiary for Women and Family. It functioned until 1997 when the right-wing government ordered it defunct. The primacy of the family institution was reflected in the fact that it was then replaced by the Plenipotentiary for Family Affairs, resorting in the Chancellery of the Prime Minister. The maternal and family duties of women were henceforth emphasized, while gender equality was pushed into the background (Karat, 1999). The Plenipotentiary merely has an advisory role, and is vulnerable to political change. The Plenipotentiary has a separate budget for selected activities. Although the Plenipotentiary in theory sees to the implementation of programs endorsed by (former) governments, such as the National Action Plan for Women, in practice full implementation has not become reality (Nowakowska, 2000). Currently, the Plenipotentiary for the Family Affairs still exists. The emphasis is still on women as 'mother-family caretaker'.

In the field of gender equality the following advances have been made. First, gender equality and laws against gender discrimination at the workplace are incorporated in the Labour Code of 1996. During 1996-1998, in cooperation with the United Nations Development Program (UNDP), the Polish government implemented a separate program ('Against Violence Equal Chances') to reduce gender-based violence. However, this program was discontinued in November 1997 after the change to a right-wing government. In addition, government does not support gender sensitive research and statistical data on women issues are hard to come by (Karat, 1999, p. 14). A positive step is the establishment of the Government Plenipotentiary for Equal Status of Men and Women in 2001 which addresses issue of gender equality and can reinvigorate the implementation of the National Action Plan for Women.

3.5 | HIV/AIDS and other STD activities

HIV/AIDS has been an issue since the first HIV infection was reported in 1985 followed a year later by the first registered AIDS case. The Polish Council of Ministers put AIDS on the list of infectious diseases by decree (21 October 1986); henceforth any AIDS case should have been reported to the National Institute of Hygiene. In 1989 a nation-wide information campaign was organized to enhance awareness of the disease and ways of preventing contracting HIV (NAC, 2000). According to the Infectious Disease Act (13 November 1963) infectious diseases should be reported to the National Institute of Hygiene, and patients are entitled to free treatment. However, testing and registration is subject to certain conditions concerning privacy and patients' consent as dictated by the Health Care Institutions Act of 30 August 1991 (NAC, 2000, p. 2). Since 1990, all AIDS carriers have access to treatment with anti-retroviral medicines.

In 1992 the government responded to the epidemic by establishing the National Coordination Office for the Fight against AIDS, located within the Warsaw Township Sanitary and Epidemiological Station. In 1993 the Ministry of Health and Social Welfare created the National AIDS Prevention Coordinating Office, in response to a greater awareness of the problem and the need to work at the national level. The office was responsible for HIV prevention and treatment and care of people living with AIDS. A special advisor on AIDS and Drug Addiction was responsible for controlling and reporting on expenditures and implementation to the MOHSW (National AIDS Center, 2000).

The government has prioritized the fight against AIDS, as testified by the establishment of a national program to combat the disease. In 1996 the government adopted the National Program of Prevention of HIV Infections and Care Offered to the People Living with HIV and AIDS (1996-1998). The main aims of this program were to rationalize the system of HIV prevention, educate society on HIV/AIDS and raise awareness of prevention and rights of HIV/AIDS carriers. Furthermore, the program calls for integrated care for people with HIV and AIDS. Although the MOHSW was the main coordinating body of the program, a number of Ministries were involved in the implementation of the tasks, including the Ministries of Labor and Social Policy-, Defence-, Education-, Justice-, Internal Affairs- and Transport and Maritime Economy.

Due to the health reform process, in 1999 the structure in place to combat AIDS was evaluated and the National AIDS Prevention Coordinating Office was transformed into the National AIDS Center (NAC). The center's tasks encompass coordination of HIV/AIDS prevention, IEC, and monitoring. In addition, the center collaborates with health care service providers in prevention, diagnosis, treatment and care. It has an advisory role in relation to voivoidships and finances the local level HIV/AIDS programs. Multi-sectoral collaboration is stimulated and collaboration between the public and NGO sectors is coordinated by the center.

The government launched its second HIV/AIDS program in 1999.⁷ The major objectives of the program are to curb the spread of HIV infections and to improve the quality and availability of care for people living with HIV and AIDS. These objectives are to be realized through awareness creation; IEC; prevention activities among high risk groups; improved HIV testing; prevention of diseases conducive to HIV transmission; blood safety; system of uniform standards for care; training of medical staff, therapists and social workers (MOHSW, 1999, p. 15). A whole gamut of governmental and non-governmental institutions is involved in the implementation of the program under the coordination of the MOHSW.⁸

In 1999, the MOHSW started with the central purchasing of anti-retroviral drugs out of the MOHSW budget, the legal basis of which was laid out in the *Regulation of the Minister of Health on Highly Specialized Procedures, 1999*. Next to a budget line for the purchasing of ARV drugs, the MOHSW budget includes a line item for prevention and drug addiction deterrence (NAC, 2000, p. 30-31).

The only STDs that are screened presently are syphilis and gonorrhoea. In general, screening in Poland on STDs was deficient and has recently deteriorated even more. In the past screening was performed via a network of outpatient clinics (50 units; one in each voivoidship plus the Institute of Venereology). After the health reform, STD screening was not high up on the agenda of the sickness funds (*Kasy Chorzych*). Previously, STDs, TB and HIV were separate categories in Polish legislative texts, but now are grouped together under the heading 'communicable diseases'. The new Law on Infectious Diseases integrated screening on these diseases under the responsibility of the sixty sanitary-epidemiology stations at voivoidship level. In practice however, screening was deficient and not integrated. Serological screening has stopped two years ago after new regulations were drafted. For the screening units at voivoidship level only PLN 200,000 (less than US\$ 50,000) per annum is budgeted, which is clearly insufficient. This is a potentially dangerous situation now that screening is reduced to one million tests in the last two years. Although the number of tests represents a mere 5-10 per cent of tests that were done before the 1999 reform, the number of infections detected (about 1000 cases per annum) remains at a similar level as before, suggesting that the real number can be far higher. The infection of foreigners (particularly in the

⁷ National Program of Prevention of HIV Infections and Care Offered to People Living with HIV and AIDS, 1999-2003 (MOHSW, 1999).

⁸ These include several ministries, the provincial and local governments, national health institutes (for example Institute of Venerology; Institute of Hygiene), Bureau of the Commissioner of Civil Rights, health funds, medical academies, regional hospitals, Polish TV and Radio, various Polish NGOs and organisations of the Catholic Church.

eastern border region where prostitution is rife) has increased by an estimated 50 per cent. In private clinics testing is done but results are not always verified.

3.6 | NGO sector in Poland

There are over 3,000 national NGOs in Poland, of which an unknown number are active in the field of family planning, reproductive health and rights and HIV/AIDS prevention and care. The Polish government has recognized the role NGOs can play in implementing population programs. The Council of Ministers ordinance on the commissioning of State tasks to NGOs (*Journal of Law* 1997, nr. 94-573) circumscribes the conditions, tasks and modes of commissioning. Among others, in the year 2000, a total of 75 grants were made through the Governmental Plenipotentiary for Family Affairs and provincial governors for NGOs supporting pregnant and childbearing women. The projects dealt with family planning and family life education, medical, social and legal assistance for pregnant women and IEC materials. The total sum involved was about US\$ 185,000 (Government of Poland, 2001, p. 36). National government funding for AIDS activities by NGOs goes via the National AIDS Center. These are sub-divided in three categories: 1) NAC activities, 2) activities by voivoidship and state institutions and 3) NGO projects/grants.

Currently, no governmental body exists for consultation and coordination of the NGO sector. In 1998 there was a government department overseeing the NGO sector, but this was discontinued. Similarly, coordination between municipalities and local NGOs is also lacking. However, NGOs can freely apply for funding from the central government (for example through NAC, MOHSW), the voivoidship (*województwo*, province) or *gmina* (local, municipal) governments and foreign donors. Some Polish NGOs have managed to acquire subsidized commodities and medicines from foreign donors and pharmaceutical companies.

3.7 | Donor coordination

Currently, there is no official coordination of foreign donor funding. There are only informal consultations among donors to streamline their activities. Formerly, the MOHSW and the EU Regional Office under the EU EuroHealth Program appointed a WHO Liaison Officer. The funding came from the MOHSW and WHO. The main tasks of the liaison officer were liaison between MOHSW, other government institutions and foreign donors; monitoring of foreign assistance; assistance in developing a national framework for international cooperation in the health sector (Sabbat, 1997, p. 214).

4. Financial Flows

In the following sections, the focus will be on the organizational and financial aspects of interventions and programs in the Polish health sector. The role of the Polish government and Polish NGOs is discussed, with an overview of the major projects and programs. The next section (par. 4.4.) focuses on the private sector. Paragraph 4.5. concerns the role the international donor community has played in past and present health sector and population programs, followed by an overview of the major bilateral and multilateral donors, and NGOs in this field. To put the activities within these sectors more into perspective, we must first discuss the organization and financing mechanisms in the health sector.

4.1 | Institutional framework and budgeting system

The organization and financing of the health system in Poland has undergone profound changes in recent years. We need to discuss health reform briefly to get a better understanding of the financing mechanisms and funding in the population and reproductive health field.

Before the 1990s, the Polish health care was based on the Soviet Semashko system. The system was highly centralized and health care was funded by the state bud get. The constitution stipulated that health care was free with universal coverage. Health facilities at all levels were state owned with salaried personnel and (historical) budgeting was the basis for the financing of health service providers. However, private practice was never totally eliminated and some private medical cooperatives remained. Since 1989 the health sector is under transformation, involving many changes, including changes in the organizational structure and the devolvement of public management and financing of health services to the lower governmental levels.⁹

In the original system, there was no local autonomy and no private practice. However, as Bossert and Wlodarczyck (2000, p. 9) note, during the end of the Communist period in the late 1980s, the system eroded and some local autonomy and room for private practice appeared. Medical doctors could run a private practice under condition that they were employed by the public health system. The 1991 Health Care Institutions Law was passed, making the establishment and ownership of health care institutions by both public and private institutions possible. This included entities such as *voivoids*, *gmina*, insurance companies and profit and non-profit organizations (Bossert and Wlodarczyck, 2000, p. 9 and Den Exter, 2001, p. 10). Furthermore, the law initiated a purchaser/

⁹ For more details on the transformations see Marée and Groenewegen (1997), Girouard and Imai (2000), Schneider *et al.* (2001) and Tymowska (2001).

provider split in health care and laid the basis for payment contracts by voivoidship governments to health care institutions for services rendered.

The Polish health care system before the 1999 reforms, consisted of a three-tiered network of health service facilities. There were ten health regions, consisting of about five provinces (*voivoids*), responsible for the implementation of health programs initiated by the Ministry of Health and Social Welfare and with corresponding tertiary level medical institutions and academic hospitals for specialized care. The management of primary and secondary level health care institutions was the responsibility of the voivoidship governments (Marée and Groenewegen, 1997, p. 7). In addition, sanitary and epidemiology stations (*Sanepids*), responsible for health promotion, were created at the provincial and local levels.

In 1972 so-called *Zespol Opieki Zdrowotnej* (or ZOZ) were created which functioned as integrated health care administration units, under the local level authorities and managed local hospitals, outpatient clinics, specialist and primary health care services, in addition to social services. The ZOZ's each served between 30,000-150,000 people (Girouard and Imai, 2000 and Schneider *et al.*, 2000, p. 181). In 1983, the MOHSW devolved some of its powers in the field of policy-making and management to the voivoidships and ZOZ's (Den Exter, 2001, p. 6). In 1990 the ZOZs were transformed into *Zaklad Opieki Zdrowotnej* (Health Care Administration Unit) and subsequently these were transformed into the SP ZOZ (Self-Public Zaklad Opieki Zdrowotnej).

In 1991, the administration of the majority health services was transferred from the MOHSW to the provincial authorities and the local governments (*gmina*). From 1993 the ownership of the public health facilities was transferred to the provinces and the local governments (EOHCS, 1999). In 1999, major reforms were implemented aimed at further decentralization, introduction of social health insurance, privatization and the improvement of primary health care. Next to the already existing elected local bodies (*gmina*), the district level (*powiats*) was re-established in 1998. The *powiats* had been discontinued in 1975. The re-established *powiats* now form an intermediary level of government between the voivoidships and *gmina*'s and will become owners of some health facilities including some district hospitals. Moreover, the former 49 voivoidships were reduced to 16 regional units carrying the same names. Currently, there are about 2,500 *gmina*, 373 *powiats* (65 urban) and sixteen voivoidships (Schneider *et al.* 2001, p. 182 and EOHCS, 1999).

At present the health system is basically made up of a three tiered administrative system with corresponding health care provision. At central level, the Ministry of Health and Social Welfare (MOHSW) is responsible for policy development, setting standards for health services and the implementation and monitoring of national health services and programs. The Ministry oversees the tertiary level medical academies, teaching hospitals and national research institutes. Secondary level health care, consisting of a network of provincial hospitals and specialized hospitals/clinics are the responsibility of the voivoidships. Each voivoidship also administers a number of ZOZs under their jurisdiction. Health care delivered through district hospitals fall under the *powiats*. Ambulatory specialist services are responsible to the county authorities. Primary and secondary health care services delivered through ZOZs falls under the responsibility of the local governments (EOHCS, 1999; Schneider *et al.* 2001; UN 2000, p. 47 and Girouard and Imai, 2000). Family doctors were introduced in 1998, and they are contracted by insurance funds on a capitation basis.

