REGIONAL STRATEGY OF HEALTH CARE AND HEALTH POLICY – CHALLENGES AND DILEMMAS

Regionalna strategia ochrony zdrowia i polityki zdrowotnej – wyzwania i dylematy

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STRESZCZENIE

Rozważania autora artykułu zmierzają do identyfikacji najważniejszych uwarunkowań skuteczności i efektywności regionalnej polityki ochrony zdrowia służącej zarówno lepszemu zaspokajaniu potrzeb zdrowotnych lokalnych społeczności, jak też realizującej cele polityki spójności. Kanwą prezentowanej w artykule refleksji nad kluczowymi wyzwaniami stojącymi przed polityką regionalną są dwuletnie badania w tym zakresie, których wyniki relacjonują teksty zamieszczone w trzech kolejnych tomach *Journal of Health Policy, Insurance and Management* (№ XIII/III 2013, № XIV/IV 2014, № XV/V 2014). W efekcie prowadzonych rozważań autor wskazuje cztery grupy uwarunkowań i problemów, których rozwiązanie stanowi warunek *sine qua non* skutecznej i efektywnej regionalnej polityki ochrony zdrowia realizującej zarówno strategiczne cele UE i rodzimego kraju, jak też służącej lepszemu zaspokojeniu potrzeb zdrowotnych mieszkańców regionu.

Pierwsza grupa dotyczy uwarunkowań systemowo-organizacyjnych oraz fundamentalnych zasad konstruowania regionalnych strategii ochrony zdrowia i planowania bieżącej polityki zdrowotnej. Druga grupa odnosi się do zasad i sposobu funkcjonowania oraz merytorycznych i zarządczych kompetencji regionalnych władz – samorządowych i administracyjnych.

Trzecią grupę tworzy brak kryteriów gromadzenia danych i doboru parametrów niezbędnych do konstruowania strategicznych planów ochrony zdrowia w regionie, a tym samym brak kryteriów oceny jej skuteczności i efektywności. Osobna grupa to problem braku wyrazistej, jednoznacznie spójnej strategii ochrony zdrowia osadzonej w teoretycznych imponderabiliach i zarazem w realiach polityki publicznej wynikających ze specyficznych, lokalnych uwarunkowań. Wynikają stąd główne cele postulowanego przez autora przedsięwzięcia badawczego obejmującego równoległe projekty zorientowane przede wszystkim na:

(1) poszukiwanie takich rozwiązań systemowych i legislacyjnych, które pozwoliłyby na opracowanie i rekomendowanie krajom i regionom UE wspólnego, jednolitego modelu organizacji i zarządzania ochroną zdrowia w poszczególnych regionach oraz

(2) formułowanie programów kształcenia kadr zarządczych w regionach, a także działań kształtujących właściwą dla współczesnych demokracji kulturę polityczną. Postulowane przedsięwzięcie badawcze będzie, zdaniem autora, istotnym wsparciem dla umacniania związku idei, celów i zadań polityki regionalizacji prowadzonej w ramach „małych, bliskich ojczyzn" z ideami spójności, konwergencji i harmonizacji służącymi integracji całej Unii Europejskiej.

Słowa kluczowe: spójność, regionalizacja, strategia ochrony zdrowia, polityka zdrowotna

Key words: cohesiveness, regionalization, healthcare politics and policy

1. REGIONALIZATION OF HEALTH CARE – CHANCE AND THREAT OF EU INTEGRITY

Regional character of public policy is among the prerequisites of harmonious and sustainable development of the EU countries, as well as a condition for integrity of European Union as an entity[6]. Such a thesis is present in all Union's program documents, as well as a majority of research studies that discuss and diagnose the increasing separatist tendencies in various European countries[7]. These are proven by ongoing transformations in most of the Union countries – ranging from Great Britain, Belgium, Spain to France and Italy – of varied geneses, characters, the drama of the processes and their potential effects. However, this pertains not only to the EU countries – it would be enough to mention recent division of Czechoslovakia, and currently Ukraine, Turkey, Balkan countries, Georgia or Moldova. Paradoxically, regionalization should be perceived as a threat, but also as an opportunity for integrity [Cichońska, Fedorowski, Holly, 2014]. Or, taken from a different perspective, a specific "forward escape", in order to prevent the disintegrating tendencies.

Regardless of it being treated as a threat or an opportunity, it can, thus, be limited to a question of how to adopt the regionalization policy for it to make use of its opportunities, and, at the same time, avoid the threats? Regionalization of health care and health policy arises as a particularly valuable area for research in order to find answers to the question. It is due to the fact that the subject of health care is equally important and similarly complex in all EU regions, even despite their being varied in terms of size, social and economic potential, political system and preferences, lifestyle, or population. Also, despite the differences in their economic, cultural, political, systemic, and even geographically -climatic conditions.

In our search for an answer to such a generally posed question, one should first establish (or at least assume), what is an opportunity and a threat of the policy, and who may perceive them as such. In other words, what is the desired, and the unwanted, outcome of the policy. Assuming that the desired outcome results from a consciously set objective and established plan, one should initially establish the objective of regionalization. Is it a single, clearly expressed and operated objective of the policy, or are these various objectives – are they complementary or only compatible, or even to a large extent, mutually exclusive, and, above all – not properly articulated or even ambiguous?

2. MAIN PROBLEMS OF REGIONALIZATION

When undertaking the attempt to create a model of regional health care and health policy strategy on the example of a typical region, such as the Lodzkie province[8], we came to a conclusion that it is not going to be successful without clearly defined and operated public objectives of regional policy, including health policy. Definitely, general political slogans cannot be regarded as such, as well as any forms of wishful thinking or even charms, such as "providing the highest quality of health

[6] For further details regarding the concept, notion and doctrine of regionalization and its opposition to territorial aspect, see Holly R. Regionalization of health care in Poland and other European countries – who and what really from it?, Journal of Health Policy, Insurance and Management (No XIII/III), 2013: 5-9 (http://journal-healthmanagement.com/pliki/zasobydokumentu-pliki/74/XIII_s005.pdf)

[7] Several references on the subject included in, see: Holly R., Ubezpieczenie w organizacji ochrony zdrowia w Polsce, KIU, Warszawa, 2013; oraz Holly R., Insurance Contracts as an Opportunity for the New Social Security Systems. Redefining ICONS and looking for new guarantees for welfare states, Journal of Health Policy, Insurance and Management (No XIV/IV), 2014.

