This paper discusses the social and political processes health care transformation in postcommunist Europe has involved in practice. It begins by suggesting a theoretical framework for the study of postcommunist welfare. Focussing on Poland, it examines what lies behind the frictions which have become an integral feature of health care change, which most recently has centred on the privatisation of hospitals. An empirically detailed interpretive analysis of the Polish nurses’ protests is put forward, drawing on interviews, protest bulletins, and official and media reports. The paper concludes that the liberalisation and privatisation currently in train can be seen as a contested ‘revolution from above’ in and through health care, and that the democratic potential offered by the protests has been subverted insofar as health care policy-making has itself become privatised.

Keywords: class, gender, neoliberalism, Polish nurses, postcommunism
Introduction

It has become almost axiomatic among some international policy experts that one source of support for the current global shift in favour of the liberalisation of health care and the formation of two-tier health care systems is the widespread repudiation, after communism, of all things associated with that regime. Yet of all the momentous changes that have taken place in postsocialist Europe over the last twenty years, perhaps the most contentious have been in the field of health care. Nowhere has this been more obvious than in Poland. The ending of communism signalled a new era for global power relations, and a new location with respect to these relations for postcommunist states. Poland offered by far the largest new market in eastern Europe for Western producers, was heavily indebted to the IMF, and at that time already had relatively strong social connections with the West. The country was presented as a model of how successful political and economic change could be achieved. Change was effected, in the first place, by the ready adoption of global neoliberal ideology in the shape of the Washington Consensus, which in practice meant the immediate introduction of private property relations and the market, the privatisation of state property and the acceptance of the rules of free trade. Devastating social changes ensued. Escalating levels of corruption, unemployment, poverty, social inequality, and mental distress became major features of the social landscape (Palska 2002; Jarosz 2005; World Bank 2005; Danecka 2006; Watson 2006a). However notwithstanding such changes, the transformation of ownership of economic enterprises met with surprisingly little outward social protest (Ost 2006).

In contrast, the struggle over the privatisation of hospitals has lasted around ten years – in fact, ever since the introduction in 1999 of major health care reform. Opposition to the reforms has been reflected in industrial action, in parliamentary debate, in social dialogue and survey responses, in extensive press reporting and in daily discourse. The reforms have proved to be the stumbling block of successive governments, with health care a burning issue in Poland’s election campaigns. In the most recent 2007 elections, hospital privatisation was a major theme. The winning Party, the Civic Platform, had consistently undertaken not to privatise hospitals if they gained power. Nine months into office, the Party proposed legislation for compulsory, universal and total hospital privatisation to be accomplished within the space of one year. In the resulting furore, the Treasury Minister Aleksander Grad explained that since the election campaign had been governed by its own priorities, citizens had not really been misled (http://www.wiadmosci.gazeta.pl).

There are conflicting ideas about how welfare change in postcommunist states is to be understood. Some writers have seen postcommunist welfare as conforming to the liberal variant outlined in Esping Andersen’s typology of welfare regimes (Orenstein and Haas 2005). However, this definition fails to take account of the unprecedented nature of postcommunist contexts. It pays little attention to the implications for social relations and subjectivities of situations where liberalism has been installed after state socialism and where societies are integrated globally on these terms. Paradoxically, Esping-Andersen’s emphasis on the importance of history is negated in the act of generalising his typology to encompass post-communist states. Another view is that welfare change after communism should be seen in terms of a specific path dependence from state socialism (Pierson 2004; Cerami 2006). However, while this approach emphasises the role of the past, it sees change as essentially continuous, as undisturbed by unforeseen or external events. For this reason, the idea of path dependence has been subject to extensive critique. For example, it has been said to be unable to account for globalisation, Europeanisation, and other forms of social change (Crouch and Farrell 2004).

The present paper starts from the recognition that in postcommunism, health care change is an integral aspect of a broader and historically unprecedented process of transformation in a shift to new forms of power and citizenship founded on capitalism. Postcommunist welfare
should be understood, in the first place, in these terms. Whatever the continuities, the
intended discontinuities at issue in postcommunist welfare cannot be ignored. These are
discontinuities which have been produced by, and are helping reconstitute, power relations on
global, national, as well as more local scales. Insofar as the concept of path dependence
ignores this ‘deep change’ in change after communism, it offers a substantially depoliticised
view of postcommunist health care.

The aim of this paper is to gain insight into the social and political processes health care
transformation has involved in practice. Thus, rather than erasing the frictions which have
become an integral feature of health care change within Poland, the paper examines what lies
behind them, why they remain relatively invisible to transnational health policy discourse,
and how this relates to a global health discourse which emphasises empowerment, the
preservation of equity and the importance of trust. In particular, the paper focuses on the
Polish nurses’ protests and draws on interviews, health protest bulletins, and official and
media reports collected before, during and after health care reform.