The major change of the 1999 reform was the introduction of statutory health insurance, and the creation of regional sickness funds, based on the 1997 Health Insurance Act. This has fundamentally changed the financing and management of the health sector (see 4.2). Basically, the health reform is aimed at creating a service market, with a split between health service purchasers (for example healthcare insurance institutions) and public and private health service providers. The new system is expected to improve the quality of health services as well as its efficiency. However, according to several observers the health reform initially has had some adverse consequences as well:

- One unforeseen result of the health reform was that some former mechanisms were abandoned.¹⁰ Under the former centralist (Semasko) system reporting was obligatory (although not always a priority due to historical budgeting), but now that the health system is being privatized, reporting is not a priority for public institutions. Due to the lack of coordination and the lack of a comprehensive overview of health expenditures what is being spent on health care, the government stepped up efforts in 2001 to improve and homogenize the reporting system. Currently, the MOHSW and the CSO collect the data on expenditure reported by the sickness funds. The data on expenditure and medical interventions are reported by the sickness funds to the Health Insurance Supervision Office (*Urząd Nadzoru Ubezpieczeń Zdrowotnych-UNUZ*) on a quarterly basis. The National Institute of Hygiene (*Panstwowy Zakład Higieny*) collects other related data (relating to ICD classification, age, gender and patient's address);
- The screening of HIV and STDs has become deficient, due to the closing down of polyclinics for venereal diseases and new legislation protecting patient's rights and anonymity (Law on Epidemiology, September 2001). The various sickness funds have to pay for screening and it is not a priority for them;
- The former system of supervision of school medicine was eliminated and decentralized. School health services (including school doctors and nurses) have been dismantled in a majority of schools and the registration system is deficient. This caused a serious hindrance in access of youth to basic health services, including preventive treatment and information on healthy life styles. However, the current government is considering a reactivation of the preventive health service system in schools, including the role of school nurses;
- The role of the State after reform was not clearly defined, resulting in some confusion as to definition and division of responsibilities. The assumption is that the market-mechanism will self-regulate the health service system and take care of any deficiencies;
- After the 1999 reform the sickness funds are the most significant players. They have decision-making power and can determine their own contracts with providers, reimbursement regulations and health service packages. There were no strict guidelines at all from the State concerning sickness funds, resulting in a large variation in health service packages and expenditures. The nomenclature used for health services is not standardized and varies widely, so data that are available are not fully comparable across sickness funds. At the time the sickness funds were set up, there was insufficient guidance or training from government side. Two years after the sickness funds were created the National Assistance Office for sickness

¹⁰ Even earlier, after the transition in 1989, the recording system for vaccinations disappeared. Since it is unclear what is spent on vaccinations. Basically, vaccinations are now paid by clinics and by households (personal communication, M and C institute).

funds was established in an attempt to put up regulations and standardize packages, refunds and budget lines. But this initiative was almost immediately ended after inception. Presently however, the Polish government has introduced legislation that makes it possible to regularize the sickness funds (see note 12 below);

- Providers are obliged to report on service package, population serviced, and budgets, but this is not working optimally in practice.

Financing of the health system after the Health Reform of 1999

Before the 1999 reform, the Ministry of Finance drew up allocations for public health and the moneys were expended via the health providers. These included the Ministry of Health and Social Welfare, other central ministries, the state medical institutions (together about 25 per cent of budget) and the forty-nine regions or voivoidships (75 per cent of budget). Gradually the role of the local governments in terms of health care revenues and expenditures increased. Until 1999, the health services were financed out of general taxation (Schneider *et al.*, 2001, p. 185).

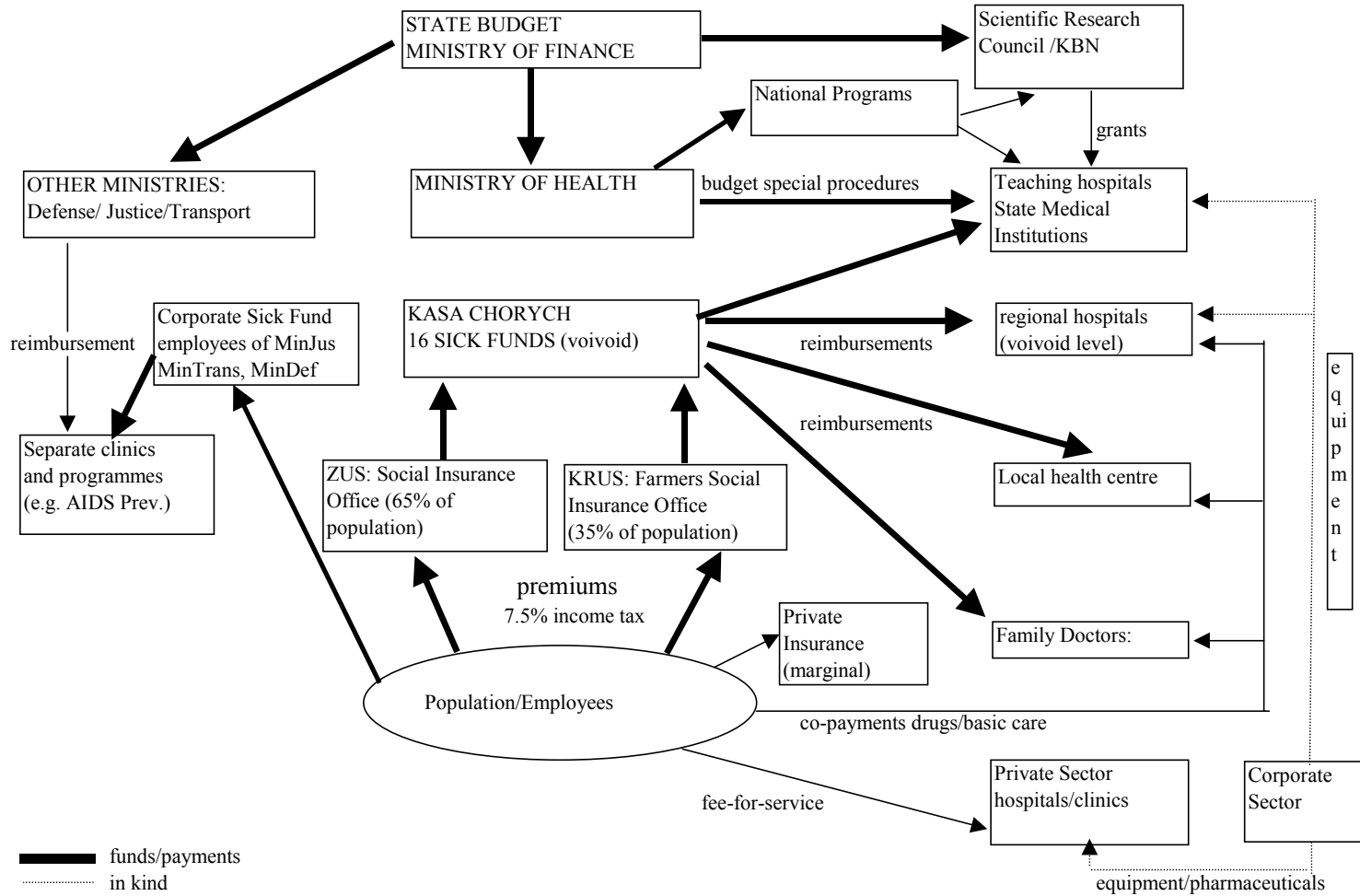
The 1997 National Health Insurance Act (and later amendments thereof), which came into force in 1999, laid the basis for an alternative system of resource mobilization and health provider payment system. *Figure 4.1* schematically depicts the major channels of financing in the current Polish health system. Basically, the new system stipulates that direct costs for health services are financed through insurance funds, via contracts with health providers. Public health services, capital costs of health services and tertiary level highly specialist treatments and certain expensive drugs (for example anti-retrovirals) are to be financed from the government budgets (at central, *voivoid* and *gmina* levels). The Ministry of Health remains responsible for the funding of highly specialized treatments (transplants) and for special national programs, such as the National Health Program or cervical/breast cancer screening, next to setting policy guidelines and health standards. The national programs are implemented at state medical institutions or medical universities, for example Institute of Mother and Child, National Institute of Hygiene or the Institute of Oncology.

Since the introduction of social health insurance, the (regional) sickness funds play a primary role. The sickness funds are non-profit organizations that are financed out of premiums collected through the Social Insurance Institution (*Zakładu Ubezpieczeń Społecznych* — ZUS) and the farmers' social insurance office (*Kasy Rolniczego Ubezpieczenia Społecznego* — KRUS). The premiums for insurance coverage collected through taxation is currently 7.75 per cent of all income of employed persons, while for farming households the calculation of the premium is based on land operated and agricultural output. For the unemployed, pensioners and disabled the State (Ministry of Finance) pays the premiums via the local authorities (*gmina*'s). The premiums cover all types of healthcare, for example ambulance and emergency services, outpatient care, hospitalization, diagnosis and some types of care at cure institutions. Except for the proportion transferred to a national equalization fund (to offset regional inequities), the contributions collected by the regional funds are spent within the regions.

Previously the sickness funds were strongly dependent on the municipal governments that elected the board members. Currently, the boards, including the chairpersons, of the regional sickness funds are nominated by the MOHSW, so that the government has influence over the management

Figure 4.1. Schematic Overview of Financial Flows after the 1999 reforms

POLAND: HEALTH FINANCING STRUCTURE (since 1999 reform)



of these funds. In case of the special corporate sickness fund, created for 'uniformed personnel' (see next section), the board members are elected by the ministries involved, for example Ministry of National Defense or the Ministry of Internal Affairs and Administration.

The sickness funds purchase health care services from providers on a contract basis: the latter include public institutions, hospitals, local level clinics and family doctors. In cases that state institutions such as the Institute of Venereology get prophylactics from hospitals, these costs are reimbursed by the sickness funds. There are 16 regional sickness funds, corresponding to the regional administrative units (voivodships).¹¹ In addition there is a nation-wide branch sickness fund, especially for public uniformed employees connected to the state railroads, the army, police and the Ministry of the Interior. However, since the insured have a free choice of sickness fund, many public uniformed personnel have switched to other funds and *vice versa*. The composition of the insured has changed significantly and it is generally difficult to define the actual employment structure of those within the corporate sickness fund as the data collected by ZUS are not transparent enough.¹² Before the health transformation, there were parallel health services for these employees. As in all former Eastern Bloc countries, under the table payments for health services were extant, although this phenomenon is becoming less significant under the new system.

As of 1999, the insured have free choice of sickness fund, but place of residence remains the basis for distribution. Until the current regularization measures, the sickness funds operated under a market mechanism and competed with each other, while offering varying contracts with providers. The sector is still not fully regulated yet and standards of health services are not standardized, while type of services, quality and reimbursements varied greatly. The Health Insurance Supervision Office (*Urząd Nadzoru Ubezpieczeń Zdrowotnych — UNUZ*) supervises the sickness funds and the sickness funds are obliged to submit to the UNUZ quarterly and annual performance reports through their boards. The audited reports should also be submitted to UNUZ, but independent auditors do the auditing. To offset the disadvantages of the currently market-based, non-transparent and unregulated system, leading to a large diversity in provider contract payments, health service packages and quality of services, it is being considered to regulate the sector more strictly. Some measures to be taken could be the standardization of health packages and reimbursements; more control over budgets and consolidation.¹³

The exact budgeted amount for specific categories of health care varies greatly between sickness funds. For instance, the reimbursements for medicines in the third quarter of 2001 varied between 57 Zlotys (US\$ 14) and 137 Zlotys (US\$ 35) per insured person. The total reimbursements costs for all health services per insured were within the range of PLN 275 (US\$ 70) and PLN 616 (US\$ 157) (UNUZ 2002). As there is a large difference between sickness funds in terms of funds

¹¹ Information (in Polish) on separate sickness funds can be found on http://www.kzkch.org.pl/kch_int.htm.

¹² Information from the Health Insurance Supervision Office (UNUZ), 18 November 2002.

¹³ The Polish government currently plans to launch the National Health Fund, based on the regulations included in the Draft Act on Insurance. This will entail a close down of the current system of Health Funds, which will be replaced with one National Health Fund with 16 regional divisions. Unified principles of contracting of services for the whole of Poland are to be introduced (Information from MOHSW, Department for Health Protection Analyses and Financing Systems, 14 October 2002).

available, a special equalization fund has been created for transferring funds from the large, rich sickness funds to the smaller ones, to guarantee their solvency. In 1999, the resources of the sickness funds account for about 80 per cent of the total public expenditures in the health sector (Tymowska, 2001, p. 86). From the beginning the sickness funds have faced tight budgets and to guarantee their solvency the government raised the payroll tax to fund healthcare to 7.75 per cent, in addition to capital injections in the form of loans.

From the annual reports of the separate sickness funds we were able to select out the relevant line items for this exercise. The total expenditures appeared to be considerable and form the bulk of current spending for ICPD costed package related health interventions. The total annual disbursements for interventions in the field of family planning, reproductive health, STDs and HIV/AIDS of the Polish sickness funds in the years 2000 and 2001 were PLN 1.9 billion and PLN 2.9 billion respectively. This is the equivalent of US\$ 448 million and 675 million (data sickness funds Poland, 2000-2001).¹⁴

Next to insurance coverage for medical treatment and services, the Polish population is also entitled to social benefits and accident compensations, including nursing, childbirth and maternity benefits (*table 4.1*). These benefits are paid out through the two social insurance organizations ZUS and KRUS.

Local governments

Until 1990, the local governments' role in financing health services was limited, but thereafter the proportion of revenue for health spending, obtained through local taxation, has increased. Since the decentralization of government and the devolving of power to local governments, they have a certain degree of autonomy as to policy-making, management and budgeting of local health services in their constituencies. Primary health care is offered by the ZOZs, which are managed at *voivoid* and *gmina* level and in rural areas by small polyclinics. The local governments supervise and finance primary health care institutions (often as owners). They can also purchase health services that are inadequately covered by the sickness funds, and in addition finance local health promotion programs. According to law, at the county level, this is obligatory, but these costs are

*Table 4.1. Poland, maternity and childbirth benefits, 1995, 1999, 2000
(millions of Zloty's)*

	1995	1999	2000
Maternity			
General population	376.40	690.60	899.30
Farmers	6.9	7.9	7.8
Childbirth			
General population	29.30	59.40	96.00
Farmers	28.90	45.60	47.90
Total	441.50	803.50	1,051.00

Source: Data from Zakladu Ubezpieczen Spolecznych (ZUS) and Kasy Rolniczego Ubezpieczenia Spolecznego (KRUS) (CSO 2001a, p. 179).