[8] Accordingly to the presumptions of our research program established two years ago by the research team (26 participants from Warsaw School of Economics, Medical University of Lodz and National Insurance Institute in Poland), the first stage of this program was aimed at formulating detailed queries and ordering research objectives that would become a part of a more complex research project aimed at designing the most proper organization-management and financial solutions within regional health strategies and health policy See: Holly R. Regionalization of health care in Poland and other European countries – who and what really, benefits from it?, Journal of Health Policy, Insurance and Management (No XIII/III), 2013: 5-9.

care", "providing wide access to health services", "reducing the costs of services", "increasing the effectiveness of public hospitals", "better use of medical staff", etc.

Moreover, operationalization of objectives for the needs of regional healthcare strategy and health policy requires not only references to the current state (national) health doctrine expressed and objectified in the officially approved health care program, which indicates current and future health priorities, and/or expressed in the form of a basket of basic medical services. It enumerates the minimum health protection of citizens, but also by political imponderables of the European Union and its directives. Without these two references, regional health care strategy plan cannot obtain financial guarantee of support on the part of central authorities as well as European funds. It cannot serve as the base for creating and/or accompanying foreign group clusters of supporting regions with similar profiles of demands, problems and objectives.

Despite the benefits, widely discussed in two-year studies mentioned in our three volumes of *Health Policy*[9], the situation may contribute to the creation of regional health care programs (for the Lodzkie province in particular), the studies allowed for a more unambiguous definition of all areas that require further works and analyses. They also emphasized the hierarchy of problems, which should be posed as subjects of research and/or solutions resulting from a public debate. They also allow to put forward crucial theses and hypotheses, which, verified, may in turn contribute to the occurrence of new, systemic, doctrinal and praxeological solutions, not only in contemporary integrated EU policy of regional health care, but also in the complex public policy as a whole.

They, above all, lead to the conclusion that the process of designing any regional policy has to be based on proper, superior program documentation – the European Union and state documentation. They define unambiguous objectives, time span, possible forms of achieving the objectives, forms of financing and rewarding possible effects. Lack of the documentation means that regional policy performed in particular regions is only declarative and incoherent, even on a state scale, not to mention the European scale. There exist no criteria to assess the usefulness of particular projects and their transfers between more than 250 regions that function within the European Union; we have not even criteria to decide which solutions should/could be transfer from one region to another.

The second fundamental barrier is the lack of model organizational, structural, functional and management solutions supporting the possibility of constructing rational, praxeologically reasonable health strategy as well as transparency of regional health policy and thereby limiting a wide scope for social pathologies, such as clientelism, nepotism and corruption.

The third barrier of regional health policy effectiveness are two groups of conditions: (1) the lack of agreement with respect to criteria of data collecting and ways of choosing parameters necessary to construct regional health care strategy; (2) the lack of theoretical and conceptual background for unambiguous connection the idea, doctrine and practice of regionalization with the idea and legal procedures of European cohesiveness.

3. IDEA OF REGIONALIZATION AND PROBLEM OF ITS CONCEPTUALIZATION AND CODIFICATION

The primary, fundamental problem we have to face, can be limited to a question concerning the already mentioned Union documentation the defined regional health care policy. Do they manage to indicate accurately and unambiguously the policy's objectives and possible methods to reach them? Do they recommend methods of adapting health care programs, taking into consideration specific discrepancies between the regions, or are they satisfactory as the base for formulating national health care programs and regional health policy

[9] See: Journal of Health Policy, Insurance and Management, No XIII/III 2013, No XIV/IV 2014, No XV/V 2014, (http://journal-healthmanagement.com/pl/e-czasopismo.html).

strategies? Do they recommend realistic methods of financing health care programs, bearing in mind the differences in economic and financial potentials of particular European countries?

Even a superficial review of the discussed documents, that directly and indirectly define Union's health care and regional policy, proves the thesis that they are more declarative and directional than designing, present more postulates than programs. Thus, it is not easy to establish their mutual relationships, coded assumptions, directions and objectives of Union policy being difficult to transfer onto national, and further, regional health care programs[10]. As a result of this, it is predominantly a set of general objectives and postulates, which are usually presented in the form of health priorities that predominate national programs of health care. The same pertains to regional documents which, even if gain the form of separate documents, are usually slogans and wishes, which is also true about the plans and schedules included.

Such remarks could probably be applied to a majority of existing national and regional health programs within the EU. As regards Poland, for several years, the health doctrine has been expressed in periodically approved continuing National Health Care Programs which give directions for health care, by means of indicating up-to-date priorities.[11] Unfortunately, the doctrine is not widely expressed in the basket of basic medical services[12], which are approved more as a form of intervention in order to solve crucial and immediate problems rather than articulate and codify a specific vision of the health doctrine, which is in line with the entire system of social and pension benefits. There occur more and more works that express the awareness of the lacking document[13].

The first attempt of complex implementation of the Recommendations of the Council of European Union is *Policy Paper for Health Care for 2014-2020*. National Strategic Frameworks, prepared by the Ministry of Health as part of National Cohesion Strategy[14]. The document presumes coordination of activities within health care on three levels: strategic (central authorities), technical-operational (Steering Committee for coordination and intervention EFSI supported by the Department of European Funds at the Ministry of Health) and executive (on central and regional level). These actions aim at prolonging healthy life span, optimizing use of resources on the part of healthcare facilities, further restructuring of the facilities within healthcare structure, implementing new organization and management solutions, to meet the demands of current and forecasted epidemiological-demographic situation. All of it results from the monitoring of demands and expectations of the beneficiaries of the system. It is also aimed at increased availability of health services, by means of improved financing within the entire system, predominantly due to the restructuring of its infrastructure and new methods of financing healthcare facilities. This, in turn, will be possible as a result of including private resources to support the system. Due to the ongoing social change, the document recommends developments in prophylaxis and prevention, focusing on civilization diseases as well as increasing fertility, developing geriatric and palliative care.