Health Care and the Social Order

Prior to the ending of communism, the health care system in Poland, as in other East
European countries, had been based on the Semashko model which embodied a planned and
egalitarian approach to health care. Poland’s socialised health care system was introduced in
1948, and its pharmaceutical industry was socialised in the same year. Originally, the health
care system catered for those in state employment. In addition, key industries had health
services of their own. Not until 1972 were peasant farmers encompassed within the system.
Like the NHS, the system was centrally funded and formally free at the point of delivery.
Unlike the NHS, much of the planning and co-ordination of the health service was performed
at the level of the state, on the basis of detailed information provided by fourteen National
Research Institutes. Primary care was not provided by family doctors as in the NHS, but from
1975 onwards a system of integrated health care complexes existed which integrated inpatient
and outpatient care, was hospital-centred, and relied heavily on specialists.

However, what crucially distinguished the impetus to health care transformation in the Soviet
Union and later in state socialist Eastern Europe on the one hand, from health care
transformation in Western Europe on the other, was that it represented part of a context of
systematic anti-capitalist social intervention which first and foremost included the abolition
of private ownership. Thus the goals of transformed health care under state socialism were
not understood to be simply technical, but explicitly included the much broader aim of
restructuring society as a whole (cf. Sigerist 1937; Ferge 1979).

The NHS was influenced by the existence of the experimental Soviet model (Ferge 1979).
The Webbs had been impressed by the Soviet achievements in the organisation of health care
and Beveridge drew on their ideas and those of the Fabian Society when he recommended a
National Health Service for Britain in his 1942 report. But the NHS in Britain differed
fundamentally from the Soviet model in that it sought to attenuate the effects of - but not
remove - the pre-existing class-based social relations of capitalism. Summarising the
difference between social policy East and West before the end of communism, Ferge wrote:

‘from its inception to our days, and everywhere where the market is a dominating
force, (Western-type) social policy has been torn by (the following) basic conflict. It
was created to fill a vacuum, to ensure the individual’s right to survive – a right
accepted by most societies as a fundamental right and categorically negated by the
market logic (sic). And yet (such) social policy could not assume this self-imposed
task unconditionally as long as it was reluctant to jeopardise the domination of the
market economy. .. If the domination of the market is abolished, then the relative
autonomy of the economy, which was only apparent, but which served the dominant interests very effectively, necessarily disappears’ (Ferge 1979: 52; 71).

While there were some writers who hoped social policy might redefine capitalist social structure (eg. Titmus 1968), in the event it was the inherent contradictions of capitalist welfare that came to the fore (Habermas and McCarthy 1975; Offe 1984; Esping-Andersen 1990).

Although current health care reforms in postcommunist countries are informed by the neoliberal approaches that prevail worldwide, the experiences of eastern European countries differ from those of Western Europe in that health care transformation in the post-communist countries is part of broader state and supra-state interventions which have been predicated on the introduction of private property and the market, and have as their overarching aim the transformation of the entire social context. In a situation the reverse of that which pertained with the making of state socialist societies, and in contrast to the current liberalisation of health care in established societies in the West, the transformation of post-communist health care has been inherent to the overt transformation of underlying relations of power. The processes involved have not everywhere been the same. In Poland, the new policies and institutions aimed at making a previously state socialist society capitalist, have come in two waves. Welfare transformation has come in the second wave of changes, and as such has been both inseparable from, and conditioned by, first wave policy outcomes.

**The Transition to Liberal Capitalism: Reform in Two Waves**

Directly after the fall of communism when the new Solidarity government had come to power, Poland embarked on its first wave of reform. It sought membership of the WTO and by signing the European agreement, gave an early signal of its intention to join the EU. In 1990, a shock therapy’ programme was introduced - virtually by decree. This involved ‘immediate price liberalization, immediate privatization, immediate establishment of an independent central bank, immediate achievement of a balanced budget, immediate introduction of free trade and immediate establishment of a fully convertible flexible currency’ (Marangos 2002: 70). The policies of liberalization, privatisation and consolidation ‘became the holy trinity in the theology of transition. ... There was broad agreement among Western economists on what needed to be done,’ (Rutland 1997: 269). The changes were underwritten by global institutions, including the IMF, the European Bank for Restructuring and Development (EBRD), the organisation for Economic Cooperation and Development (OECD), and the World Bank. By exercising power over the terms of the country’s accession to the EU, the European Union also played a key role in determining the neoliberal direction of social and economic change in Poland. The first-wave reforms did not explicitly encompass the welfare sector; they were oriented towards enterprises and institutions in the sphere of production and offered new opportunities for Western companies to enhance profits, as well as opportunities for those appropriately placed within Polish society to immediately acquire wealth.