¹⁴ This excludes expenditures for Pediatric Departments (total of US\$ 94 million in 2000 and US\$ 110 million in 2001). For a full overview of expenditures by category see the table in the Appendix.

often left out of health care expenditure estimations (Tymowska, 2001, p. 87). The local governments fund primary health care partly through local taxation. An example is anti-alcohol campaigns, funded out of tax on alcohol sales. From the Central budget some funds for specific health interventions flow straight to gmina's; this is also true of interventions not covered by compulsory health insurance (for example transplantation's) (*table 4.2*).

As a result of the decentralization of public finances in 1999, following territorial-, health and social security reform, a comparison of data from before and after 1999 is not possible. Reproductive health, family planning and HIV/AIDS do not figure as line items in local government budget and expenditure accounts.

Due to limited data, and budget and time constraints, we have not been able to collect expenditures on activities in the fields of reproductive health, family planning, HIV/AIDS and basic research and policy analysis on all levels of government. However, to get an idea of how the budgets are allocated among the different government strata consider the following table concerning specific health interventions. It is clear that general hospitals and occupational medicine feature prominently on the voivoidship budget, while under-five health care, outpatient care and the Sanepids are large categories on the powiat and gmina levels.

4.2 | Role of the Government of Poland

In general, although the public sector still is the major source of financing in the health sector, private sector funding has increased in the 1990s'. In 1990 the public sector still accounted for 94 per cent of all funding, but this declined to 73 per cent in 1997 (EOHCS, 1999). The response to the UNFPA/NIDI surveys indicated increasing aggregate expenditures from Polish government sources: from PLN 8.4 million (US\$ 2.5 million) in 1997, PLN 71,9 million (US\$ 20.7 million) in 1998 up to PLN 149 million (US\$ 37.6 million) in 1999 (UNFPA/NIDI RF database).¹⁵

In the following sections we will describe the activities and budgets of major governmental institutions which are involved in population and reproductive health policies and programs. The information is based on responses to the UNFPA/NIDI survey, interviews held with representatives of these public bodies, supplemented by written documentation.

Table 4.2. Health budget, Poland, by administrative level, 2000 (Zloty's)

Health budget, Poland, 2000		
	Health	Social welfare
State budget	4,300,000,000	27,700,000
Gmina	293,400,000	1,059,200,000
City powiats	379,200,000	1,052,500,000
Powiats	649,600,000	1,358,800,000
Voivoidships	64,400,000	14,300,000

Source: Statistical Yearbook Poland, 2001.

¹⁵ This only includes data from the NAC, the Central Statistical Office and the Ministry of Education, but excludes the major spender in this field namely the MOHSW.

Governmental Population Council of Poland (GPC)

The Governmental Population Council of Poland was established in 1979, which replaced the Governmental Population Commission of Poland, established in 1974. At the time population matters were dealt with in different ministries and public (research) institutions. The members of the current Governmental Population Council of Poland are appointed by different ministries including the Ministries of Health, Foreign Affairs, Defense etcetera. The main tasks of the GPC are drawing up reports on demographic developments in Poland, initiating scientific research and preparatory work in the field of legislation, population and social policies.

Since 2000, the GPC is connected with the Government Center for Strategic Studies. The GPC works together with international organizations, including UNDP. Since 2002, Poland is member of the UN Population Development Committee and also in the Population Commission of the Council of Europe. The GPC forms part of a network of population organizations and has advisory function in population matters, including legislation, demography and health. The GPC is responsible for the preparation of the report for the Council of Ministers on population and for presentations to the Council of Europe, of importance in connection to EU accession process.

In September 2001, the First Demographic Congress was staged, which was assembled as an initiative of the Governmental Population Council of Poland, the Polish Demographic Society and the Committee of Demographic Sciences of the Polish Academy of Science. The UN Resident Coordinator and the Polish CSO participated in the organization of the Congress, which was held under the auspices of the President of the Republic of Poland, Aleksander Kwasniewski. The general aim of the initiative is, *inter alia*, an evaluation of Polish demographic output, a specification of the needs for its further development, research methods and didactics.

Due to the range and complexity of the problems under consideration, it was decided to divide the Congress into four parts, as follows:

1. The inauguration, which took place in Warsaw on 15 September 2001, was dedicated to an appraisal of the demographic situation in Poland and included presentations on Polish demography, ethical dimensions of demographic processes, the role of the family and the population census;
2. In 2002, a series of thematic conferences and seminars are planned, dealing with important factors in demographic development in Poland, including health conditions, ecology, education, housing and cultural factors. Specific themes cover, among others, fertility, migration, cancers, MCH, adolescent health, alcohol/drug abuse, genetics and disabled people;
3. Regional seminars are planned which are dedicated to demographic problems in contemporary Poland;
4. Three-day long plenary debates dedicated mainly to the demographic perspectives of Poland against the background of Europe and the world and to the challenges of future demographic policies in Poland.

The Governmental Population Council of Poland gets its budget directly from the central government budget. In 1998 only PLN 110,000 (US\$ 32,000) was available for their activities (RF database).

At lower levels there are no specific population councils, but in certain areas (for example alcohol abuse) *gmina* commissions are set up to address a problem. There are special funds for these programs that flow from central level to *gmina*'s (extra-budgetary). At present there is no monitoring system as to population activities at these levels. Basically *gmina*'s have own revenues (7,75 per cent of personal income tax) and earmarked state subsidies (for example healthcare provision). The state subsidies are budgeted basically on the basis of population size. In health there are also funds on district level. At district and voivodship level there is also funding from the sickness funds. At tertiary level, the Ministry of Health and Social Welfare is basically responsible for teaching hospitals and Medical Academies. These are problematic in that they are educational institutions but also responsible for service provision: as of yet it is unclear which Ministry is responsible for the budgets of these institutions.

Ministry of Health and Social Welfare (MOHSW)

The Ministry of Health and Social Welfare (MOHSW) budget consists of two major budget lines: 1) health policy and 2) highly specialized interventions. Some highly specialized health interventions (about fifty) are paid by public funds through MOHSW: this concerns for example transplantations, cardio-vascular surgery, child surgery and neurological procedures. In addition, the State pays for a number of national health programs such as the National HIV/AIDS Prevention program or the Reproductive Cancer Screening program (since 2001)¹⁶. These national programs require a total annual budget of PLN 1 billion (US\$ 255 million), of which 75 per cent is MOHSW funded and 25 per cent from the sickness funds.

A number of programs financed by the MOHSW are coordinated by the Institute of Mother and Child in Warsaw and the Institute of Medical Genetics (Medical Academy of Poznan). These programs include (Government of Poland, 2001, p. 16-19):

- *Optimization of Perinatal Care, 2000-2004* (Institute of Mother and Child). The program aims at implementing a three-tiered system of perinatal care, providing surgical equipment for infants with congenital defects, producing IEC materials on MCH, promotion of breastfeeding and the monitoring of mother and child care. The total outlay in the year 2000 was PLN 4.7 million (US\$ 1.1 million);
- *Program of primary prophylactics of neural tube defects in Poland*, implemented by the Institute of Mother and Child. This includes the promotion of folic acid for pregnant women, IEC and training of medical workers. Total expenditure in 2000 was PLN 540,000 (US\$ 125,000);
- *Program of neonatal screening examination in Poland* (Institute of Mother and Child). The program aims at improving analytic tests and clinical examinations of congenital defects of infants. The total MOHSW expenditure in the year 2000 was PLN 7.5 million (US\$ 1.7 million);

¹⁶ In 2001, the Reproductive Cancer Screening Program covered 177,000 women, including 140,000 mammographs. Breast cancer is leading cause of death of Polish women with about 5000 annual deaths. The primary male death cause is lung cancer (16,000 per annum).

- *Program of monitoring and improvement of primary prophylactics of congenital development defects in the years 2000-2001* (Institute of Medical Genetics). The total MOHSW funding in 2000 was PLN 327,000 (US\$ 75,000).

Within the framework of the national program for HIV/AIDS prevention, the MOHSW has budget allocations for purchasing ARV medications, AIDS prevention and the anti-drug addiction program. The budget allocations for these programs in 1999 were US\$ 7.0 million, US\$ 5.0 million and US\$ 2.8 million respectively (NAC, 2000, p. 31). The total budget allocations of the national HIV prevention program over the different ministries for the period 1999-2003 is shown in *table 4.3*. It is clear that the Ministry of Health covers the bulk of expenditures (between 85-92 per cent), followed by the Ministry of Defense and the Ministry of Internal Affairs and Administration.

The planned budget for 2002 on health interventions included 1) AIDS medications; 2) vaccines; 3) neo-natal screening; 4) optimization of neo-natal care and breast and cervical cancer screening. Of the total budget about a third of appropriated funds from the Special National Program were ICPD related.

The National AIDS Center (NAC)

In 1992 the Minister of Health and Social Welfare created the National Coordination Office for the Fight against AIDS, then located within the Warsaw Sanitary and Epidemiological Station. Since 1993 the office was transformed and its scope of operations was broadened to implement HIV/AIDS prevention and care activities in the whole of Poland. The office was supervised by the Chief Sanitary Inspector and an advisor on AIDS and drug prevention, both directly responsible to the MOHSW. In 1999, the National AIDS Coordinating Office was transformed again into the National AIDS Center (NAC), resorting under the MOHSW. The main tasks are coordination of HIV/AIDS prevention and education, multi-sectoral collaboration and monitoring of prevention, diagnosis and treatment of HIV/AIDS of the Polish health care services. The NAC coordinates the National Program for Prevention of HIV Infections and Care for People living with HIV/AIDS and promotes research in the field. They cooperate with the Bureau for Drug Prevention and the UNDP, WHO and UNAIDS. NAC's expertise is put to use in cooperative projects in eastern European countries, such as Belarus, Ukraine, Russia, and the Baltic countries. For instance, Ukrainian doctors have been trained for two weeks by NAC. NAC also cooperates with about 30 Polish NGOs, and in some cases co-funds their activities.

Table 4.3. Polish National Program for HIV Prevention and Care for people living with HIV/AIDS, budget allocations in thousands of Zloty's, 1999-2003

Responsible Ministry	1999	2000	2001	2002	2003
Health	43,986	55,600	67,700	71,500	72,000
Education	94	240	260	280	300
Internal Affairs and Administration	0	3,000	3,400	3,600	3,700
Defense	1,605	2,720	2,915	4,495	4,595
Justice	210	250	300	3,500	350
Labor and Social Policy	1,488	918	919	920	921
Transport and Maritime Economy	0	60	60	60	60

Source: MOHSW (1999).

NAC is active in counseling through the web and via the hotline/greenline and publishes IEC material, for example the bi-monthly periodical 'Kontra'. The NAC undertook behavioral and attitude surveys under students, youth, nurses and doctors.

NAC has established (December 2001) a network of eleven anonymous testing points, each with a certified doctor and psychologist and funded from state funds through NAC.¹⁷ IEC materials and Anti-retroviral drugs are distributed through this network and at the lower administrative levels through the Sanitary and Epidemiology stations.

NAC gets its funds from the State budget through the MOHSW. NAC does not get any funding from international donors, but the NGOs with whom they work do get donor funds (independent from NAC). The NAC finances the approved HIV prevention programs at voivoidship and local levels. In 1999, the MOHSW provided NAC with subsidies for AIDS prevention (US\$ 2.8 million), AIDS anti-retroviral treatment (US\$ 7 million) and drug addiction prevention program (US\$ 5 million) (NAC, 2000, p. 31).

The NAC budget for the year 2001 (total PLN 50.5 million or US\$ 11.6 million) was divided as follows: 1) Anti-retroviral therapy (PLN 40 million); 2) HIV-AIDS testing (PLN 1,5 million); 3) office and staff costs (PLN 2,5 million; 30 staff) and 4) projects with NGOs (mainly IEC; PLN 4 million). Thus, of their budget almost 80 per cent is spent on anti-retroviral therapy; for specific tasks/projects 16 per cent is spent, of which part is executed through cooperating agencies (NGOs), about eight per cent of the total. The 2002 budget will only be approximately 65 per cent of the 2001 budget due to government financial downsizing. There will be no cuts in the budget for purchasing ARV drugs however.

From the MOHSW budget for the National AIDS prevention program, PLN six million was allocated in 2000 for the NAC and the Center for AIDS Diagnosis and Therapy and in the period 2001-2003 PLN four million (US\$ 920,000) annually (MOHSW, 1999, p. 38).

Ministry of Education

In the National Health Plan (1996-2005) one of the targets was the improvement of health education and health promotion programs. This would include education at primary and secondary level schools on topics such as drug abuse, family life (sexual) education and HIV/AIDS (MOHSW, 1996, p. 52). At lower levels (*voivoidship, gmina*) the Education Supervision Office monitors and guides family life education by certified teachers in schools. Basically the responsibility and funding for these activities remains with the local governments.

In the year 2000, the Ministry of Education drafted a document on implementation of the school curriculum on *Upbringing to Life in the Family*, which forms the basis of the current government's sexual health program in schools. The first activities involved the training of teachers of over 10,000 teachers in 47 centers all over Poland. In addition, training conferences were supported by the Ministry and educational materials provided to schools. The total costs in 2000 for these activities amounted to almost PLN 400,000 (US\$ 90,000) (Government of Poland, 2001, p. 42).

¹⁷ A total of 16 –one in each voivoidship was planned, but postponed due to budget cuts.

Some other initiatives the Ministry of Education is taking include the publication of a booklet on HIV/AIDS for use in schools (in cooperation with UNDP) and preparing for an international Conference on the topic of sex education in schools to be organized in 2003 or 2004.

As to the budget and expenditures of the Ministry of Education, the response to the UNFPA/NIDI survey in 1999 and 2000, indicated an income for financial years 1998 and 1999 of PLN 26 million (US\$ 7.5 million) and PLN 56 million (US\$ 12.8 million) respectively (UNFPA/NIDI database). Due to budget cuts at central level, the Ministry of Education and Sports budget for 2002 was considerably downsized. Exact figures for 2000-2002 could not be provided however.