[10] Zalecenie Rady z dnia 8 lipca 2014 r. w sprawie krajowego programu reform Polski na 2014 r. oraz zawierające opinię Rady na temat przedstawionego przez Polskę programu konwergencji na 2014 r. Official Journal of EU No C247 from 29.07.2014.

[11] Compare: National Health Program 2007-2015 Ministry of Health, National Institute of Public Health PZH, Warsaw 2007.

[12] On the possibility to regard the basket of basic medical services as a base of health doctrine see: Holly R., Ubezpieczenie w organizacji ochrony zdrowia w Polsce, KIU, Warsaw 2013:54-67.

[13] Working document by the Committee from 02.06.2014r. Ocena krajowego programu reform i programu konwergencji na 2014 r. dla Polski towarzyszący dokumentowi Zalecenie Rady w sprawie krajowego programu reform Polski na 2014 r. oraz zawierające opinię Rady na temat przedstawionego przez Polskę programu konwergencji na 2014 r., http://ec.europa.eu/europe2020/pdf/csr2014/swd2014_poland_pl.pdf (access: 22.09.2014).

[14] Policy paper dla ochrony zdrowia na lata 2014-2020. Krajowe ramy strategiczne, Ministerstwo Zdrowia, Narodowa Strategia Spójności, Warsaw, September 2014.

The contents of the discussed document prove that it has a more directional character, whereas its programming character is limited – shows objectives without defining them or indicating ways to reach them. It is, however, a premise to design research programmes and expert studies in order to make it real, and create uniform assumptions for the local strategies and plans prepared by local authorities. Thus, it seems that even after thorough analysis of the documents, the thesis presented here, indicating that they are unambiguous and too general may be regarded as daring and far-reaching, there is still the need to prepare a set of guidelines on the documents for regional authorities and their experts.

4. BARRIERS OF EFFECTIVE ORGANIZATION AND WAYS OF MANAGING IN REGIONS

According to the studies conducted, the roots to indefiniteness – ambiguous objectives, lack of realistic financial plans, schedules and the resulting, difficult to evaluate effectiveness and efficiency of regional health care policy – lie not only in scarce superior formally-legal and program regulations, but also, or perhaps on should say, predominantly, in organization. Oftentimes, the way of functioning and poor regional management preparation among the self-governmental and administrative personnel.

As it may seem, these organization-management causes are of various character, source and conditions. They fall, however, within a group of, at least, two types. Some of them derive directly from the system of a particular country, other, indirect, are a result of psycho-social and typical behaviours of people governing in specific circumstances, which in turn create formally-legal regulations to define organization and rules of governing.

In Poland, according to T. Dąbrowska-Romanowska, systemic conditions are crucial, as some regulations of the Constitution regard territorial government as a decentralized state authority[15]. Self-government in Poland is, above all, a complementary instrument to improve state governing. The authors of a report on the condition of territorial self-governance in Poland[16] notice that "territorial self-government is only a consequence of the state's decentralization, not an approval of the existence of territorial community" [Hausner, 2013]. Such a view means that regional self-government authorities may be recognized only as a specific form of reincarnating national councils, present in communist Poland. This gives rise to multiple consequences: increasingly dominant role of civil servants over Councillors [Hausner, 2013], common passiveness of citizens regarding self-governance [Hausner, 2013], ritual and ostensible character of citizen participation [Hausner, 2013], as there exists a paternalistic pushing and preaching of civic organizations by the governors", "civic consultations are superficial" [Hausner, 2013], and consequently "citizens are pushed back to their private space and limited to the role of a client" [Hausner, 2013].

Therefore, competencies imposed on local governments by the central one in order to best fulfill the common needs of local communities, make best use of public resources and a part of public assets, are used by local authorities against central authorities' intentions. This allows for uncontrolled access of civil servants to the beneficiaries (and the possibility to appoint new ones) and the right to distribute them. Thus, apart from a difficult to assess influence of local authorities on shaping local market relationships, by managing huge public resources, these authorities own another important advantage, namely the ability to search, approve and transfer pension. Thus, the pension as a set of various

[15] Dąbrowska-Romanowska T., Prawne i pozaprawne uwarunkowania skuteczności gwarancji wynikających z art. 167 ust. 1 i 4 Konstytucji, [in:] Izdebski H, Nielicki A, Zachariasz I (ed.). Finanse komunalne a Konstytucja, Trybunał Konstytucyjny, Warszawa 2012. Statutory limitations are aslo mentioned by the father of Polish Regional, prof. M. Kulesza [Gospodarka komunalna – podstawy i mechanizmy prawne. Samorząd terytorialny (7/8), 2012].

[16] Narastające dysfunkcje, zasadnicze dylematy, konieczne działania. Raport o stanie samorządności terytorialnej w Polsce, Collective work ed. J. Hausner, Uniwersytet Ekonomiczny w Krakowie, Małopolska Szkoła Administracji Publicznej, Kraków 2013.

benefits (financial, access to limited goods, privileges) becomes a major subject of care and activities of self-governing local authorities. As a result of such "pension quest" there is a "developing erosion of an institutional system, resulting in, among others, improper allocation of resources and an increase in the costs of public tasks"[17].

Pension quest, as a fundamental thought of civil servants, or even a norm of their culture, with simultaneous monopoly and lacking competitive pressure or supervision and responsibility for their decisions, creates a syndrome of "institutional irresponsibility" [Kotlarz, 2011]. Polish lack of responsibility enforcement in case of mistakes, instead of being an advantage of stimulating initiative and creativity, in reality strengthens their "free bureaucratic entrepreneurship" [Hausner, Morody, 2000].