Postcommunist capital formation rested on privatisation and involved administrative and interpersonal processes designed to achieve appropriation/ dispossession with respect to the wealth accumulated under communist rule. In the process it offered unprecedented possibilities to those introducing the changes to subvert the process for personal gain. ‘Opportunity,’ wrote the sociologist Maria Jarosz in this connection, ‘makes the thief’ (Jarosz 2006). Although they resulted in scandals widely reported in the press, such activities were pursued with relative impunity since politicians and administrators from opposing parties were concerned to preserve the field for action when they in turn gained power (Jarosz 2004). At the same time, frantic competition for the spoils of privatisation and for the new title to rule, lent an overwhelming primacy to inter-party political warfare.
The health arena has been one of the most widely reported examples of the corruption of officialdom. For example, it has been said that the illegal lobbying and suspect links between power holders and pharmaceutical companies has resulted in losses to state finances to the tune of billions (Jarosz 2007: 217). The effect has been that in everyday thinking, the corruption endemic to privatisation has loomed large: public opinion polls have consistently shown that it is seen – after poverty and unemployment - as Poland’s greatest social ill, with politics usually regarded as the sphere most prone. Deep and widespread social mistrust of the country’s political elite has been a major outcome of the privatisation process, as has disillusionment with the perceived failures of the postcommunist state. In 2005 the State and Justice Party (PiS) came to power on an anti-corruption and, ostensibly at least, a less neoliberal platform. The Central Anti-Corruption Bureau (Centralne Biuro Antykorupcyjne CBA) was formed the following year. Its purpose was to investigate the ‘questionable process of privatisation and commercialisation’ that had occurred since 1989 (www.transparency.pl).

Significantly, as new privatised wealth became concentrated in relatively few hands, impoverishment simultaneously came to encompass broad social groups, giving rise to an income distribution the reverse of the affluent majority/small underclass which Esping-Andersen defined as typical of Western liberal welfare regimes. ‘The wealth of the 100 richest Poles in 2006 AD is worth two times this year’s (2006) budgetary deficit,’ commented the current affairs magazine Wprost on the publication of the 2006 rich list, ‘and is the same as the amount the ruling coalition would like to spend in order to fulfil its election promises. - Luckily it cannot do that,’ (Cielomęcki 2006). At the same time the percentage of the population living below the social minimum rose from about fifteen to 54 percent between 1990 and 2001 (Beskid 2001; Głowczyk 2002). By 2003, unemployment had risen to over 20 percent. A period of relative prosperity followed between 2004 - the year of EU accession, and 2008, when the effects of economic crisis began to be felt. The labour market improved with the deployment of EU structural funds and with large-scale migration to the West. Nevertheless, the rate of employment in Poland has consistently remained the lowest in Europe: in 2008 only 42 percent of the working age population had a non-short-term job (calculated on the basis of Eurostat (2008)). Among people aged 55-64 years, the rate of employment for all forms of contract stood at just under thirty percent (Eurostat 2008).

This then gives a sense of the context of which the second wave of reform formed part. By 1999 the privatisation of enterprises was virtually complete. New pension, education, and health systems were introduced, while the administrative map of Poland was redrawn. Sixteen voivodeships or provinces replacing the previous forty-nine, and a new, three tier model of territorial administration – gmina, powiat and voivodeship - was put in place, each with formal responsibilities for health care. This went some way to realise the neoliberal health care norms exerted by the World Bank. These included the break-up of the single state health care structure, promotion of the idea of individual responsibility for health, and of a market orientation and the eventual introduction of private health insurance. The path towards marketisation had also been facilitated by the World Trade Organisation’s new GATS agreements, which allowed markets to be extended into the service sector as profitability in manufacturing industry declined worldwide (Price et al 1999).

The 1999 Health Care Reforms

Changes to the Polish health care system had been made soon after the ending of communism. The 1991 Health Care Institutions Act allowed for the existence of diverse owners beyond the Ministry of Health. These included regional and local government, other ministries, private bodies, and non-governmental organisations. It provided the legal basis for publicly owned hospitals in Poland to become substantially autonomous and responsible for managing their own budgets. After 1993 ownership of most public sector health facilities
passed from the central state to the regions (voivodeships) and to local government (Karski, Koronkiewicz and Healy 1999). But while primary health care was quick to privatise, for political and economic reasons hospitals were not.

The 1997 Law on Universal Health Insurance which came into force in January 1999 was largely fiscal in nature. In place of central state funding, it introduced a system based on the Bismarckian social insurance model – whereby funds raised from a compulsory deduction from taxable income finance the direct costs of health services to patients through contracts between providers and purchasers of health care. The purchasers originally took the form of 16 Regional Sickness Funds (kasy chorych), one in each of the new voivodeships, together with one Sickness Fund for uniformed services. The sickness funds were replaced in 2003 by a recentralised National Health Fund (NFZ – Narodowy Fundusz Zdrowotny), which performed largely the same functions, and had a branch in each voivodeship.