National Institute of Hygiene

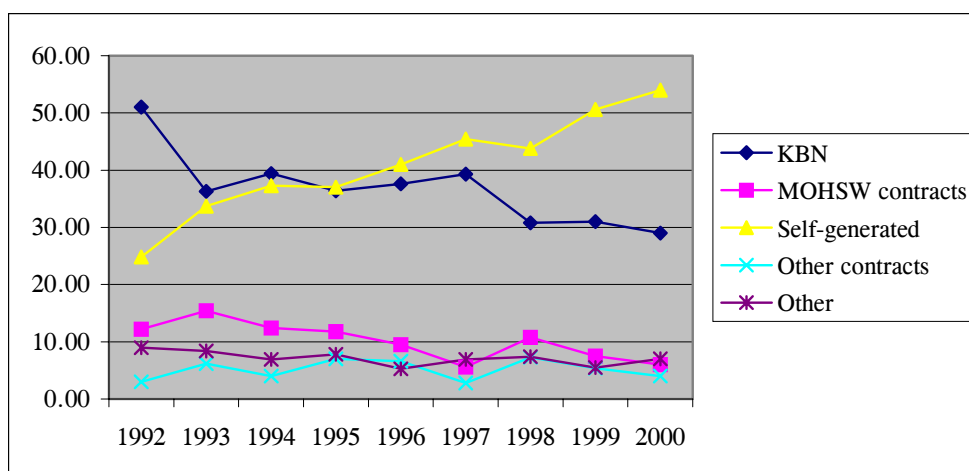
NIH established in 1918. It currently consists of 14 departments including Epidemiology, Health Promotion, Medical Statistics and Communal Hygiene. The scope of research is wide and includes HIV/AIDS, hepatitis, vaccines (for the EPI program), epidemiological analysis, breast-feeding and effects of pollution (for example atmospheric pollution and PCBs). NIH functions in cooperation with the WHO as the national reference center for hepatitis and HIV infection and AIDS. The NIH collaborates with WHO, the *Institut de Veille Sanitaire* in Paris and the Polish TB Institute, with which data are exchanged and published.

NIH collects epidemiological data; they have HIV/AIDS data but not on STDs. AIDS data are collected, analyzed and sent to the WHO for publication. A recent problem for the NIH is the new law on Epidemiology (September 2001) protecting the rights of individuals, i.e. anonymity. Certain data are not collected and some data on risk groups cannot be published. In addition, registration is deficient in that time series data sets are often not comparable due to lack of unique ID keys for cases; this results in double counting.

As to blood safety, since 1993 blood banks registered no HIV contaminated cases anymore. Blood donors are screened rigorously. The data are derived from 150 screening labs, 15 medical institutes and one lab for the Polish Army. About 1,5 million blood samples are investigated annually. The NIH publishes epidemiology fact sheets fortnightly, with quarterly, half-yearly and yearly summaries. However, it was noted that the decreasing number of screened people/blood samples was an issue of concern, in addition to the unreliability of data and the number of people who were tested but got no test results/confirmation.

Figure 4.2 shows that there is a shift in funding for NIH from KBN funding to own income from the health centers for services rendered (testing, examinations). The NIH gets about 50 per cent of its income from the State Scientific Research Council (KBN) although this has been decreasing since 1997. NIH's self-generated income has shown a progressive trend during the 1990s and in 1999 about half of all income was self-generated. The income out of contracts with the MOHSW has remained relatively stable through the years. Currently, the NIH gets some funding from the EU 5th Framework Program for a project on 'Effects of environmental degradation and pollutants (PCBs) on health and reproductive health'.

Figure 4.2. National Institute of Hygiene, income by source, 1992-2000



Source: Sprawozdanie z dzialalnosci naukowej i usugowej w roku 2000, Warsaw: National Institute of Hygiene.

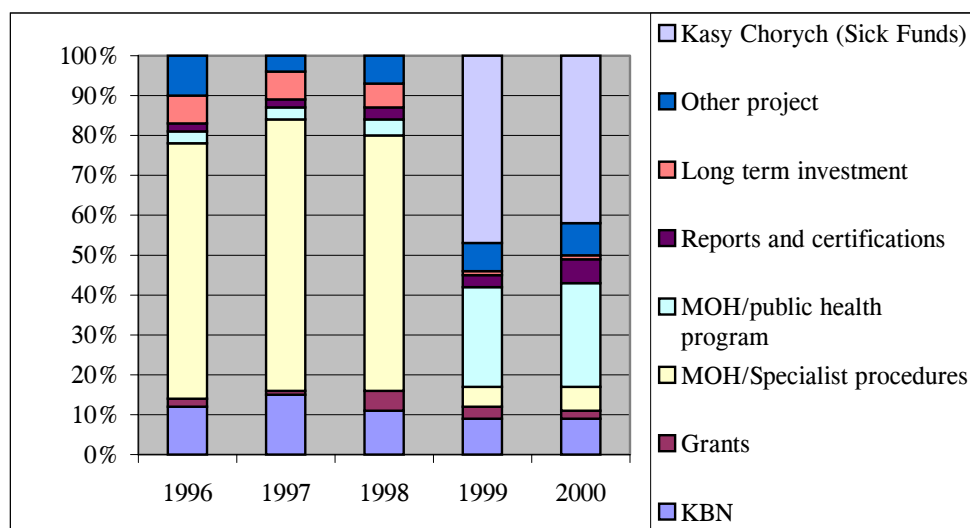
Institute of Mother and Child (*Instytut Matki I Dziecka*)

The Institute of Mother and Child (IMC) was established 50 years ago. The main tasks of the institute are research and implementation of activities in the field of health promotion, prophylactic, curative and rehabilitation care for children, adolescents and mothers. This includes some highly specialized diagnostic and treatment procedures. Initially, the major focus of the Institute of Mother and Child was on family planning, but this has gradually shifted to reproductive health and HIV/AIDS. From 1992, the institute provides obstetrical and gynaecological care for HIV+ women and psychosocial services for people living with HIV/AIDS and their families. The institute conducts research, collects epidemiological data and develops medical standards for specific treatments. The institute collaborates with the MOHSW, the State Committee for Scientific Research (KBN), the National AIDS Center, the Warsaw Medical Academy (childhood infectious diseases) and regional health services. The institute is responsible for the supervision of MCH services at voivodship level. There are 17 units at voivodship government level; these are paid straight from the Ministry of Finance budget.

Before the 1999 reform, the Institute for Mother and Child received the bulk of its income from the MOHSW for services rendered, with a far smaller proportion of income came from the State Committee for Scientific Research (*figure 4.3*). Since the reform, the principal sources of funds are the sickness funds, the MOHSW and KBN, in that order. Foreign donors (for example Netherlands, Denmark, and France) only incidentally provide limited funding.

The income of the Institute of Mother and Child increased from around PLN 27 million (US\$ 9.9 million) in 1996 to about PLN 50 million in 2000 (US\$ 11.5 million). As to the expenditures, these showed a similar trend i.e. total expenditures almost doubled between 1996-2000. It is not possible to break down expenditures according to family planning, reproductive health or HIV/AIDS interventions.

Figure 4.3. Structure of income, Institute of Mother and Child, Warsaw



Source: Institute of Mother and Child, Warsaw.

National Institute of Venereology

The only STIs that are screened are syphilis and gonorrhoea. In general screening in Poland on STIs is deficient and becoming worse. Formerly STIs were screened via a network of outpatient clinics (50 units; one in each voivodship plus the central unit (Institute of Venereology), but after the health transition the *Kasa Chorych* were to pay, and these did not consider this priority so screening was limited. In private clinics testing is done but results are not always verified.

Previously, STDs, TB and HIV were separated in Polish law; now these are grouped under the heading communicable diseases. The new Law on Infectious Diseases integrated screening on these diseases under responsibility of the sixty Sanitary and Epidemiological Stations at *voivodship* level. In reality however, screening is deficient and not integrated. It was noted by respondents that there is a potentially dangerous situation; although the number of tests represents a mere 5-10 per cent that were done before the 1999 reform, the number of infections remained at a similar level as before (about 1000 per annum). Thus, the number of infections is much higher than the official figures suggest. For the screening units at voivodship level only PLN 200,000 (US\$ 46,000) per annum is budgeted which is considered clearly insufficient.

Institute of Oncology, Warsaw

With UNDP support the Institute of Oncology developed a Population Based Screening Model: this involved the screening in Warsaw gmina of women aged 30-60 years. The Institute of Oncology applied for a World Bank grant in 1999 to set up a Screening Program (1999-2000) in six out of eleven oncological centers in Poland. The funding for this came from the World Bank (US\$ 2.3 million) with matching funds from the MOHSW (US\$ 2.5 million). The six selected centers were two independent medical institutions, two centers connected with medical universities and two cancer centers in Warsaw. At present the final report is being drafted. The results were encouraging and the model seems a cheap, cost effective model: cost of year life gained was US\$

1000 which is a lot less than cost one year life gained in USA (US\$ 6000). The Institute of Oncology has applied for a follow-up project with the EU and the World Bank.

Other smaller projects carried out are a 1) Screening program Warsaw in 2000, which was funded by MOH, the local gmina office and the sickness funds and 2) a Cancer Register, containing screening data for five million Polish people.

Central Statistical Office (Główny Urząd Statystyczny — GUS)

The Social Statistics Division of the Central Statistical Office (CSO) collects and analyses statistical information concerning demography, fertility, projections, migration and public health. The CSO is currently restructuring. At present there are 12 departments, but these will expand to 22 next year.

In 1996 CSO executed a demographic and health survey; the next is planned for 2004. The survey covers issues such as lifestyles, use of drugs, alcohol consumption, smoking and reproductive health (use of health services such as mammography, cervical cancer screening). In 2001 a Family and Fertility survey was conducted in cooperation with Institute of Economics. In 2002 a National Population and Housing Census has been executed, data of which will be published in 2003-2004. Data related to demography can be found in the GUS 2002 civil registry.¹⁸

The CSO is directly funded from the State Budget via the Ministry of Finance. The CSO expenditures in the years 1997, 1998 and 1999 have increased from US\$ 849,000 in 1997, to US\$ 878,000 in 1998 and US\$ 1,7 million in 1999 (UNFPA/NIDI database). The total budget for statistical surveys in 2002 is PLN 3,927,446 (US\$ 900,000), but excluded the Population and Housing Census. For the Population and Housing Census 2002 an extra PLN 400-500,000 is budgeted. For the Agricultural Census 2002 PLN 90,000 is budgeted. The grand total for these activities is about PLN 4,467,446 (CSO Warsaw, budget sheets).

Polish Committee for Scientific Research, Department of Medical Research (Komitet Badan Naukowych-KBN)

KBN is the governmental institution that is responsible for the organization of bidding and selection of scientific research projects. KBN gives out grants for scientific research in all disciplines. KBN gets its funding directly from the State Budget through the Ministry of Finance. Grants can take the form of:

- 1) Individual grants for scientific research. The total annual budget for all grants is PLN 22-24 million (US\$ 5-5.5 million). These funds come from State Budget through KBN. This includes grants for PhDs; this is to a maximum of PLN 50,000 (US\$ 12,000), excluding fees for academic supervisors. About 50 per cent of PhD grant applications are approved;
- 2) Grants based on matching funds of implementing institution;
- 3) Institutional grants for basic research; current priorities are genetics and xeno-transplantation and BSE research. The institutional grants are divided among 1) thirty-two medical universities (1999: 46 million PLN); 2) six institutions of the Polish Academy of Sciences (1999: 32

¹⁸ See for more information CSO website: <http://www.stat.gov.pl/english/index.htm>.

million PLN); 3) twenty-one state institutions (for example Institute of Hygiene; Institute of Venereology) (1999: 88 million PLN) and 4) Physical/sports Universities (1999: 2 million PLN). The total amount in 1999 was 168 million PLN (approx. US\$ 50 million).

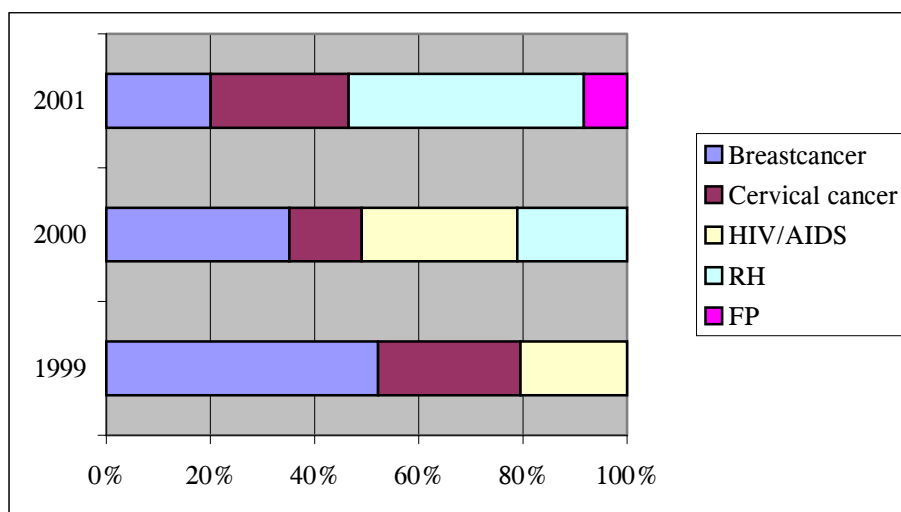
Areas of research eligible for funding are announced in the State Journal. In health the MOHSW guides tender procedures. There is a separate Commission for each scientific discipline and the proposals are refereed independently. The total number of project proposals reviewed each year is between 1000-1200. About 25 per cent are approved. This system of grants was established in 1995 and refined ever since with new regulations. In reproductive health few projects are supported by KBN at present. There are pipeline projects on the vertical transmission of HIV, on infertility, on genetical screening for breast cancer (Institute of Oncology; US\$ 100.000 in 2002) and placenta blood cell research/blood banks for cancer prevention.

Total spending of KBN on scientific research grants in 1999-2001 was about PLN 220,000 (1999), 700,000 (2000) and 330,000 (2001). *Figure 4.4* shows the division of research grants across the categories relevant for this inquiry. As is clear family planning hardly figures as a significant area of research, whereas cervical and breastcancer is assigned more priority.

Local level government programs

As was explained above local government has a certain degree of autonomy to develop, implement and fund health programs. The local governments can make recommendations for requirements in health promotion to the regional commission, including advice from health chamber professionals.