In a situation "of bureaucrats escaping sanctions with groups interested in the transfer of pension, there may occur a modification in the method of financial management, thus transferring the decisive centres outside administrative forces" [Kotlarz, 2011]. It happens that within the same region there are two decisive centres that execute public policy, whereas their hierarchy and mutual relationships are not established. What makes the situation even worse is the fact that their competencies may result from different formally-legal regulations, their ranges of objectives and tasks intersect, whereas the standards of executing are incompatible.

In case of the researched Lodz region, health care is subject to various, practically independent management centres: the Province Governor, representing central authorities, Provincial Assembly Marshal, the city's President[18], Rector of a Medical University which is one of the biggest in the country, which owns a network of clinical hospitals. Moreover, the Minister of Health supervises one of the biggest specialist hospital Polish Mother Memorial Hospital and a hospital subject to the Minister of Internal Affairs, is the Province Specialist Hospital. Outside that, there functions a network of the biggest private medical centres, together with several hundred out-patient clinics. But there is no coordinating centre that would supervise those hospitals.

All reflections here regarding regional health care policy – those unambiguously recognized, but also those potentially plausible, or anticipated – show that even a superficial analysis of the conditions and implications, as well as their causes, gives rise to two groups of problems. Finding a solution to them should be regarded as a *sine qua non* condition of effective and efficient regional health care policy, i.e. one that executes both, EU's and state's strategic objectives, at the same time meeting the health demands of citizens.

The first group involves systemic-organizational conditioning and fundamental rules of structuring regional health care strategies and current health care policy. These problems are a predominant challenge to a research project, which aims at finding proper systemic and legal solutions, in order for the EU countries and regions to work out and recommend a uniform health organization and management model within the particular regions, including a set of rules to create regional health care strategies.

The other group of problems deals with rules and methods of functioning, as well as substantive and managing competencies of local authorities – administrative and self-governing[19]. The challenge is equally demanding for a parallel project whose results should provide us with some programme ideas on management personnel training in the regions, as well as creating proper bureaucratic culture, in line with modern democracy.

[17] The notion of *bureaucratic free enterprises* was spread by G. Turlock (Bureaucracy, Liberty Fund, Inc., Indianapolis, 2005) for the use of theory of public choice which discusses the processes of collective decision making in the circumstances of various limitations.

[18] As we can notice – in case of Lodz region – the urban agglomeration together with satellite towns accounts for 1,2 mln. inhabitants, i.e. nearly a half of the entire population.

[19] These problems being crucial for regional development and social integrity are indicated in a report on studies conducted by UNDP. cf. United Nations Development Programme. Podsumowanie Krajowego Raportu o Rozwoju Społecznym. Polska 2012. Rozwój regionalny i lokalny, Biuro Projektowe UNDP w Polsce, Warsaw 2012:12.

5. GENERAL AND PARTICULAR CONDITIONS OF REGIONAL POLICY EFFECTIVENESS AND EFFICIENCY

If we agree with generally accepted presumption that the most important criteria of health care efficiency and effectiveness are quality and accessibility of healthcare services and benefits, the problem of conditions of regional health care strategy one should investigate taking into account at least following aspects: (1) accuracy of selection and accessibility of epidemiological and statistical data; (2) the number of medical staff and its professional competence of as well as infrastructural basis; (3) financing-sufficient with regard to health purposes enrolled in regional health care strategy; (4) quality of health benefits and services; (5) accessibility of health care benefits and services.

Usefulness of data that are collected in these fifth aspects for creating health care strategy in region we can examine calling for example five appropriate groups of data that have been gathered in the course of two years research studies carried out in the "lodzkie" – typical Polish region in the heart of the country.

5.1. Epidemiological and statistical data[20]

The official statistical data taken from Central Statistical Office, National Health Fund, regional statistical reports, medicines consumption and selected epidemiological studies were recognized as the main tools for prioritization and aiming regional strategies and policies. The important differences between sources were found and the need of verification of data as well as the interpretation of results by experts is stressed.

Setting aims and objectives is the crucial point of any activity, including health care and/or business. One have to differentiate the real aims from the declared ones, as the declared aims sometimes cannot be achieved, but they are very useful from the political point of view[21]. So, the serious discrepancies can be noted when the political declarations are not kept in practice, causing serious disappointments, especially in patients/voters opinions. That is a very strong stimulus for politicians to declare less, or to promise more than it is available, especially when time of election is considered. So the political impact on declarations is the important factor influencing the preparation of regional health policies and strategies. The ethical aspects of such declarations cannot be overestimated, although generally voters are not able to distinguish what can be achieved from what can be promised. The majority of problems presented during elections and later, in practical actions, may be beyond the interests of general public, until a serious problem is presented by the media. TV and newspapers are usually more interested in faults than in successes of healthcare. So the incremental model of health policy is still in use, in contrast to the very rare cases of rational health policies.

The most important question should be asked: do the people want to be cured or do they want to be healthy? If the general public wants to be healthy, the life-style should be also healthy, e.g. the number of smokers, number of overweighed persons should be decreased; but the physical activities – increased. Looking at the actual data the answer is: neither healthy behavior nor health are the priorities for general public. Quite different results may be expected when the patients (but not general public) are asked the same question. In such a case the increased number of facilities, doctors, nurses, services etc. may be the priority for the patients/voters. The politicians should react to such demands. However, another factor – financial limitations – is presented as the main problem of healthcare. As the consequence, the problem

[20] This part of text has been prepared by J. Michalak on the basic of: Health Needs Assessment at Regional Level in Poland – Analysis and Evaluation of Sources in Łódź Region, Journal of Health Policy, Insurance and Management (No XIII/III), 2013:11-22.

[21] The reader should keep in mind the differences in the meaning of terms „policy" and „politics". Those terms in Polish are translated to only one "polityka".

of hospital debts seems to be more important than any health issue. Recently the Prime Minister decided that the queues and waiting-time for specialists consultation are the priorities for national health care system, including National Health Fund.