The deduction was originally set at 7.5 percent of taxable income; between 2003 and 2007 this increased annually by one quarter percent until it reached its present level of nine percent. At 7.5 percent of taxable income the initial health insurance premium was clearly inadequate for the maintenance of pre-existing levels of care. Revenue was also depleted by the fact that one fifth of the working population was unemployed at the time. In a recent interview discussing current reforms, a former minister of health went so far as to suggest that the 1999 reforms had been consciously designed to bring about the privatisation of hospitals by stealth:

‘in 1998 a few people met in the office of the then vice-premier Leszek Balcerowicz and decided that the health care system in Poland would be privatised. This was to be done by reducing health care expenditure as a proportion of GDP and at the same time by introducing an inadequate system of sickness funds … Within a year health expenditure as a percentage of GDP had fallen from over 4.5 percent to less than four. That was one of the lowest indices in Europe, and if you take into account that we were one of the poorest countries, that represented a very modest amount (…). this time no-one’s trying to hide the fact that it’s about privatising the hospitals’. (Plński 2008: 38-39).

Whatever the intention, dramatic underfunding translated into new limits to publicly funded care, beyond which payment was required. With contractual rates of payment to hospitals significantly less than the cost of services in practice, levels of hospital indebtedness soared (Chmielewski 2002). The word limity became one of the most frequently used in the new health care lexicon. Resolute non-specification of where those limits lay in practice, that is, the continuing failure to define the specific basket of health care services where payment via public funds was guaranteed, further undermined the notion of social entitlement, infused uncertainty into the system, and created opportunities for abuse. The effects of reform were felt most keenly by socially vulnerable groups – not only through inability to pay for unfunded services, but also because critical social groupings including people who had lost their homes during the transition, as well as the children of those who had lost their jobs, were initially excluded from coverage in the new design. Research showed the dissatisfaction and distress to which the reforms had given rise (Watson 2006a and b).

Health care security thus became a dimension of the postcommunist construction of relations of class. This can be illustrated by changes in access to pharmaceuticals (cf. Watson 2006b). After the end of communism, spending on pharmaceuticals increased to the point where by 2007 it had come to account for 31 percent of total expenditure on health care. Approximately 59 percent of these costs was covered by the direct payments of patients, 32 percent by reimbursements, and about nine percent by hospital drugs (Ministerstwo Zdrowia 2008). As access to pharmaceuticals became increasingly dependent on income, the social groupings experiencing greatest loss of access to them were those who needed them most,
that is, the social groupings most prone to premature death. One study showed that the percentage of people without access to essential drugs varied from four percent among those with higher education to 38 percent among people with primary schooling (Górecki 2004). Meanwhile, mortality and census data for 2002 show men aged 35-50 years with higher education account for 12 percent of the population and 5 percent of deaths; for men with primary education the figures are 25 percent of the population and 35 percent of deaths.

Going Public: The Nurses’ Protests

In the two years following the changes (1999-2000), the country was swept by unrest among health care personnel - including doctors, radiographers, medical technicians and ambulance staff. However, it was the industrial action of nurses which seized the headlines. Nurses represented one of the largest occupational groupings in Poland and one of the lowest paid. The All-Polish Union of Nurses and Midwives (Ogólnopolski Związek Zawodowy Pielęgniarek i Położnych – OZZPiP) became a visible political actor at this time. The national Union grew out of a local union originally formed in Włocławek in 1991. Bożena Banachowicz, the Union’s founder and until 2005 its leader, was interviewed in the course of the present research. She explained how the idea of an independent union for nurses was prompted by the founding after 1989 of the Solidarity Union. The original aim of the nurses’ Union was to act in the welfare interests of nurses and to give them a greater voice within the clinical team. By 1995, when it gained its national statute, 86,000 nurses, one half of those employed in hospitals, had joined.

The nurses were strategically positioned with respect to the 1999 reforms. Ward sisters had been charged with overseeing the itemised costings on which the post-1999 funding of hospitals was to be based. After the reforms, they saw contractual payments to hospitals noticeably lower than the costings they had made. They realized that nurses would in effect be paying the price for the reforms. ‘And that’s what happened,’ said Banachowicz, ‘that’s what happened.’

The nurses’ first national protest was a 10,000-strong march in Łódź in December 1998. Unaddressed pay issues led to a week-long sit-in in the Ministry of Health the following month. The Union’s high profile protest action drew from the ‘repertoire of contention’ created by the 1980s’ Solidarity protests (Tilly 2008). It included hunger strikes, the occupation of government buildings, the blockade of national borders and road blocks. On 20 May 1999, 16 union members occupied the Ministry of Labour and thirteen days later, a 50-man police squad carried them out. Camp-beds were set up on the pavement, and until 11 July, a street sit-in continued outside. Meanwhile, nurses occupied the Sickness Fund Surveillance Authority in Warsaw demanding extra funding for hospitals from the state budget. By this time, nurses all over the country were occupying regional administration buildings and sickness funds. ‘Luckily true worker solidarity is being created once more’ the Union declared in July. ‘Unions under the banner of the OPPZ, ‘Sierpień 80’, Samoobrona’, ‘Solidarity 80’ and many local committees of NSZZ ‘Solidarity’ are with us’ (Łęcka 1999).