Figure 4.4. KBN research grants by category, 1999-2001



Source: KBN, Overview of grants, 1999-2001.

Note: RH includes projects on C-sections, IVF and safe delivery.

Within the framework of this case study it was not possible to cover projects and expenditures on lower administrative levels. Although it is not necessarily representative for all Polish towns, as an example, the Krakow City government was selected as an example to gain a better understanding of funding for population projects at the lower level.

The city council controls some hospitals and clinics as owners and funds capital investments. The Krakow local government spends on local health promotion programs, for example cancer screening programs or alcohol abuse programs financed out of local taxation on alcohol sales. Local projects in the field of health promotion are put out for public bidding; private and public health providers and NGOs can tender for project funds.

In 2001 the total budget for health promotion of the City of Krakow was PLN 1,5 million (US\$ 345,000). For 2002, PLN 3 million (US\$ 690,000) was budgeted for these project grants. In the new budget cycle there are 107 separate programs, but there are no separate aggregate budget lines for reproductive health or family planning. However, one can identify relevant budget line items. In 2001, Krakow city implemented a program on oncology (Krakow City Council, 2002). Under this program eighteen different activities were funded by the local government and carried out by different local hospitals and clinics in the field of breast and cervical cancer. The total expenditure in 2001 was PLN 94,000 (US\$ 22,000). The Krakow city council also supported a small project on prostate cancer screening with PLN 4,000 (US\$ 1,000). There is an independent budget for NGO projects funded by local government; this special reserve fund in 2002 was about Polish Zlotys 3-4 million (US\$ 700-900,000). These projects concern for example conferences, publications or IEC executed by NGOs.

4.3 | Role of national NGOs

In Poland, there are many NGOs working in the field of family planning, reproductive health and HIV/AIDS. In terms of sustainability the funding situation of NGOs in Poland is less favorable. They have to apply every year for government funds and funding is bound to strict accounting rules (for example no shifts between items, no salaries or travel grants). In general, the funds need to be spent in the same year, although actual disbursement of government funds could take a few months.

Next to grants from central government bodies some Polish NGOs also receive funding from *gmina*'s. The Polish NGOs working in the field of population are very donor dependent. Data from four Polish NGOs working in the population field for the years 1997-1999 indicated that over 95 per cent of their combined income originated from external sources (RF database) ¹⁹

In general, the budget situation of Polish NGOs could become more difficult as international donors are pulling out of Poland. It is considered a high middle income country, is in fact a donor

¹⁹ Federation for Women and Family Planning; Society for the Development of the Family; Society of Volunteers for AIDS Victims; Social AIDS Committee.

country and will join the EU in 2003. It is therefore assumed Poland will get more EU funding. In practice this proves to be difficult.

Federation for Women and Family Planning

The Federation for Women and Family Planning (FWFP) was established in 1991 and the current members are: 1) League of Polish Women 2) Polish Feminist Association 3) Pro Femina Association, Warsaw; 4) Neutrum, Association for Ideologically Free State, Warsaw 5) Young Women Christian Association; 6) Family Development Association; 7) Women's Democratization Union; 8) Movement for the Protection of Women's Rights, Poznan, 9) Assistance Centre for Family Association, Olsztyn.

FWFP is basically an advocacy organization, promoting reproductive health and women's rights, including prevention of unsafe abortion, accessible family planning methods, gender sensitive sex education, patients' rights and the partnership model of relations between medical personnel and clients. FWFP has outreach programs, counseling and educational programs and actively participates in international forum and conferences including UN conference (Cairo and Beijing). FWFP has a counseling hotline, organizes open days for the public and produces publications on reproductive health and women's rights issues. A highlight in 2000 was the publication of the book entitled *The Anti-Abortion Law in Poland: the functioning, social effects, attitudes and behaviors*. Currently, FWFP has a staff of six people.

FWFP does not get any government funding but mainly relies on national and international donors, including among others the Stefan Batory Foundation (Warsaw), Open Society Institute, UNFPA, European Union, Ford Foundation, British Know-How Fund, Women's Health Project (Johannesburg, South Africa) and the International Women's Health Coalition (FWFP, 2000b, p. 25).

Total expenditures of the FWFP in the period 1997 and 2000 was between US\$ 100-150,000 per annum, most of which went to advocacy work in the field of women's reproductive health rights and modern contraception (UNFPA/NIDI Resource Flows database).

Society for the Development of the Family (*Towarzystwo Rozwoju Rodziny*)

The Society for the Development of the Family (TRR) was established in 1956. It is the IPPF Affiliate in Poland and the largest NGO in the field of Family Planning. They offer medical counseling, family planning services, sex education and advocate women's reproductive health rights. TRR operates medical centers in Warsaw, Krakow, Opole, Wroclaw and Lublin.

A hot issue is sex education at schools. In response to the governments' conservative sex education program, emphasizing natural family planning, TRR lobbies for better sex education, including IEC on modern methods. TRR organized a conference in 2001 on 'Sex education: state and our needs'. There are signs that the present government is more receptive to their pleas but a problem is that the Ministry of Education has limited funding for new programs. In the near future, funds permitting, TRR plans to plan to organize a 'World Congress on Sex Education' in Poland; and open a Center of Sexuology in Warsaw, offering family planning and reproductive health coun-

selling. Main tasks will include the improvement of sex education in Poland and advocacy for change of the anti-abortion law.

Under the former and current governments family planning remained of very low priority and government does not support family planning promotion activities. A recent example was a grant for TRR from Switzerland for ultra-sonograph equipment (over US\$ 200,000) which was forbidden by government. TRR does cooperate with the NAC in the context of HIV/AIDS prevention however. The government has only sponsored some medical consultations, and funded US\$ 10,000 (2001) for services rendered to parents with mentally handicapped children. TRR's medical centers currently generate about 35 per cent of their total resources. In 1998 total expenditures were US per cent 73,000 and in 1999 US\$ 105,000, which were spent on counseling services, training projects and publications.

TRR occasionally gets commodities from pharmaceutical companies and local governments. In addition they received 10,000 condoms from RVSU (Sweden) and also from UNIMIL (Poland). From UNFPA they received 10,000 units of Marvelon (pills) in 1999.

'TADA' Association for Prevention of HIV/AIDS and other STDs

TADA received NGO status in 1998. Its main focus is the IEC on and prevention of STDs and HIV/AIDS. Since 1995 TADA has undertaken prevention activities among high-risk groups, for example male and female prostitutes, customers of prostitutes, gays, and escort and nightclub owners. Through street work, training, IEC, social care and counseling, advocacy work, publications and participation in conferences, TADA aims to promote safe and responsible sexual behavior, reduce the spread of STDs and HIV/AIDS and improve the plight of people living with HIV/AIDS.

The TADA activities are implemented in six cities in Poland, viz. Warsaw, Gdansk, Szczecin, Zielona Gora, Poznan and Katowice. TADA has cooperated with UNDP, TAMPEP (Netherlands) and the tripartite Commission of Three Partners (Poland, Czech Republic, Germany) for advancing cross-border cooperation in HIV/AIDS prevention. At present, TADA does not receive any financial support from the Polish government.

TADA Warsaw is part of the TADA network in Poland. It is a small NGO established in 1998 with a staff of eight people. They aim at harm reduction and HIV/AIDS prevention aimed mainly at female/male and child prostitutes working in the central Warsaw area (railway station, clubs, hotels). Other target groups are call girls and escort agencies.

In the past various donors have supported TADA Warsaw's activities: the National AIDS Center (1999: 32,000 PLN for maintenance costs), UNFPA (condoms), Batory Foundation, Warsaw City Council, Siemens, UNIMIL (Poland), Krakoje Centrum ds. AIDS and Radio Kolor in Warsaw. In 2000 their total budget was US\$ 65,000 and in 2001 US\$ 28,000.

Polish Foundation for Humanitarian Aid 'Res Humanae'

The Polish Foundation for Humanitarian Aid Res Humanae was established in 1993, and built on existing voluntary work in the field of HIV prevention, IEC on HIV/AIDS and care for people living with HIV/AIDS. Res Humanae is a non-profit NGO with a present staff of five people.

Their main objectives are the operation of a hospice for AIDS patients; the promotion of human rights and humanitarian attitudes for people living with HIV/AIDS through IEC; assistance to drug users, prostitutes and others in need and fund raising in support of HIV/AIDS activities.

Res Humanae currently runs a center for care of adopted children and children of drug addicts in Warsaw. Total funds in 2002 were EURO 120,000. Funding comes from EU –PHARE (EURO 100,000), ten per cent from *Associazione Volontari per il Servizio Internazionale* (AVSI) and five per cent from Warsaw Gmina. Res Humanae also trains NGO volunteers, journalists, educators, students, social workers on HIV/AIDS and coordinates local community AIDS prevention projects undertaken by local NGOs.

Main past activities were the organization of charity concerts (for example 'Tolerance' and 'Rock for AIDS' in 1990), which were supported by government and celebrities; organization of annual international conference on 'Persons Living with HIV in Family and Society' on World AIDS day and the establishment of a Center of Education, Documentation and Information on AIDS in Warsaw. This latter initiative was initially financed from an EU PHARE-LIEN grant. The conferences in 1999 were sponsored by the AIDS Fonds (NL), UNAIDS and the International Community of Women (UK).

A successful project on AIDS prevention in Podlasce (East Poland) was closed in 2001. This was aimed at IEC and training of police, local government, social workers, teachers and priests, in HIV/AIDS, treatment/care and human rights of HIV/AIDS sufferers. Funding came from NAC (US\$ 50,000) and from UNDP for a small conference. Despite the implementation of the IEC project in highly conservative area where HIV/AIDS prevalence is high, the model was successful and there are plans to copy the project model in voivoid Mazijewski in Warsaw, where the local government will implement it. Res Humanae will only some advisory input of Res Humanae.

Res Humanae runs a HIV/AIDS Hotline: the number of counseling calls is about 150 per month. In 2001 this was supported by gmina funds and NAC, but this year no funds. This project maybe will be terminated in 2002 out of lack of funds.

The total budget of Res Humanae for 2001 was US\$ 250,000, of which US\$ 150,000 was for a training course for teachers, nurses and physicians (funded from NAC, Ministry of Education, and National Bureau on Drug Addiction (MOH)). About 1600 people took part in this for 3-7 days. The rest was spent on salaries, running costs and smaller projects.

Social AIDS Committee

The Social AIDS Committee is a non-profit NGO that was established in 1993. The aim of the organization is to promote rational and humane behavior toward people living with HIV/AIDS and to help prevent the spread of the disease. The organization is involved in a whole range of HIV/AIDS prevention activities including sex education among students, teachers and health

professionals and sex workers; counseling training for doctors, nurses, midwives, prison staff, educators and street workers; financial and material support for people with AIDS; cooperation with the Center for HIV Anonymous Testing; publications and seminars. The Social AIDS Committee has cooperated in these efforts with organizations such as the national AIDS Center, UNDP, TADA, the SANEPID of Warsaw voivodship and other NGOs such as the 'Monar' Association and the 'Lambda' Association.

For their activities implemented between 1999 and 2001, the Social AIDS Committee received financial support amounting to PLN 730,000 (US\$ 220,000) from governmental, non-governmental and international sources. Donors included the Krakoje Center ds. AIDS, Batorego Foundation, Warsaw City Council, Warsaw gmina Centrum and the Open Society Institute. These funds were expended on HIV prevention program for women and children (with TADA) and training projects for nurses, family doctors, health workers and gynecologists. The Social AIDS Committee reported expenditures for HIV/AIDS projects in 1997 and 1998 to the amount of approximately US\$ 17,000 per annum (UNFPA/NIDI Resource Flows database).

MONAR, Krakow

MONAR is a national NGO established about 22 years ago. MONAR is a Poland wide organization with its headquarters in Warsaw and with sub-centers in Gdansk, Krakow and Szczecin. Their main target groups are intravenous drug users (IDU) and their families, prison inmates and more recently commercial sex workers. MONAR offers counseling, treatment, family support, legal advice and needle exchange programs for intravenous drug users. MONAR also cooperates with regional employment offices for job placements and with sickness funds to enable drug treatment.

MONAR's center in the city of Krakow has a staff of about 40 people. Their main aim is harm reduction and IEC on HIV/AIDS. Recent and current MONAR projects include:

- A rehabilitation center for drug users in Krakow, established in 1993. It is therapeutic community where information, counseling, legal advice and treatment are given. Relapse clients receive attention here;
- A detoxification center with 15 beds. Drugs and other commodities are paid under contract with the regional sickness fund;
- A hostel for drugs users offering over-night accommodation and meals;
- Since 1996 MONAR has an exchange program with the International Harm Reduction Program (IHRP, New York). They receive some funding from IHRP;
- MONAR staff (16) was trained on HIV/AIDS prevention, under initiative of UNDP and with IHRP (New York). This knowledge is passed on through training of outreach workers, policemen and prison staff. MONAR also has training projects for the police, border police, and drug crime squad in other Eastern European countries (Belarus; Russia);
- Umbrella program: IEC and condom distribution for sex workers. Condoms are acquired from UNIMIL (Polish condom producer) and in the past from UNDP;
- Needle-exchange program (since 1996);
- Polish prison project, aimed at harm reduction and IEC. About 28 prison workers from all over Poland are trained. Funding is from IHRP, (total US\$ 60,000). But no condoms;

- An exchange program was sponsored by Levi-Strauss program via UNDP (US\$ 10,000) in 2000;
- Counseling by e-mail project, with funding from the Polish NAC;
- They also work on a methadon program for heroine addicts; in prisons no needles are allowed and programs problematic.

MONAR Krakow works with a limited budget: in 2000 total of PLN 421,000 (US\$ 97,000) and in 2001 PLN 578,000 (US\$ 133,000). MONAR's main sponsors are the regional sickness funds (reimbursement of medicines), the Krakow City NGO grants program, MOHSW/Bureau for Drug Abuse, IHRP (New York), SOROS Foundation and UNDP.

National Coalition to Combat Cancer (NCCC)

In 1996 established as a grass roots, non-profit NGO with the aim advocate action against cancer in Poland. The aim is awareness building through health promotion, a hotline, and cancer prevention educational campaigns. Their activities include actions against breast cancer and cervical cancer. They support Mobile Mammography Network ('mammo-buses'). They also cooperate with Ukraine, Byelorussia and the Baltic States.