Moreover, the preparation of strategy requires the accurate, reliable, consistent and timely information covering all aspects of health, and health determinants in a given area (local, regional or national level). The number of indicators is enormous – exceeds 80. So it is important to choose the appropriate ones for regional health policy and health strategy. On the other hand, the healthcare needs are identified with the number of services provided but not in the change of health status. In other words, the patients are usually treated but not necessary – cured. It is not only the semantic problem, as the "treated" means that a procedure was used and "cured" should be understand as the relief from signs or even end of a disease. It is quite obvious, that "treated" refers to process and output, according and the term "cured" is the equivalent to outcome according to Donabedian's classification.

The "structure" of healthcare is usually understood as the number of facilities and personnel. However according to the Curation Activities Act (Ustawa o działalności leczniczej) from 2011, the hospital is defined as an enterprise, so the rules governing any enterprise are adopted to a very specific institution which – till now – has not been really devoted to such kind of activities.

So, setting priorities in health policy and health strategy one must face, at least, the following problems:

1) attitudes and priorities of general public in relation to health,
2) patients opinions, demands and activities,
3) healthcare needs in terms of services expected,
4) structure of healthcare facilities and services provided,
5) economic evaluation methods and results (if any).

Only some of those parameters are available in routine evaluations performed by the hospitals or/and local authorities.

Sometimes, but rarely, selected epidemiological studies are useful in determining the quantities of services identified as the healthcare needs.

According to current legislation the NHF may identify every single prescription prescribed for every single reimbursed medicine for every patient. It is obvious that the health data – as the most vulnerable ones – are under rigid protection of law. However when used for statistical and scientific purposes those data may be published in such a form that makes impossible to identify the given person. That is the most valuable source of information on health needs but restricted to those who are insured in NHF – in practice the whole population of Poland.

The crucial role in setting priorities for local health policy is setting the appropriate relationship between epidemiological data and other information obtained from different sources. That means the need for critical analysis of data sources basing mainly on the experts, their knowledge and experience. Nevertheless, the epidemio-logical data are usually scars and usually take into account neither comorbidities nor multi-morbidities.

The critical analysis of data obtained from epidemiological and statistical reports was performed by the desk research methodology. The data were retrieved from the following sources:

1. "Health and Healthcare in 2012", edited by the Central Statistical Office (CSO)
2. "Statistical Bulletin of Ministry of Health 2012", approved by the Ministry of Health
3. "Statistical information on healthcare in Lodz voievodship" (Informator statystyczny ochrony zdrowia województwa łódzkiego 2012) issued by the regional Centre of Public Health in Lodz – Łódź – 2013
4. "Local Data Bank" (Bank Danych Lokalnych) Central Statistical Office (CSO) http://www.stat.gov.pl/bdl/app/strona.html?p_name=indeks
5. The data from National Health Fund on medicines consumption by diabetics in Lodz region

6. "National Index of Healthcare Performance" (Krajowy indeks sprawności ochrony zdrowia 2014)
7. The report on Diabetes in Poland "Cukrzyca. Ukryta pandemia, sytuacja w Polsce 2013"

The data from NHF and "Diabetes in Poland" were used for the case study of discrepancies in health needs assessment.

The official statistical data are collected according to Public Statistics Act. The statistical forms related to health and healthcare problems are prepared and updated every year, according to decrees issued by Ministry of Health. Every healthcare facility registered in Poland is obliged to deliver the current data to different institutions depending on their type of structure (e.g. hospital, primary care facility), and kinds of activities (cardiology, occupational medicine, oncology, rheumatology etc.) either to Voievodship Centre of Public Health, Voievodship Statistical Office or selected Institutes (eg. Institute of Oncology, Institute of Occupational Medicine) or directly to the Center of Health System Information – affiliated to Ministry of Health. The last way is used by electronic forms mainly.

This group of data refer mostly to the structure of healthcare (e.g. number of hospitals, doctors, nurses, facilities, beds). However the elements of processes are also available (e.g. number of hospitalizations[22], visits to doctors) as well some outputs (e.g. number of vaccinations). The aggregated data are presented in different reports. The most general reports describing the whole country are "Health and Healthcare in 2012", "Statistical Bulletin of Ministry of Health 2012", and CSO websites. The annual reports on "Statistical information on healthcare in Lodz voievodship" has been published every year for 53 years and it is the most comprehensive information on regional health issues published till now. Special information can be also retrieved from the CSO website "Local Data Bank".

However, the statistical information on health status in Lodz region is based on negative indicators: mortality rates, and morbidity rates. The only positive indicators are the number and rate of live births. Also, the numbers of patients visiting general practitioners (family doctors, primary care units) and some specialist outpatient clinics (tuberculosis, mental health, alcohol dependence, some communicable diseases etc.) are presented in official sources. All those parameters refer to structure of.

Only the number of patients in primary care was presented:

- Health status of persons in age 0-18 years
- Health status of persons in age 19 and more

The second group of data is collected by the National Health Fund – this is information of reimbursed, contracted services and medicines. That is the most accurate information as the great majority of healthcare services and remarkable portion of medicines are reimbursed by NHF. It seems reasonable that the patient will buy only those prescribed medicines which are really needed.

5.2. Funding system[23]

Due to the close relationship with the regional strategy funding system at the regional level, its main guidelines in this area should include: the financial sustainability of health care solutions to the problems of financial imbalances therapeutic entities, increase resource efficiency and reduce unwarranted/uncontrolled use, improve relationships in the business environment.

The key design issues of strategic regional health strategy in terms of cost and price of health care services include:

- Supervision and impact on running costs and investments as a factor

[22] But not the number of hospitalized patients. One patient may be treated at the hospital even several times in a year and each hospitalization is considered as a separate issue.

[23] This part of text has been prepared by I. Rydlewska-Liszkowska, M. Klimanek, M. Klimczak on the basis of: Health Care Services Financing in the Region, an example of Łódź Province, Journal of Health Policy, Insurance and Management (No XIII/III), 2013:79-106.

in defining entities profitable and "defeated", reinforcing "Financial IQ" [Van Horrssen, 2014] healthcare entities and basis for the creation of a database of costs. Costs making strategic choices criterion should take into account the cost of creating / improving the system of financial reporting (including IT) to monitor the effectiveness of expenditures on stages of project and to ensure transparency of information in order to impact on the change of consciousness in relation to the cost of health care.