The government eventually conceded to the nurses’ demands the following year and signed an agreement awarding all health workers a 203 złoty salary increase. The resulting ‘Law 203’ came into force on 1 January, 2001. But since no extra funds were made available for the purpose and responsibility for payment remained with the directors of health care institutions, the law was not always observed in practice and served to drive hospitals deeper into debt. Privatisation continued to be suggested as the financial cure, but for nurses this route represented a threat to jobs, pay and workers’ rights, as well as to equality of access among citizens to health care, and was opposed (Kamieniecki 2008).
By the summer of 2007 the OZZPiP was engaged in mass protests again, this time under new leadership. The hub of the action was an encampment (the białe miasteczko or ‘white village’) along the grass verges opposite the Prime Minister’s Chancellery, where a request for pay negotiations had been handed in. In an echo of the 1999-2000 protests, a number of nurses occupied the building with the intention of waiting until an interlocutor appeared. The białe miasteczko dominated the Warsaw horizon for a short but significant time. During the 27 days of its existence (from 19 June to 15 July) hundreds of nurses arrived from all over Poland to show solidarity with nurses already engaged in protest. The encampment developed its own internal organisation, with round-the-clock security provided by members of the Sierpień ’80 Mining Union.

The protests received overwhelming public support. The encampment was visited by Warsaw residents, by politicians as well as figures from academia and the arts, who also voiced their support. Stefan Bratkowski, Honorary President of the Association of Polish Journalists, said: ‘The entire Polish intelligentsia really is behind you.’ ‘Today’s Poland has the face of a nurse,’ said the writer Jerzy Pilch. Nevertheless, the nurses had to strike camp without negotiations having taken place, when Parliament broke up for the vacation and the parliamentarians left town.

Contesting Social Change

The nurses’ protests can be interpreted on a number of planes. In narrow terms, the nurses’ demands referred to pay, work conditions, and adequate funding of health care. Not only had they seen no pay improvements with the 1999 reform, benefits such as the inflation-link to their salaries had disappeared. In her 2004 Statement to the Tripartite Social Dialogue Commission, Banachowicz pointed out that between 1999 and 2002, the number of hospital beds fell by over 35,900, and over 92,000 health workers lost their jobs – sometimes in contravention of minimum staffing norms. Unrealistic budgets and the increasing proportion of budget expenditure being accounted for by drugs, meant extreme downward pressure on staffing costs. While spending on personnel was slightly higher in 1999, by 2003 total spending on drugs was 29 percent higher than the combined wage bill for all categories of health care personnel (Ministerstwo Zdrowia 2008). Understaffing had also contributed to deteriorating conditions of work.

But in addition to these questions, the protests also invoked broader social issues that were integral to the context of which the demands formed one part. That context was one of fundamental societal transformation, and the issues raised by the nurses’ actions related to new wealth, poverty, and social inequality, postcommunist state-society relations, and party political warfare. Issues of gender were also implicated in the protests.

Gender There has been a suggestion that gender was the key social issue raised by the nurses’ protests (Olczyk 1999); other commentators have been less sure (eg. Graff 2008). The nurses’ protests encapsulated issues of gender, insofar as the quest for emancipation had formed part of the 1999-2000 protests. As a feminised public sector profession, nurses had for years not only experienced low rates of pay, but had constituted a voiceless grouping, expected to carry out instructions rather than expressing a view. Gender also shaped the protests insofar as nurses frequently referred to their role as mothers, and the way their ability to fulfil that role was affected by how little they earned. But despite this, and in spite of the fact that the protesters were overwhelmingly women, gender issues were not at the forefront of the nurses’protests.

Poverty and Social Inequality With their 2007 slogan: ‘A Solidary, not a Liberal Poland’(Polska Solidarna Nie Liberalna), the nurses did no less than raise a fundamental challenge to the official vision of the kind of country Poland should be. They were placing a
question mark against the broad contextual changes constitutive of postcommunism in Poland. But rather than seeing themselves above all as sexually defined grouping, a primary identification for the nurses was with everyone experiencing material hardship, regardless of sex. ‘We consider that the worst-paid workers should be treated with particular respect’ stated a *białe miasteczko* communiqué on 25 June. In according respect to the low- rather than the highly-paid, the nurses departed radically from the liberal moral economy that calculates high earnings and social position as the praiseworthy outcome of individual predispositions for example, to entrepreneurship. Instead, poverty was seen as the obverse of the greed of corrupt politicians. A nurses’ leader interviewed in Kraków in 2003 made the point with force. Having described school nurses’ insights into the extent to which schoolchildren now went hungry - in some schools this had reached 50 percent - she went onto excoriate politicians and others for what she saw as their recent ill-gotten gains: ‘it shouldn’t be like that – with on the other hand fortunes, people who don’t stand out in any way (...) just canny, informal ties, well it’s barbarism, simply barbarism - fortunes that grow on the spot, for which there really should imprisonment (..).’