Stefan Batory Foundation

The Stefan Batory Foundation is an independent non-profit foundation created in 1988 by George Soros, who also founded the Open Society Institute. The foundation aims at the development of democratic and open society, including the fostering of civic attitudes, educational development, cultural activities and international cooperation. Next to organizing conferences and training programs, the foundation manages fifteen programs for which it gives out grants and scholarships. These cover, *inter alia*, women's health issues and rights, youth, alcohol and drug abuse, corruption, child abuse and palliative programs.

Under the women's and NGO programs, grants totaling US\$ 58,000 were made to over twenty-one Polish NGOs in 2000, particularly concerning breast cancer and care for women after mastectomy (Batory Foundation, 2000).

The Stefan Batory Foundation receives the bulk of its funds from the Open Society Institute. Total donor income (all programs) in 2000 was PLN 35 million (US\$ 8 million). In 1996, the Ford Foundation donated US 2.5 million for five years for the execution of its programs. A range of other international and national donors support specific programs, including the World Bank, United States Embassy in Warsaw, Polish TV, Bertelsmann Foundation. Irene Mroz from Paris provided funds (US\$ 4000) especially for the Women's program (Batory Foundation, 2000).

Society of Volunteers for AIDS Victims

The Society of Volunteers for AIDS Victims is a Polish NGO, which deals mainly with HIV/AIDS prevention and care projects. In 1997 this organization reported a total expenditure of US\$ 82,000 for various HIV/AIDS projects. Financial support (total US\$ 82,000) in 1997 came from the Polish Ministry of Health and Social Welfare, the NAC, local government, the European Commission and the UNDP (UNFPA/NIDI RF database).

4.4 | Role of the Private Sector

Since the health reforms the private sector plays a large role in offering services in the field of reproductive health. The public sector does not support family planning services; the main outlets for contraceptives are private sector establishments. It was not possible to collect comprehensive data of market shares of contraceptives in the private sector. However, some limited data showed that the Polish market for oral contraceptives had remained relatively stable at around two million strips during 2000-2001 with a value of over US\$ 8 million. The market for intra-uterine devices (IUD) has doubled in the period 1997-2000 to about 60,000 packages in 2000 with a value of over US\$ 600,000 (IMS 2002).

Damian Private Hospital, Warsaw

Due to time and money constraints it was not possible to collect comprehensive information on the private sector in Poland. To get a rough idea of the role of private clinics, a visit was paid to a clinic in Warsaw. Damian hospital started six years ago and number of patients has risen ever since. Per annum they now have about 2000 surgeries. The hospital offers a wide range of medical interventions. There is an outpatient clinic, hospital ward, delivery department, surgery department, emergency ward/intensive care unit, and diagnostic services. The Damian hospital has no contracts with *Kasa Chorych* because these have too little funds and the reimbursements are too low: mainly they only pay for instruments (non-disposables; so they have to sterilize more often) and some running costs but not for salaries (large chunk). Basically, services are paid on a fee-for-service basis. Damian hospital sometimes gets medical equipment and supplies from medical equipment manufacturers and pharmaceutical companies at subsidized prices. The private sector is not regulated yet and private insurance is insignificant. The different private sector clinics are competitors and offer different services, different standards and different prices.

4.5 | The Role of the International Donor Community

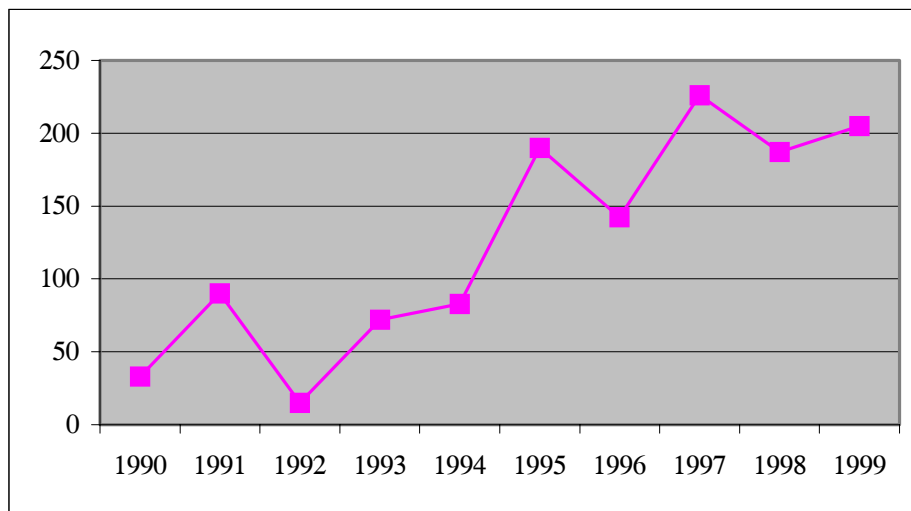
4.5.1. Development of foreign donor funding in Poland

In general, international assistance for population is rather modest in Poland as compared to other countries. Total donor funding for population activities in the period after the ICPD Conference did not exceed US\$ 250,000 per year, most of which was channeled through the multi-lateral channel.

As is shown in *figure 4.5*, except for a decrease in 1992, the total donor expenditures for population activities in Poland have been progressive, in particular after the ICPD conference in 1994. During 1990-1999, multilateral organizations (mainly UNDP and UNFPA) have been the main conduit for funding population programs in Poland. While the WHO is active in the health sector, UNAIDS is the main source of donor assistance in the field of HIV/AIDS while UNFPA is the main donor in the population field.

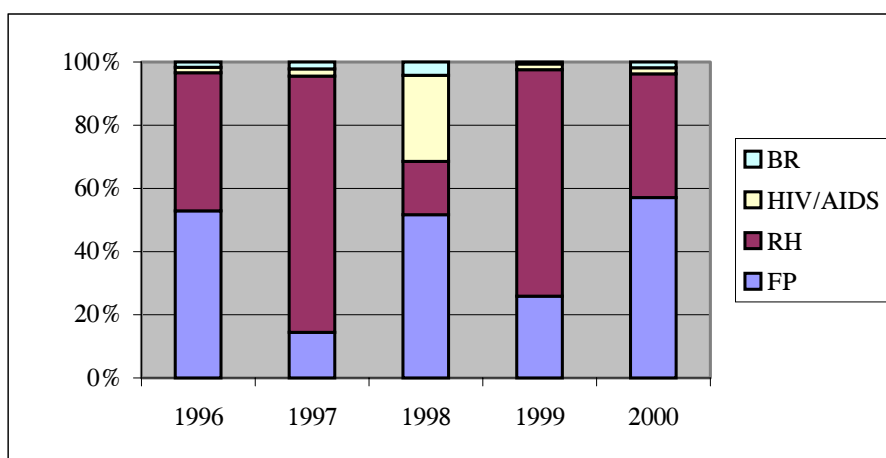
As to the trend in total foreign assistance in terms of the four ICPD 'costed package' categories of activities (*figure 4.6*), it is apparent that for the period 1996-2000, the bulk of funding went into

Figure 4.5. Total donor expenditures for population activities, Poland 1990-1999 (US\$000)



Source: UNFPA/NIDI RF database.

Figure 4.6. Donor funding by population activity category, Poland, 1996-1999



Source: UNFPA/NIDI RF database.

family planning and reproductive health activities. Little funding is used for basic research and policy analysis and only in the year 1998 a substantial proportion (27 per cent; US\$ 50,000) of total funds was geared toward HIV/AIDS activities through the Joint United Nations Program on HIV/AIDS.

International Donors in Population and Development

a. Bilateral donors

As noted above, bilateral funding for population programs in Poland has been limited. Most funding is through the multilateral channel.

Sweden

Sweden (through SIDA) has supported development projects in Poland in the fields of environment, democratic governance, social sector development, human rights and gender equality. In 1999, SIDA has supported projects in Poland in the field of sexual and reproductive health. The total disbursements for this program in 1999 were Swedish Krone 306,000 (US\$ 37,000; UNFPA/NIDI RF database). The total disbursements for health care projects in Poland were SK 463,000 (US 50,000) in 2000 (SIDA web site).

The European Union

The main channel for EU assistance in the field of health has been the EU PHARE Program. In 1991, the PHARE program supported health sector reform with a total budget of ECU 20 million, of which 94 per cent was expended at termination of the program in 1996 (EU 2002). The program addressed issues such as primary health care and management development. However, this program did not specifically concern reproductive health, family planning or HIV/AIDS prevention. In Poland, the EU currently does not support any programs in this field.

b. UN Organizations

UNFPA

UNFPA is the main donor supporting population projects in Poland. In the past UNFPA has supported projects in the field of family planning, contraceptive supply, MCH, IEC and basic research on population.

In 1996 UNFPA provided finances of US\$ 200,000 for contraceptive supply for free distribution to family planning organizations around Poland, including the Federation for Women and Family Planning. Total expenditure up to 2001 was US\$ 114,000.

Other projects supported by UNFPA in the period 1990-2000 are:

- *Fertility and Family Survey* (POL/89/P02) this was executed by the Institute of Statistics and Demography of the Warsaw School of Economics. The project started in 1989 and was completed in 1999. The budgeted financial support from UNFPA was PLN 122,000 (US\$ 28,000);
- *Socio-demographic and health determinations of infant mortality* (POL/89/P03), executed by the CSO. UNFPA input was US\$ 54,000;
- The project *Promotion of Responsible Family Planning and Healthy Lifestyles for Adolescents and their Parents* (POL/94/P01) was executed by the Ministry of Education (1994-1999) with UNFPA funding. The total UNFPA budget for this project was US\$ 420,000;

- *Reinforcing MCH and family planning activities (POL/94/P02)*. The Institute of Mother and Child and Ministry of Health implemented this project during 1994-1999. The total budget was US\$ 480,000 of which about 75 per cent funded by UNFPA and 25 per cent by the Polish Ministry of Health;
- *Reproductive health network (UNFPA POL/98/P01)*: the aim of the RH network is to bring together MPs, politicians, media, teachers, health personnel, NGOs, women groups to inform about and advocate on reproductive health. In addition, the aim was to contribute to the governments' efforts to introduce sex education in schools (in February 1998 this theme was to be introduced in schools). Publications were included in the planning budget. Project lifecycle was two years. (June 1998-2000) The executing agency was the Government Population Council and the implementing agency the Federation of Women and Family Planning. The total budget was US\$ 158,300 of which US\$ 5,000 NGO input and US\$ 153,3000 from UNFPA.

In the year 2001, only one UNFPA project was active, namely the 'Training course for Paediatric nurses, adolescents on RH and STD', executed by the Malopolska Nurses and Midwives Association in Krakow. The project started in 2000. In total 316 nurses have participated and 286 completed the course.

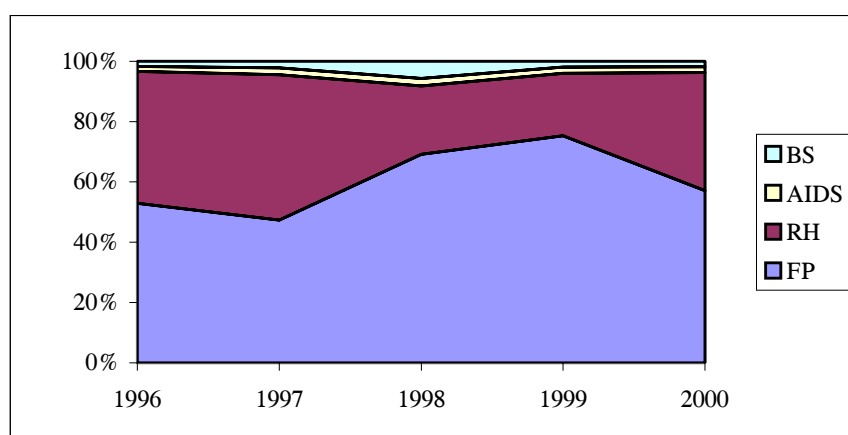
The total expenditures of UNFPA for projects in Poland in the 1996-2000 period was around US\$ 160,000 per annum. Expenditure peaked in 1997 (almost a quarter of a million US\$), but declined thereafter to just over US 100,000 in 2000. In terms of 'ICPD costed package categories' (*figure 4.7*), it is clear that the bulk of expenditures has gone into family planning activities (50-60 per cent), followed by reproductive health.

United Nations Development Program (UNDP)

The UNDP office was established in Poland in August 1990. The UNDP resident Representative is also the representative for UNFPA, UNDCP and the World Food Program (WFP) in Poland. Currently, UNDP together with the Polish government is implementing a Cooperation Program for 2001-2003, aimed at supporting Poland's integration with Europe. The program encompasses social development and institutional restructuring including the government apparatus at all levels. Next to supporting activities in the field of gender and countering domestic violence, UNDP Poland has also been active in the field of HIV/AIDS. From 1995 UNDP assisted the Polish Government in the HIV prevention and provision of support to people living with HIV/AIDS.

UNDP also supported the drafting and implementation of the Polish HIV/AIDS Prevention Program 1996-1998. In 1997, UNDP initiated and published the results of a social survey on HIV/AIDS, providing useful information for government and NGOs working in this field. UNDP forms part of the Polish UN Theme Group on HIV/AIDS, together with UNICEF, UNESCO, UNFPA, WHO and the World Bank. The major thrust of UNDP's program in Poland consists of awareness building, promoting sexual health, IEC and advocacy.

Figure 4.7. UNFPA expenditure in Poland by category, 1996-2000



Source: UNFPA/NIDI RF database.

UNDP's activities in the field of HIV/AIDS in Poland include:

- Awareness creation and education at schools;
- Harm reduction of sex workers, MSM, drug users, in cooperation with Soros Foundation and Polish NGOs;
- Prison-inmates project (IEC and condom distribution), in cooperation with the National AIDS Center and Ministry of Justice. This is ongoing project until 2003. Funds for this project comes from the Polish government with extra funding from Soros Foundation and UNDP/UNAIDS;
- A new project with MOHSW has been initiated in 2002 aimed at the creation of a better coordination mechanism between stakeholders at *voivoidship* level, in cooperation with the MOHSW Plenipotentiary on HIV/AIDS. After piloting this project will be extended to *gmina* level;
- Publication on Safe Health with AIDS: information booklet for schools (teachers and pupils) in cooperation with the Ministry of Education. This has been distributed to 6,000 high schools in Poland in 2002. In 2002 UNDP funded (UNDP Facilitation Fund) the publication of a book on AIDS at the Work place (2002). UNDP has cooperated with the mass media in putting out HIV/AIDS prevention messages, for example within the framework of World AIDS day (*table 4.4*).