- Strengthening of cost in the conclusion of contracts for performance of health services and health programs by moving away from the irrational criterion of the lowest rates of benefit to the prices resulting from the justified costs resulting from the analysis of financial performance of providers. The result may be to provide a basis for constructing cost-effective health strategy in conjunction with other criteria to design strategies (quality, continuity of care, equality in access to health services or forms of delivery of care).
- Use of information on costs to determine the boundaries (constraints and opportunities) financial resource mobilization strategy for health as a "starting point" to develop strategic objectives. This approach avoids the unrealistic planning strategic activities and opens the possibility of developing alternative scenarios for execution. In their study should be guided by the mission of healthcare entities and their targets. Due to the fact that the essence of each chosen path strategy are the limitations of a financial (cost/effective ratio), they are one of the most important selection criteria in the design phase.
- The structure and size of the investment is an important factor to choose a strategic path. Availability of equipment, medical equipment but nevertheless important state of infrastructure in conjunction with the investment costs should be included in the draft strategy not only as an output scenario selection criterion but also as decision-making criteria (in terms of fixed costs) for the implementation of the objectives in this regard. Fixed costs may in fact cause a destabilization of the financial management of medical entities and consequently – the pursuit is not always justified increase productivity.
- Use category of costs far less prevalent in the design processes in health care by the entities forming methods:
  - taking into account the strategy of indirect costs of the disease can be critical when assessing medical technologies (drug programs, health programs, therapeutic programs). Implementation of their contribution to improve the health of the population, and also to the length of life of the patient. Applied medical technologies by improving the health also increase the patient's ability to work thereby reducing the economic costs generated by the disease. This leads to greater production, increased payroll and contributes to increased consumption. These factors conducive to higher revenues from taxes and contributions, improving the situation of the public finance sector – increase the ability to finance the growing health needs of the population of the region. At the same time a more comprehensive analysis of the costs and benefits of medical technology used allows for the financing of some previously inaccessible to patients medicines and therapies , and by improving the result of health sector financing will allow more health benefits[24]. Given the demographic structure of society Lodz region is extremely important,
  - operating costs of medical devices used in long-term planning based on the cost of medical technology depending on the methods used, the cost of consumable items (equipment, supplies, et al.). Technologies used and the methods of their implementation, the cost of periodic inspections of equipment and medical equipment (ensuring continuity the per-

[24] Metodyka pomiaru kosztów pośrednich w polskim systemie ochrony zdrowia, Warsaw 2013, EY building a better working world, Sprawne Państwo, Program EY.

formance of health services at the time of inspection, the reorganization of work of employees, access and cost of surveillance apparatus after the expiry of the warranty, the cost of replacing supplies equipment after the expiry of the guarantee, the cost of insuring equipment and medical equipment), costs applicable to specific technologies adapting premises, security, individual protection employees, maintenance and disposal of equipment and consumable parts, etc.,

- life cycle costs of health care products (medical technology),
- costs associated with the unjustified empty unused resources of the state, mainly in hospitals,
- marginal costs associated with a possible increase in the number of health benefits.

Defining the role of prices in the design of regional health care is particularly difficult due to, system adjustments, non-uniformity of price categories in the protection of health and consequently their different roles under the assumptions of the health system in the process of buying and selling between the actors of the system. Therefore, particularly important but difficult issue is to restore prices to their health information function, redistribution and stimulation in transactional processes between providers and payers public in the region. Such activities may be severely limited due to systemic regulations in this regard. This also applies to the relationship between benefit recipients pricing and service providers in terms of guaranteed access to health services. No possibility of flexibility to charge beneficiaries (prices from the point of view of the patient) at the same time prevents the stimulation of the costs incurred by public funds which in turn does not allow the rationalization of the available budget allocated to health care in the region by the principle of cost-effective.

5.3. Infrastructural conditions[25]

Healthcare infrastructure planning in the region should be consistent with the strategic documents EUROPE 202026 and „Health 2020".[27] The concept of „Health 2020" refers to modern wide understanding of public health (*evidence-based public health*)[28] and health care system building.[29] Health care infrastructure plans are an integral part of regional strategies[30], and one of the requirements of the European Commission is the so-called smart specialization in the regions.

Physical infrastructure (grounds, buildings, medical instruments and appliances and IT equipment) and intangible assets (knowledge and experience of medical personnel) can be analyzed in different aspects:

1) current status (number, kind, location and use),
2) future needs taking into account demographic and epidemiological changes, which is necessary to ensure adequate health care,
3) strategic decisions concerning maintenance and development of the existing infrastructure (health care units, teams of workers),

[25] This part of text has been prepared by H. Saryusz-Wolska on the basis of: The adjustment of health care infrastructure to the health care needs and expectations of the region's residents – based on the Province of Łódź, Journal of Health Policy, Insurance and Management (No XIII/III), 2013:23-38.

[26] EUROPA 2020 – Strategia na rzecz inteligentnego i zrównoważonego rozwoju sprzyjającego włączeniu społecznemu – http://ec.europa.eu/europa2020/inde_pl.htm.

[27] www.euro.who.int/en/about-health-2020.

[28] European Observatory on Health Systems and Polices, www.euro.who.int/en/what-we-do/data-and-evidence/databases/>, http://www.oecd.org/health/healthpoliciesanddata/.

[29] Opolski J.T., Wysocki M. J. „Health 2020" – new framework for health policy, part I. Przegląd Epidemiologiczny 67(1), 2013:87-9 oraz Opolski J.T., Wysocki M.J. „Health 2020" – new framework for health policy, part II. Przegląd Epidemiologiczny 67(4), 2013:47-50.

[30] Strategia regionu łódzkiego 2020, cel: dostęp do dobrej jakości usług publicznych (www.strategia.lodzkie.pl) opracowana w oparciu o Krajową Strategię Rozwoju Regionalnego 2010-2020: Regiony, miasta, obszary wiejskie (www.mir.gov.pl).