During the 2007 action, the nurses consistently invoked the symbolism of the 1980 Solidarity protests. In this way, they mobilised historical resources to critique the direction of change. Visually, many of the signs in the encampment invoked the famous Solidarity logo. In addition, the nurses appointed Henryka Krzywonos as an advisor and potential negotiator in the protests. Krzywonos was an iconic figure – a former tram-driver, signatory to the 1980 Solidarity Agreement, and one of three women critically involved in getting the original Gdańsk shipyard strike off the ground. When interviewed for *Kurier*, the encampment newsletter, she was asked to compare the Solidarity strike of August 1980 with the 2007 nurses’ protests. The Solidarity strike was easier, she said, in so far as all of Poland had risen up, and the strikers had not had to endure rainy conditions while living in tents. ‘I look at (the Prime Minister’s Office) over the way,’ she went on to say, and I read the sign: *Honour and Fatherland*, and feel a glow. But then I look to one side where a (homeless) woman is lying on the asphalt and I feel terrible; this is not the Poland we were fighting for’(p.4).

*State-Society Relations* Issues of political corruption and illegitimate wealth, as well as poverty and social inequality, flowed into questions concerning the relation between citizens and the state. For example, an ironic ‘Prayer for our Rulers’ was circulated in a *OZZPiP* Special Bulletin on 24 June. The critique of the quality of political representation in Poland that it contained, echoed what had been spelled out by the nurses’ leader interviewed in Kraków in 2003. She had described at some length the struggle the nurses’ professional body had had, to have the anomalous position of the homeless with respect to health care rights recognised after their exclusion from social health insurance with the 1999 reforms. She spoke of how little thought politicians had given to homeless people, and how it had only been after the nurses had held a press conference and journalists had made a fuss, that the issue began to be addressed. ‘In a civic state,’ she concluded, ‘politicians are concerned about how they come across to people, and (they) would be ashamed to do something against (the interests of their) electors. Here they’re not ashamed, because they’re seasonal. One day they’re here, the next they’re gone – he’s not bothered, he just wants to set himself up’.

Issues of political misrepresentation permeated the protests, and this contributed to a discourse that resonated with the state versus society thinking that prevailed under conditions of state socialism. The nurses saw themselves as representing not only their own interests but those of their patients; by constructing patients as citizens in the face of an unresponsive state, they were constructing themselves as acting on behalf of society as a whole. Issues relating to the quality of democracy and citizenship were brought to the surface in an *OZZPiP* Special Bulletin on 15 July at the conclusion of the protests: ‘we’ve learned about the other side, a ruthless side which only wants to pretend to be a partner, who wants to create the appearance of dialogue, but which really only wants to produce camouflage and the semblance of seeking consensus. We ask ourselves – is this what the civic state and the
exercise of democratic rule is supposed to entail? (…) Let us point to all the anomalies (…) to which we do not have to acquiesce – not us, and not the patients’ (p.2).

Party-Political Warfare Although the charge was made that the 2007 protests had been politically inspired by vested interests who opposed the PiS coalition who had come into power in 2005, opinion polls indicated that the public in general did not agree. Nevertheless, Bożena Banachowicz, former leader of the nursing and midwives’ union, said that offers to nurses’ leaders from all parties of first place on candidate lists, had been frequent during her period in office. This appeal to private interests laid nurses open to party-political manipulation and control. Given that prior to the 2007 protests negotiations were in fact already in train, according to Banachowicz entry into, and occupation of, the Prime Minister’s Chancellery had been designed to undermine the ruling party (PiS) by mobilising nurses, who spontaneously travelled to Warsaw to the vicinity of the Chancellery to protest in support of their colleagues inside. The nursing union leader during the time of the 2007 protests was offered – and refused - the post of vice-Minister of Health when the opposing Civic Platform Party gained power later in the year.

Producing Capitalists Through Health Care

If nurses saw themselves and patients as paying the price, who stood to gain from the health care reforms? Among the beneficiaries were the new health care debt servicing firms. Health service debt, which started to be sold on a mass scale from the mid-1990s onwards, has, it is said, been a ‘real hit and milestone’ in the development of the Polish debt servicing trade (Witul 2006). Until the law was changed in 1997, hospital debt was mainly sold by power and pharmaceutical companies, and bought by high tax-paying companies at a fraction of their nominal value, and then used as a way of paying tax. Banks later bought debt at up to 100 percent of face value, as an investment on which profitable interest returns could be made.

Enterprise Investors (EI), one of the oldest and largest private fund management companies running foreign direct investments in Poland and Central and Eastern Europe and who had been heavily involved in Poland’s pharmaceutical and medical services market, was one company active, via daughter companies such as Magellan, in buying up hospital debt. Another company, Electus, was originally founded as an intermediary between the health services and the banks (Witul 2006). Its co-founder Marek Falenta, ‘made his first million’ on the strength of this. Falenta saw that in the case of health care, 100 percent of debt value could be recovered from the state. ‘You can get people’s out-of-date debts or bank credits for pennies, but usually you only get about 5-10 percent of the (nominal) value back – we got it all’ (Falenta, quoted by Witul, 2006). Subsequently, the company began to buy debt and to propose to the health service long-term restructuring loans. ‘Now we produce debt in-house and have an assured source of income for many years to come’ (Falenta, quoted by Witul, 2006).