UNDP has established strategic partnerships with UNFPA and WHO, next to the Polish MOHSW, bilateral donors, Soros Foundation, Polish NGO networks, and the private corporation Levi-Strauss.

Table 4.4. UNDP budget, Poland, 1996-1999

Budget	US\$	%
GOP cost sharing	10,895	1
3rd party cost sharing	952,434	73
UNDP funds	336,134	26
TOTAL	1,299,463	100

Source: UNDP Poland

In the field of international cooperation, UNDP together with MOHSW proffers its expertise on HIV/AIDS prevention to Ukraine, the Russian Federation, Lithuania and Belarus. For their regional program for Eastern Europe UNDP has a budget US\$ 35,000 (for six months in 2002).

UNDP works with a system of cost sharing. Table gives an overview of the UNDP expenditures over the period 1996-1999. The Polish government's cost sharing contribution was a mere one per cent of the total, while UNDP funds formed about a quarter. The remainder was third party cost sharing and included funds from local NGOs, the Dutch and Danish embassies, Levi-Strauss and the Soros Foundation.

World Health Organization (WHO)

WHO in Poland works with the government, mainly on the basis of biannual agreements (Biannual Contract Agreements-BCA) with the MOHSW. Up to 1999, programs were supported in the fields of infant and reproductive health. Some specific problems that were addressed were low birth weight (due to smoking during pregnancy), obesity among youth and drug/alcohol abuse. Presently the WHO program covers:

- National policy development, through capacity building and advisory services in collaboration with outpatient clinics in three voivodships (1995-1999) and the Polish Institute of Mother and Child;
- Health promotion activities in 800 schools, addressing RH issues;
- Health promotion among the elderly, including menopausal problems;
- Supporting the development of an improved health management information system.

The budget from WHO-HQ for activities in Poland was US\$ 50,000 in 1999-2000. The budget for 2001-2002 is US \$ 108,000; however, reproductive health activities are no longer included. Poland contributes about US\$ 1 million annually to the WHO (core) budget.

World Bank

In 1992 the World Bank supported Poland in carrying out health reform under the Ministry of Health. World Bank financial support in the form of an IBRD/IDA loan came through the Health Services Development Project (P00-8587), which was approved in 1992 and would be terminated in March 2002. The World Bank provided an IBRD loan of US\$ 130 million. The specific aims of the project are to improve the health status of the Polish population. This was done by strengthening health promotion and prevention programs; supporting the transition from institutional care to primary health care via training and capacity building and institutional restructuring; improvement of health management systems and improve effectiveness, cost-efficiency and quality of services of national and regional health services (World Bank, 2002).

c. International NGOs and Foundations

Open Society Institute

The UNAIDS Secretariat is supporting the Open Society and *Medecins sans Frontieres'* large-scale prison program in Belarus, Estonia, Latvia, Moldova, Poland and Russia. The aim is to train prisoners as peer educators, provide counseling for injecting drug users, offer confidential and free

HIV testing, train administrative staff and police, as well as distribute condoms, and where feasible, clean needles or bleach in prisons. George Soros' Open Society Institute is the major financier of the Polish NGO Stefan Batory Foundation.

Ford Foundation

In 1999, the Ford Foundation awarded a grant of US\$ 200,000 to the Polish Federation for Women and Family Planning for the advancement of reproductive health rights in Poland. In addition, the Women's Association for Gender Equal Status-Beijing '95 received a grant of US\$ 122,000 in 1999 for advocacy work concerning women's rights (Ford Foundation web site, grants database).

5. Concluding remarks

5.1 | ICPD within the Polish context

Although Poland has endorsed the ICPD and the Beijing Programs of Action, full implementation has not been achieved. Due to opposition from conservative forces within the country, including the church, political factions and some parts of those in medical professions, progress has been slow and haphazard. Family planning and reproductive health do not appear high on the political agenda, although these themes are more systematically integrated in national development or health programs. Thus, there is a lack of knowledge and systematic data collection on family planning, reproductive health and financial flows.

The Polish government has recognized the interdependency of population and development issues. However, due to conservative forces within government and society, although the government endorses the Cairo and Beijing programs of action, (modern) family planning and reproductive health have remained controversial issues. The full implementation of the Cairo Program of Action still leaves much to be desired. In terms of funding, the present health reform implies a fundamental shift in responsibilities and financing mechanisms. As the health sector is still very much in flux, the tracking of resource flows for population activities has not been a straightforward exercise. However, the present case study has proved fruitful in identifying sources and methods for gathering relevant data.

Although the role of Polish NGOs in terms of funding is modest, their significance lies in the taking up of activities the government neglects, particularly the promotion of modern contraceptive methods and reproductive health issues such as safe abortion. The Polish NGOs are donor dependent, and appear vulnerable in terms of the sustainability of funding.

5.2 | Discussion: future data collection on resource flows

There are different sources of information that need to be examined in order to arrive at a more comprehensive overview of expenditures in the field of interventions related to family planning, reproductive health, HIV/AIDS activities and basic research and policy development. These can be summarized as follows:²⁰

²⁰ We are grateful to Ms. Dr. Dorota Kawiorska (School of Public Health, Jagiellonian University, Cracow), who kindly provided useful information.

1. In the National Budget documents there is a budget/expenditure classification: next to aggregate line items there is sub-division.²¹ At central government level, at the Ministry of Finance two departments are important for data collection: 1) Central Budget Department (national programs) and the Department of Budgets for Territorial Units (*voivoids, powiats, and gmina*). The respective budgets are sub-divided in health intervention categories. For example, for the MOHSW (excluding social security) there is a budget classification and reporting on section 85 (health care chapters), including sub-categories Prevention and counteracting of AIDS (8534); Programs of State Health Policy (8522) plus MOHSW report on selected specialized health programs. Similar reports of lower level government levels (*voivoids, powiats, and gmina*) are to be obtained from the Ministry of Finance. The health programs by the Ministry of Defense are covered in the survey once one has the budget information from the Central Budget of the Ministry of Finance;
2. Social Protection: under the responsibility of the Ministry of Labor and Social Policy, Polish women are eligible for maternity leave. To calculate total expenditures we need to know total number of eligible women (in 2000 603,000 women);
3. Government grants for scientific research in reproductive health and HIV/AIDS can be obtained from the Polish Committee for Scientific Research (KBN) and additional data from national scientific institutions, for example National Institute of Hygiene or Institute for Venereology;
4. Social security funds (*Kasa Chorych*): The different regional sickness funds and the Corporate Fund in Poland cover the bills for gynecology and obstetrics. However, the package of health services provided by the different hospitals, specialized clinics and in the field procreation, pregnancy care, prenatal and genetic screening, varies by regional health insurance fund (Government of Poland, Warsaw 2000, Table 3; p. 11).

For tracking resource flows this means that to get a more precise estimation of RH/FP expenditures, a number of steps need to be taken:

- A basic list of interventions in the above field should be drawn up. There is a breakdown of funds by resort codes, covering reproductive health and HIV/AIDS interventions (see appendix for overview of codes). This information can be obtained from the regional health insurance funds in Poland, or from the Health Insurance Supervision Office. This is based on the assumption that the registration system of interventions by the clinics is adequate and that this information is provided to the health insurance funds in detailed form.
5. Data concerning maternity and childbirth benefits can be obtained from reports from the Social Insurance Institution (*Zakladu Ubezpieczen Spolecznych, ZUS*) and Agricultural Social Insurance Fund (*Kasy Rolniczego Ubezpieczenia Spolecznego, KRUS*) and from the MPiPS report (*Ministerstwa Pracy i Polityki Spolecznej/Ministry of Labor and Social Affairs*). This

²¹ For example AIDS Prevention and prophylactics (8535 *Zapobieganie I zwalczanie AIDS*) and the sub-category MCH (*Program doskonalenia opieki Matki I Dziecka*). Co-financiers are generally identified (for example UNFPA).

includes social insurance benefits such as monthly cash payments for pregnant women under a certain income threshold;²²

6. Private insurance data on for example pregnancy management need to be obtained from private insurers; this is difficult. Private Insurance is still a small market in Poland, merely estimated at 0,4 per cent of total health spending. At present about 60 private insurance companies: to estimate one could send questionnaires to a selected few and calculate an aggregate figure. The different levels of coverage and service packages (Blue, Green, Gold Card) should be taken into account. As to the non-profit institutions, the CSO has conducted a survey in 1998;
7. Out-of-pocket household expenditures on health care can only be gleaned from the 'Health care in households' modular surveys conducted in 1994, 1996, 1998 and 2000 by the CSO. These use sub-categories for example hospital expenditure, medicines, gynecological care, under the table payments etcetera However, no information is available on expenditure for contraceptives;
8. Data on contraceptive sales are difficult to obtain but can possibly be acquired from corporations such as Organon or Schering and the Institute for Medical Statistics (IMS).

5.3 | Recommendations

It proved to be very difficult to get comprehensive information on resource flows concerning family planning, reproductive health and (lesser so) HIV/AIDS given the reformed health system and the low priority given to these issues. Considering the current situation, we would make the following recommendations:

- The concept of reproductive health is still not commonplace; therefore, more public debate on reproductive and women's health is desirable, if possible, given the extant political views. More funds for prevention and prophylactics in all fields of reproductive health is needed with special attention to the family planning services;
- There is a lack of understanding among policy-makers of the usefulness of clear financial reporting for the development of health policy. Thus, regular reporting on reproductive health and funds in this field is desirable in the future. The present report is a first modest attempt, but can form the basis for further monitoring. Such reports are useful for all stakeholders in the field, for example health professionals, government policy-makers, academics, civil society, donor organisations and the public media.
- A centrally located database, accessible to all stakeholders could be a useful tool for planners, policy makers and other stakeholders in the health sector;
- The method hitherto used by the UNFPA/NIDI resource flows project, for example a (bi-) annual survey using questionnaires needs reconsidering. While not totally abandoning this approach, we recommend more use of supplementary sources in the case of Poland, as indicated above.

²² See internet: <http://www.mpips.gov.pl/Swiadczenia/Zpomocypolecznej.htm>.

References

- Batory Foundation (2000), *2000 Annual Report*. Warsaw: Stefan Batory Foundation.
- Bossert, Thomas and Cesary Włodarczyk (2000), *Unpredictable Politics. Policy Process and Health Reform in Poland*. Working Paper, Harvard School of Public Health (pre-final draft, January 2000).
- Brzezinski, Zbigniew (1998), L' état de santé de la femme et du nouveau-né en Pologne. In *La Santé de la mère et de l'enfant dans une période de transition en Pologne. Colloque Franco-Polonais*, Institut de la mère et de la enfant, Varsovie, 12-13 Novembre 1998.
- Chazan, Bogdan, Magdalena Nehring and Elwira Gugulska (2001), Baby Friendly Hospital in Poland. In: *Proceedings of the European Society for Social Pediatrics (ESSOP) 2001 Meeting Mother and Child Care in the Community*, Warsaw 3-6 October 2001.
- Chodyncka, B., A.B. Serwin, M. Janczyo-Jankowska and M. Waugh (2000), Epidemiology of Syphilis and Gonorrhoea in Eastern Poland in the years 1988-1997, *Bulletin of the Central Eastern European Dermato Venereological Association (CEEDVA)*, No. 2 (September), pp. 26-29.
- CSO (2001a), *Statistical Yearbook of Poland, 2001*. Warsaw: Central Bureau of Statistics.
- CSO (2001b), *Demographic Yearbook of Poland, 2001*. Warsaw: Central Bureau of Statistics.
- EOHCS (1999), *Health Care Systems in Transition, Poland, 1999*. European Observatory on Health Care Systems.
- EU (2002), European Union PHARE projects database, at: <http://www.europe.del.pol/english/phare/index>.
- Exter, A.P. den (2001), Legal reforms of the Polish health care system in view of accessing the European Union, *European Journal of Health Law*, (8), pp. 5-25.
- FWFP (2000a), *The Anti-Abortion Law in Poland, the functioning, social effects, attitudes and behaviors*. Edited by Wanda Nowicka. Warsaw: Federation for Women and Family Planning.
- FWFP (2000b), *Report 2000*. Warsaw: Federation for Women and Family Planning.
- Girouard, Nathalie and Yutaka Imai (2001), *The Health Care System of Poland*. Paris: OECD, Economics Department, Working Paper no. 257.
- Government of Poland (1999), National Report Poland. In: *Population in Europe and North America on the Eve of the Millenium: Dynamics and Policy Responses*. New York, Geneva: United Nations. Report of the United Nations Regional Population Meeting, Budapest, 7-9 December 1998, pp. 137-144.
- Government of Poland (2001), *Report of the Council of Ministers on the Implementation in the year 2000 of the Law of January 7, 1993 On Family Planning, protection of the fetus and conditions of pregnancy termination*, Council of Ministers, Warsaw 2001).
- Government of Poland (2002), *Report of the Council of Ministers on the Execution in 2001 of the Act of January 7, 1993 on Family Planning, Protection of the Human Foetus and Conditions for Permission for Abortion*, Council of Ministers, 30 July 2002, Warsaw. Submitted to the Sejm of the Republic of Poland on 31 July 2002. Online: www.sejm.gov.pl/Druk4ka.nsf.
- IMS (2002), Unpublished data sheets, International Medical Statistics.
- Izdebski, Zbigniew (1997), *Zachowania Prozdrowotne I Seksualne w Aspektie HIV/AIDS w Polsce* (Health promoting and sexual behavior in the aspect of HIV/AIDS in Poland), Warsaw: Ministry of Health and Social Welfare and UNDP.
- Karat (1999), *Regional Report on Institutional Mechanisms for the Advancement of Women in the Countries of Central and Eastern Europe*. Prepared for the 43rd session of the Commission on the Status of Women. The Report of NGOs. Warsaw: Karat, Coalition for Regional Action, regional Network among Women's NGOs in Central and Eastern Europe.
- Korzeniewska, Maja and Urszula Nowakowska (2000), Women's Health, in *Polish Women in the 1990s*. Edited by Urszula Nowakowska. Warsaw: Women's Rights Center, pp. 187-218.