4) decisions of owners and investors concerning infrastructure development (infrastructure investments).

The goals of health care strictly related to proper preparation of infrastructure, most frequently mentioned by international sources include [Joumard, André, Nicq, 2010]:

1) improvement of efficiency of treatment and its cost effectiveness and
2) justice and reducing inequalities in access to health care.

The basic goals in planning health care infrastructure in the region are:

1) adaptation to future health needs,
2) improvement of health care quality and access to services,
3) improvement of effectiveness of health care units.

These goals are interconnected and require permanent action. The currently developed plans are in line with the 2014-2020 Financial Framework of the European Union budget and take into account the possibility of using European funds to improve and develop health care infrastructure.

Health promotion and health care belong to responsibilities of local authorities defined by appropriate legal acts. The new regional policy of the European Union[31] ascribes a special role to regions as functional and territorial units, where most health needs of their inhabitants should be met.

Inadequacy of financial resources at the disposal of the local authorities to their tasks in the area of health care is frequently stressed. [Rapkiewicz, 2012] Apart from their own resources, local authorities may apply for European funds to develop their infrastructure (Priority V – Social Infrastructure). Health care units transformed into commercial companies may run business and apply for private resources to maintain and develop their infrastructure. The effects of transformation in health care are considered unsatisfactory and thus further systemic reforms are necessary.[32]

The following decision making conditions and procedures concerning the development, implementation and monitoring of health care infrastructure plans in the region should be mentioned:

1) high number and diversity of infrastructure owners,
2) lack of institutional responsibility for decision making processes and co-ordination on the regional level,
3) necessity to consult and involve numerous regional stakeholders in the decisions concerning maintenance and development of infrastructure,
4) political circumstances (each level of government strives primarily for the development of its own infrastructure),
5) free market mechanisms (competitiveness) in applying for contracts with the public payer (NFZ – National Health Found), which affects the maintenance and development of the infrastructure and may bring benefits but also pose threats[33],
6) rapidly developing private sector,
7) necessity of co-existence of public, private and social sectors.[34]

Recommendations for regional health care infrastructure planning with a view to regional needs and EU cohesion policy:

1) critical and realistic assessment of health care infrastructure needs,
2) promotion of organizational projects which improve effectiveness of health care units in the health care system (including fusions, strategic alliances, service-provider networking, horizontal and vertical integration) [Burns, Bradley, 2006],

[31] The aim of the new EU regional policy should be: a. To reduce inefficiencies and very durable lasting social exclusion (report of Fabrizio Barca).

[32] Collective work: (Instytut Organizacji Ochrony Zdrowia Łazarskiego University, PwC, Kancelaria Prawna Domański, Zakrzewski, Palinka), Report: Ustawa o działalności leczniczej – podsumowanie dwóch lat funkcjonowania. Próba oceny skutków, Pricewaterhouse Coopers Sp. z o.o., Warsaw 2013 (access to report: www.lazarski.pl).

[33] Concept of "bad competition", ibid.: 30.

[34] In the new EU regional policy point to the potential benefits of public-private relations and social.

3) flexibility of plans and projection of new forms and kinds of health care which require modification of infrastructure (including development of telemedicine, mobile monitoring equipment and supported self-care),
4) development of infrastructure to ensure improvement of quality, continuity and comprehensiveness of health care (promotion of cooperation, coordination and exchange of information) [Hofmarcher, Oxley, Rusticelli, 2007] [Oxley, 2009]:
   a) adaptation of health care infrastructure to European[35] and national legal regulations,
   b) striving to achieve the recommended standards concerning medical equipment, especially in intensive care units, operating theatres, cancer wards, cardiology wards and diagnostic departments,
   c) widespread use of HIT (*health information technology*).

1) Improvement of effectiveness of health care infrastructure operation:
   a) widespread use of economic analyses (costs, cost-effect) and technical analyses (use, productivity),
   b) introduction of regional health infrastructure benchmarking,
   c) elimination of units and/or processes with the lowest effectiveness.
2) Improvement of access to modern health care infrastructure:
   a) widespread implementation of HIT to monitor the use of health care services (information, registration, waiting lists),
   b) expansion of primary health care capacity,
   c) improvement of distribution of health facilities (reduction of travel times, reduction of hospitalization rates and strengthening the role of outpatient treatment),
   d) increasing the number of places in long-term care units and development of other forms of services provided to elderly people (home hospitalization, day care centres).
3) Decision making processes concerning health care infrastructure should involve multi-stage debates with a great number of stakeholders of the system, using consultation procedures and joint decisions.

5.4. Healthcare quality[36]

According to R. Holly the *healthcare quality* means the compliance of the effects (treatment) with the assumed purpose (defined/desired health condition) [Holly, 2013]. Quality is the driving force of the internal processes of service institutions, progress indicator, a measure of the competitiveness and efficiency of operations. There are a few reasons for which it is important to provide *healthcare services* at the highest attainable quality: the growth in the responsibility of healthcare units for the people's health included, together with the efficiency in the use of resources, the identification and minimizing of medical events with the simultaneous maximizing of healthcare efficiency, and the improvement in results and also the adjustment of healthcare to the requirements, expectations and needs of the patients [Campbell, Braspenning, Hutchinson, Marshall, 2002]. According to the US National Academy of Sciences *"there are few issues more important in healthcare than its quality" [America's Health in Transition: Pro-tecting and Improving the Quality of Health and Health Care, 1994]*.

Improving the quality of health services, especially in the area of hospital services, is the most serious challenge to the healthcare system [Campbell, Braspenning, Hutchinson, Marshall, 2002]. High health services quality concerned are/should be all the entities of the system – patients, providers, payer and

[35] Dyrektywa Parlamentu Europejskiego i Rady 2011/24/UE z dnia 9 marca 2011 w sprawie stosowania praw pacjentów w transgranicznej opiece zdrowotnej (Dziennik Urzędowy Unii Europejskiej L 88/45).