Generally, prospective entrepreneurs were said to be encouraged by the financial success of colleagues active in the health care field: ‘between 2001 and 2004 Euromedic International, a holding owned by General Electric, the Dresdner Bank and the Global Environment Fund constructed 13 dialysis stations and 7 diagnostic centres, signed contracts with the NFZ for their operation – and is making great money’ one commentator enthused (Waszkielewicz 2004: 25).

For some, the development of market services pointed to the priority for government of private interests. The Kraków nurses’ leader, for example, said, ‘it’s the pharmaceutical companies, the big Western businesses, that influence what’s happening in the health service, people who have not much in common with the health service. So it’s hard to have something
rational. … (…) .. a section of the politicians think that you can make money on everything and that, for example, the state has no obligation towards its citizens, that no, what’s the good of some hospital, a powiat hospital in some geographical area, what’s the good of it if all it does is make a loss, well, liquidate it and make a beauty clinic, or something like that.’

The Privatisation of Policy

In the months following the end of the nurses’ protests, health care problems remained high on the political agenda. During the election campaign late in the year, the CBA released tapes of a conversation it had secretly recorded during the summer, between a Civic Platform parliamentarian, Beata Sawicka, and a CBA official posing as a businessman.

‘I have a group of people’ Sawicka was caught on tape as saying, ‘it’s not a large group of people, because there’s three of us.. who have, make, you know, the law and so on.. but most of all who have enormous knowledge about what’s going to happen in the future, that’s to say the privatization of organizational units in the health service.. there’s going to be a rationalization of the hospital network, the local authorities are going to get rid of the assets (majątki trwałe), that’s to say they’re going to sell them and turn hospitals into commercial companies (spółki prawa handlowego).. well as everyone knows - medicine’s going to be private, hospitals are going to be private … What’s it going to start from? From having to submit a tender for a hospital and then having to buy it … But if… let’s say, you turn a hospital or a clinic into a commercial company, then you simply take over the building, and the structure, and the people.. The people with a head start will be the ones in the know’ (Misiak 2007).

Sawicka’s remarks appeared to indicate that legal changes were afoot which would mean that for those in the know hospitals could then be acquired virtually free-of-charge. The tapes caused a furore. Prime Minister Jarosław Kaczyński described the affair as ‘a gigantic plan to rob Poland, and to rob Polish patients’, the former President Aleksander Kwaśniewski criticized the use of the CBA during the election campaign, and Sawicka was expelled from her Party on the spot.

Nevertheless, the tapes did not prevent the Civic Platform from coming to power. Among its early actions were high profile consultations - the ‘White Summit’ (biały szczyt), with stakeholders in health care change. The Health Care Workers’ Unions, professional bodies and other social organisations, were all present at the meetings – held between January and March 2008 in the Centrum Dialog. Despite the claims of some participants that the consultations were a sham, a number of points were eventually agreed. These included the right to buy treatment to avoid queues, the introduction of modest fees for clinic visits and hospital meals, and the right to buy private health insurance in addition to, or instead of, social insurance. Importantly, the introduction of a basket of guaranteed services was deferred until after a debate, while agreement to hospital privatisation that was optional and partial, was secured.

Only weeks after the White Summit – on 8 May 2008 - the newspaper Rzeczpospolita published a leak. Out of the blue, legislation was being prepared which departed radically from the White Summit agreement. It was to make it compulsory for all hospitals – most of which were still independently functioning units under local authority management, only about eight percent of hospital beds being private – to become businesses, thus opening the way for their sale. At the same time, the newspaper presented the results of a telephone poll in which over half of respondents were against privatisation, as compared with about one third who were for. ‘Let us not frighten people with the word ‘privatisation,’ responded Health Minister Ewa Kopacz in the debate. ‘What the Civic Platform is currently proposing is
the transformation of ineffective hospitals into efficient businesses’. Inefficiency in this discourse was unequivocally signified by hospital debt. Hospital indebtedness meanwhile had fallen since legislation in 2005 to deal with the issue, and as a result of rising revenue from social insurance.

For former Health Minister Marek Balicki, interviewed in the course of the study, what had taken place between the March and May policy announcements, was generally unknown. For former Health Minister Łapiński, however, the situation was clear: ‘There are firms in Poland which are ready to take over indebted hospitals, firms which bought hospital debts earlier on. The lobby acting on behalf of those firms has been forcing through changes in the law which will allow this kind of operation’ (Piński 2008: 38). Bożena Banachowicz expressed a similar view: ‘the firms which have been buying up hospital debt, as well as the kind of dodger that the parliamentarian Beata Sawicka spoke of in 2007, they are the ones that are pleased with the possibility of privatising hospitals or hospital wards. Doubtless it will be good business, because as well as funding from the NFZ, patients will also pay’(Kamieniecki 2008: 18).