- Krakow City Council (2002), *Sprawozdanie z wykonanie programow profilaktyki I promocji zdrowia dla mieszkancow miasta Krakowa na rok 200. Miejskiego programu profilaktyki-zdrowy Krakow*. Urzad Miasta Krakow.
- Marée, Jörgen and Peter Groenewegen (1997), *Back to Bismarck. Eastern European Health Care Systems in Transition*. Aldershot: Avebury.
- MOHSW (1996), *National Health Programme, 1996-2005*. Warsaw: Ministry of Health and Social Welfare. Department of Systemic Transformations in Health Care.
- MOHSW (1999), *The National Programme for HIV Prevention and Care for People Living with HIV/AIDS, 1999-2003*. Warsaw: Ministry of Health
- NAC (2000), *HIV and AIDS in Poland. Prevention Policy*. Warsaw: National AIDS Center.
- Niemiec, Tomasz (1998), L'organisation de la prise en charge périnatologique de la femme enceinte infectée par le VIH et son enfant in *La Santé de la mère et de l'enfant dans une période de transition en Pologne. Colloque Franco-Polonais, Institut de la mère en de la enfant*, Varsovie, 12-13 Novembre 1998.
- NIH (2001), *HIV/AIDS Data sheet, information as of 31 December 2001*, Warsaw: National Institute of Hygiene.
- Nowakowska, Urszula (2000), Government Mechanisms. In: *Polish Women in the 1990s*. Edited by Urszula Nowakowska. Warsaw: Women's Rights Center, pp. 7-18.
- Nowakowska, Urszula and Emilia Piwnik (2000), Women in the Family. In: *Polish Women in the 1990s*. Edited by Urszula Nowakowska. Warsaw: Women's Rights Center, pp. 105-144.
- Nowakowska, Urszula and Maja Korzeniewska (2000), Women's Reproductive Rights. In: *Polish Women in the 1990s*. Edited by Urszula Nowakowska. Warsaw: Women's Rights Center, pp. 219-248.
- Nowakowska, Urszula and Magdalena Jablonska (2000), Violence against Women. In: *Polish Women in the 1990s*. Edited by Urszula Nowakowska. Warsaw: Women's Rights Center, pp. 147-186.
- Nowicka, Wanda and Monika Tajak (2000), The effects of the Anti-abortion Act. In *The Anti-Abortion Law in Poland, the functioning, social effects, attitudes and behaviors*. Edited by Wanda Nowicka. Warsaw: Federation for Women and Family Planning, pp. 11-33.
- Okólski, Marek (1983), Abortion and contraception in Poland, *Studies in Family Planning*, 14 (11), pp. 263-274.
- Pniewski, T. and S. Majewski (2000), Prevalence of Syphilis in Poland, *Bulletin of the Central Eastern European Dermato Venereological Association (CEEDVA)*, No.2 (September), pp. 24-25.
- Sabbat, Jolanta (1997), International assistance and health care reform in Poland: barriers to project development and implementation, *Health Policy*, (41), pp. 207-227.
- Schneider, Markus et al. (2001), *Health Systems of Central and Eastern Europe*. Augsburg: BASYS.
- Sito, Aldona (1995), Demographic trends in families in Europe — with particular reference to Poland. In: *Social Paediatrics*. Edited by Bengt Lindström and Nick Spencer. Oxford, New York: Oxford University Press, pp. 81-94.
- Szamotołska, Katarzyna, Natalia Stankiewicz (2000), *Masa urodzeniowa, czas trwania ciąży I rozwój wewnątrzmaciczny noworodków oraz umieralność niemowląt I umieralność okołoporodowa noworodków w Polsce u progu nowego tysiąclecia*. Warsaw: Institute of Mother and Child.
- Szata, Wanda (2001), AIDS i zakażenie HIV w 1999 roku (AIDS and HIV infection in 1999), *Przegląd Epidemiologiczny* (Polish Epidemiological Review), (55), nr. 1-2, pp. 165-174 (in Polish).
- Tymowska, Katarzyna (2001), Health care under transformation in Poland, *Health Policy*, (56), pp. 85-98.
- UNAIDS-WHO (2000), *Epidemiological Factsheet on HIV/AIDS and Sexually Transmitted Diseases. Poland 2000 Update*. Geneva: UNAIDS-WHO.
- United Nations (2000), *Common Country Assessment Poland 2000*, Warsaw: United Nations.
- UNDP (2001), *Human Development Report 2001*. New York: UNDP.
- UNUZ (2002), *Analiza Finansowa Kas Chorych, 1999-2001*, Warsaw: Urzad Nadzoru Ubezpieczen Zdrowotnych, Departament Ekonomiki i Finansow (Health Insurance Supervision Office, Department of Economics and Finance), unpublished report for the meeting of 24 January 2002.
- WHO-EURO (2001), *Highlights on Health in Poland*, Copenhagen: WHO Regional Office for Europe (<http://www.euro.who.int/countryinformation>).
- Women's Association for Gender Equality (2000), *Implementation of the Platform of Action by the Polish Government*. Alternative Report prepared for the 44th session of the Commission on the Status of Women. Warsaw: Women's Association for Gender Equality-Beijing 1995.
- World Bank (2002), *World Bank Project Data*, on internet: <http://www4.worldbank.org/projects/project.asp?pid=P008587>
- Wróbleńska, Wiktoria (1995), Can we use the experiences of others? – Changes in fertility and morality of teenage females, *Studia Demograficzne*, 122(4), pp. 47-61.

Wróblewska, Wiktoria (2002), Wybrane aspekty Zdrowia Reprodukcyjnego w Polsce (Aspects of reproductive health in Poland), *Studia Demograficzne*, 141(2).

Annex 1

POLISH EXCHANGE RATES

Zloty's to US\$ dollars

Currency	Year	Currate	Country
Polish New Zloty	1996	0.3663	Poland
Polish New Zloty	1997	0.30494	Poland
Polish New Zloty	1998	0.287737	Poland
Polish New Zloty	1999	0.2520733	Poland
Polish New Zloty	2000	0.23009135	Poland

IMF Period average exchange rates

Source: UNFPA/NIDI RF database.
1996: OANDA (date 15-6-1996).

Annex 2

Polish Sick Funds, expenditures by line item, 2000-2001

Code	Name	2000	2001
0030	Local family nurse and midwife outpatient clinic	23,686,209	54,205,688
0032	Local family nurse outpatient clinic	239,525,907	627,981,790
0034	Local family midwife outpatient clinic	41,937,514	147,791,046
0041	School medical cabinet	96,662,612	126,235,589
1032	Endocrinological-gynecological outpatient clinic	7,819,920	2,842,927
1036	Infertility outpatient clinic	989,993	1,041,556
1202	Venereology outpatient clinic	34,418,836	35,645,650
1342	AIDS outpatient clinic	2,225,284	2,507,980
1344	Hepatitis virus outpatient clinic	6,475,993	7,549,140
1421	Neonatal outpatient clinic	1,933,642	1,994,225
1450	Obstetric gynecological outpatient clinic	125,537,246	186,720,622
1452	Gynecological outpatient clinic	82,882,804	95,343,793
1453	Gynecological outpatient clinic for young girls	2,314,283	2,861,533
1454	Pregnancy pathology outpatient clinic	2,098,949	2,843,922
1456	Menopause outpatient clinic	810,707	1,189,880
1458	Breastcancer prophylaxis outpatient clinic	13,006,862	13,835,693
1470	Family planning outpatient clinic	625,831	343,854
1472	Child birth classes	1,578,282	2,534,070
1474	Lactation outpatient clinic	35,005	46,722
1750	Health promotion outpatient clinic	0	0
3118	Neonatal emergency	6,544,366	6,803,275
4246	Gynecological oncology outpatient clinic	32,661,353	36,973,160
4342	AIDS department	10,214,031	8,759,677
4344	Hepatitis virus department	11,815,752	75,851,508
4403	Infantile department	22,501,127	28,790,948
4421	Neonatal department	204,882,338	229,306,927
4450	Obstetric gynecological department	484,584,008	592,182,192
4452	Gynecological department	187,809,189	261,774,222
4454	Pregnancy pathology department	81,194,635	129,462,925
4456	Obstetric department	195,555,024	205,196,516
4458	Obstetric (rooming-in) department	26,006,268	48,382,243
	Sub total	1,948,333,970	2,936,999,273
	Sub total in US\$ (PLN=0,23 US\$)	448,116,813	675,509,833
	Sub total (inclusive pediatrics)	2,233,987,960	3,378,499,804
	Sub total in US\$ (PLN=0,23 US\$)	513,817,231	777,054,955
4401	Pediatric department (in Zloty's)	409,483,596	479,676,269
	(in US\$)	94,181,227	110,325,542

Source: Kasa Chorych datasheets, 2000-2001.
(UNUZ, Warsaw, Poland).

Annex 3

Annex I. Persons contacted

Multilateral Organizations

Mr. Marc Destanne de Bernis, UNDP-UNFPA Representative in Poland, Warsaw
Ms. Beata Balinska, UNFPA Focal Point Poland, Warsaw
Mr. Dr. Tomasz Niemiec, Obstetrician, National Consultant for UNFPA/NIDI in Poland
Ms. Aleksandra Duda, HIV/AIDS Project Coordinator, UNDP, Warsaw
Mr. Dr. Andrzej Zbonikowski, WHO Liaison Officer, WHO Liaison Office, Warsaw

Government of Poland

Mr. Dr. hab. Zbigniew Strzelecki, Undersecretary of State, President, Government Population Council, Warsaw
Mr. Dr. hab. Andrej Ochocki, Secretary General, Government Population Council, Warsaw
Ms. Dr. Lucyna Nowak, Deputy Director, Social Statistics Division, Central Statistical Office, Warsaw
Mr. Mieczysław Błaszczyk, Director, Department of Public Health, Ministry of Health, Warsaw
Mr. Prof. Stanisław Radowicki, National Consultant of Gynaecology and Obstetrics, Warsaw
Mr. Andrzej Zieliński, National Institute of Hygiene, Warsaw
Ms. Dr. Wanda Szata, National Institute of Hygiene, Warsaw
Mr. Dr. Bogdan Wojtynek, National Institute of Hygiene, Warsaw
Mr. Prof. Wojciech Woźniak, M.D., Director, National Research Institute for Mother and Child, Warsaw
Mr. Prof. Bogdan Chazan, M.D., Ph.D., former National Health Advisor, National Consultant, National Research Institute for Mother and Child, Warsaw
Ms. Dr. Katarzyna Szamotulska, Msc., PhD, Epidemiologist, National Research Institute for Mother and Child, Warsaw
Ms. Prof. Aldona Sito, Deputy Head Public Health Department, Institute of Mother and Child, Warsaw
Mr. Włodzimierz Paszyński, Undersecretary of State, Ministry of Education and Sports, Warsaw
Ms. Anna Marzec- Bogusławska, Director National AIDS Center, Warsaw
Ms. Elzbieta Ciaston-Przeclawska, M.A., Head of Programs Department, National AIDS Centre, Warsaw
Ms. Magdalena Rabsztyn, Liaison Officer, National AIDS Center, Warsaw
Mr. Prof. dr. hab. med. Sławomir Majewski, dermatologist, venereologist, allergy specialist, Institute of Venereology, Warsaw

Mr. Inz. Krzysztof Guttman, Head, Secretariat Board of Medical Research, Polish Committee for Scientific Research (KBN), Warsaw

Mr. Prof. dr. hab. med. Zgnibiew Wronkowski, Specialist in Oncology and Epidemiology, Institute of Oncology, Warsaw

Mr. Miciej Tokarczyk, Vice-President; *Urząd Nadzoru Ubezpieczeń Zdrowotnych*- UNUZ Health Insurance Supervision Office, Warsaw

Mr. Michal Kaminski, p.o. Director; *Urząd Nadzoru Ubezpieczeń Zdrowotnych*- UNUZ Health Insurance Supervision Office, Warsaw

Mr. Marek Opasnik, Public Relations Officer; *Urząd Nadzoru Ubezpieczeń Zdrowotnych*- UNUZ Health Insurance Supervision Office, Warsaw

Mr. Stoicych, First Secretary of the City Council of Krakow, Dept. of Public Health, Krakow

National NGOs

Ms. Wanda Nowicka, Federation for Women and Family Planning, Warsaw

Mr. Zbigniew Izdebski, Ph.D., President, Association of Family Planning (TRR), Warsaw; Youth Counselling and Sex Education Unit, University of Zielona Gora

Mr. Witold Mateusz Liwshi, President, Polish Foundation for Humanitarian Aid Res Humanae, Warsaw

Mr. Marek Zygadlo, Director, MONAR, Krakow

Mr. Artur Lutarewicz, TADA, Warsaw

Universities / Research Departments

Mr. Prof. Cezary Włodarczyk, Dept. of Public Health and Management, School of Public Health, Unit of Health Policy, Jagellonian University, Krakow

Ms. Dr. Dorota Kawiorska, Jagiellonian University, School of Public Health, Unit of Health Policy and Health Economics, Krakow

Ms. Dr. Irena Kowalska, Warsaw School of Economics, Department of Statistics and Demography, Warsaw

Ms. Dr. Wiktoria Wróblewska, Warsaw School of Economics, Department of Statistics and Demography, Warsaw

Private Sector / Companies

Mr. Krzysztof Urbaniak, Medical Director of Damian Private Hospital, Warsaw

Contacted by telephone:

Ms. Grażyna Konieczny, Social AIDS Committee, Warsaw

Mr. Dr. Andrej Ryś, former Vice-Minister of Health, Krakow

Mr. Dariusz Atlas, Department of State Budget, Health Sector, Ministry of Finance, Warsaw
Organon Poland, Warsaw