Despite the radical nature of the new proposals, they were eventually put to Parliament, not by government, but in the form of a members’ bill instead. This meant that the statutory requirement for consultation with social organisations in the field of health care no longer applied. Most of these organisations were against the compulsory commercialisation - and hence privatisation - of hospitals, and had said so at a meeting with the President (Cichocka 2008). A bid to hold a referendum, an idea supported by 71 percent of respondents in a survey commissioned by the newspaper Rzeczpospolita, also failed. In October 2008, the bill was accepted by the Polish Senate. The healthworkers’ unions continued to argue that commercialisation meant an open door to privatisation. It would bring a worsening of living conditions both for workers and for patients, less access to health care for the poor and a bigger gap between the poor and the better-off, they said (http://www.polskieradio.pl/iar/wiadomosci/artykul76723.html). Approximately one month later, Lech Kaczyński of the opposing PiS Party used his Presidential powers to veto the bill. The consequence was the introduction by the government of a ‘Plan B’ for hospital privatisation via an extra-legislative route.

Plan B was introduced in April 2009, and is scheduled to run until 2011. It offers to cover from government funds one part of the outstanding debts of hospitals where local authorities have agreed to privatise hospitals and have put forward an acceptable business plan. However, the sum earmarked for the purpose was reduced from an initial 2.7 billion złoty (the total outstanding debt of Polish health care institutions), to 1.38 billion złoty, with no earmarked funds shown in the most recent budget. As of writing no agreement has been signed between a local authority and the Ministry of Health within the framework of this programme, and where local authority preparations are underway, they have provoked health workers’ protests (Kasperska 2009). Although the government has not withdrawn Plan B, some hold the view that it would now suit the government to defer the implementation of the programme until 2011, when the effects of financial crisis may be less keenly felt (Sikora 2009).

Neoliberalism, Health Care and Democracy

Health care change is perhaps a key site of confrontation between expectations and values produced under the old system, and the realities of the new. But the frictions that have resulted have not simply been the path-dependent consequence, as has been suggested, of egalitarianism inherited from the previous regime (Cerami 2006). What has been critical has been the sudden propulsion of postcommunist Poland into a world dominated by neoliberalism, the positioning of the country with respect to global power relations, the
opportunities and opportunism that were part of this process, and the implications all this had for the way in which capitalism and class have been installed.

The neoliberal regime introduced in Poland after communism bears many of the hallmarks of the contemporary politics described by the political scientist Sheldon Wolin (2008). Contemporary politics, he writes, is moving in the direction of what he terms ‘inverted totalitarianism’, distinctive of which is the domination of the economy over the political – in contrast to classical totalitarianism where the reverse prevailed. The regime ideology, capitalism, underpins a faith that social issues such as health care are best managed outside politics, via the market. Inverted totalitarianism exercises power without appearing to do so, and professes to be the opposite of what it is. It extols the virtues of democracy, but in fact practises a form of ‘managed democracy’ centred on containing electoral politics, while the degree to which it promotes social democracy is strictly limited. For Wolin, the US is the prime example of how democracy can be managed without appearing to be suppressed (p.47).

The meaning of the shift to neoliberalism, however, depends on context (Fourcade-Gourinchas and Babb 2002). Rather than emerging imperceptibly and appearing continuous with political traditions as in the West, the onset of neoliberalism in Poland has been defined by its sharp discontinuity with the past. Furthermore, neoliberalism after communism has entailed the instantiation ab novo of class. The transformation of health care has been integral to this process since, given income inequalities, commodification renders health care security a critical dimension of new class difference. Secondly health care itself is being developed as a site for the formation of capital, that is, one where income inequalities can be produced.

The European Social Model is based on the values of equality, social inclusion, participation and dialogue (Golinowska and Żukowski 2009). By emphasising democracy and eliding class and capitalism formation, this discourse has contributed to a gulf between rhetoric and reality – a kind of neoliberal ‘politics of duplicity’ in Polish health care (cf. Kligman 1998). ‘For many politicians,’ a former Polish vice-Minister of Health has written, ‘patients’ empowerment and citizens’ participation were seen as a luxury of wealthy nations – another ‘imported issue’, like feminism or gay marriage’ (Mierzewski 2005: 226). But it is not just in political circles that the notion of ‘empowerment’ – central to global health care discourse - has had so little resonance.

The extent to which the nurses’ protests tapped into the social distress associated with transformation is reflected in the overwhelming level of public support which they received. Yet although health care change gave rise to politics, the democratic potential of such developments was not realised. This is in part the result of the privatisation of policy that has taken place. Evidence put forward in this paper suggests that with respect to the privatisation of hospitals, policy has been shaped in significant measure outside the public arena and has prioritised private interests over and above citizens’ preferences or the common good. Insofar as Wolin’s vision of ‘inverted totalitarianism’ is becoming reality, what is happening in ‘post-totalitarian’ Poland can be seen as a social revolution from above in and through health care for the second time within a single lifespan.

References


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