[36] This part of text has been prepared by A. Rybarczyk-Szwajkowską on the basis of: Healthcare quality management in the province of Łódź, Journal of Health Policy, Insurance and Management (No XIII/III), 2013: 65-78.

government. Standardization of these services increases the safety of the process, but does not always cause positive assessment of patients [Hibner, 2013]. Implementation of healthcare quality management system begins the long process of transformation throughout the organization, which is a hospital. This transformation applies to all employees, implies a change in the culture, habits and behavior, disrupts the existing hierarchy of force in the system [Francois, Peyrin, Touboul, Labarere, Reverdy, Vinck, 2003]. Such changes are necessary to create an organization whose aim is to improve the quality of health services.

Approach to improve the quality should begin with the development of quality management policy, which means that it is necessary to define clear purpose, the introduction of a unequivocal division of responsibilities of employees, and above all increase the involvement and responsibilities of executives, which is the most important factor contributing to the implementation of quality policy [Whitfield, Surowiec, Kautsch, 2001]. It should be emphasized that the manager is both a lens and a prism process of continuous quality improvement. As the lens of the eye, must be able to focus on the specific needs of all stakeholders microenvironment and the prism must be able to cleave specific tasks [Hajdukiewicz, 2003]. The role of manager in accordance with the concept of quality circles Deming – *plan, do, check, act* – fundamentally affects to the quality policy. On its invention depends on choice action to recognize needs and plan changes lead to improving the quality. Choosing ambitious and creative staff, economize resources, not only financial, construction plan of action and make implementations, and evaluation of results are the tasks for which responsibility is managing the facility in the process of quality improvement [Hajdukiewicz, 2003]. In the healthcare environment managers must translate multidimensional definition of quality for individual actions, as a consequence improve the quality of services provided by the hospital in which they work [Lawthers, 1999]. Therefore, it becomes important to know how to understand the quality, define it, selecting and establishing a hierarchy of factors that determine it, which affects the choice of methods/tools to quality management of health services.

The own research, which the aim was to assess the perception of quality of health services by the managers of public hospitals of Lodzkie province and analysis of available data[37] made it possible to predicate the following relationships and/or to make the following findings:

- lack interest of employees of founding authoritiesof the healthcare units (people having management functions in all organizational units, dealing with the health) the subject of healthcare quality, despite the declarations made in the laws/reports/regulations/reports/interviews[38];
- the greatest interest in the quality of health problems observed among the heads of wards in hospitals;
- hospital workers[39] claim that the founding authority of their hospital does not imposed on them an obligation/tried to entice them to introduce activities for the quality improvement of the healthcare services. All employees of founding bodies, who took part in the survey, confirmed the information. *Provincial Program – Strategy of Health Care Policy for Lodzkie Province between 2006 and 2013*[40] is a document, which identifies one of the objectives

[37] Analyzed data from the following websites: the National Health Fund, the Regional Centre for Public Health, Łódź Provincial Office, Central Statistical Office.

[38] For example: ustawa o działalności leczniczej, ustawa o świadczeniach zdrowotnych finansowanych ze środków publicznych, ustawa o refundacji leków, środków spożywczych specjalnego przeznaczenia żywieniowego oraz wyrobów medycznych, ustawa o akredytacji w ochronie zdrowia, National Health Program for 2007-2015, Provincial Program – Strategy of Health Care Policy for Łódź Province between 2006 and 2013; establishment National Center for QualityAssessment in Health Care.

[39] Directors, heads of wards, ward nurses.

[40] Provincial Program – Strategy of Health Care Policy for Province between 2006 and 2013, Attachment to Resolution LIII/886/2006, No. of the Province Diet of 28th March 2006.

of improving the quality of medical services. It can be presumed that the actions leading for that purpose: (1) do not represent factor motivation for managers and/or (2) the managers do not know the contents of the Program and/or (3) have been mis-defined action pro-quality;

- in the opinion of managers of public hospitals on the quality of healthcare services to the greatest extent is influenced by: (1) competence, understood as a component of knowledge (education) and acquired skills (abilities) employed medical staff, (2) the number of medical staff employed by the hospital, (3) financial aspect;
- in the opinion of managers of public hospitals increase financial resources for treatment in hospital in the Lodzkie province by an average of 13% would significantly increase the quality of services;
- in the opinion of managers of public hospitals the offer of healthcare services (their scope and variety) in the Lodzkie province cover the needs of patients an average of 82% and to assess the health needs of the most commonly used socio-demographic parameters such as: (1) age, (2) genetic load, (3) gender;
- there are no statistically significant dependencies between opinion about quality of healthcare services in relation to the professional group (directors, heads of wards, wards nurses, employees of founding authorities of the healthcare);
- lack of conformity in the various professional groups in assessing the ratio of the number of medical staff to the number of treated patients – the directors and employees of founding authorities of the healthcare claimed that the hospital employ an adequate number of medical staff (doctors, nurses) in relation to the number of treated patients, different opinion have ward nurses – most of which claimed that in hospital work too low number of nursing staff;
- for managers working in hospitals subordinate to the Medical University the most important motivating factor is *possibility of development*. The opposite view are people working in hospitals for which the Ministry of Health is forming authority;
- there is a correlation between the type of founding authority the hospital and: (1) the opinion of the atmosphere of the hospital, which makes it an attractive place of work, (2) opinion about the impact of the relationship with line manager to the motivation for greater action in responsibilities performed. Respondents working in hospitals for the Medical University is forming authority responded affirmatively to this question, unlike the respondents working in hospitals for which the Ministry of Health is forming authority;
- the quality of healthcare services is under an impact of, first of all, treatment standards, whereas ISO certificate and CMJ accreditation standards have a lesser importance[41].

The research results further define areas of research related to the topic of quality to which they belong for example: measuring the quality of health care, assessment of quality of health services, the design of the quality management system and its implementation and monitoring. Unfortunately this is not possible if the interest in the quality of healthcare services by persons involved in the management of therapeutic entities will not be backed up by actions, and remains expressed in the declarations on the document.

[41] The relationships and defined proposals represent only a part of the analyzes, the complete and detailed description is a issues of the doctoral dissertation: Rybarczyk-Szwajkowska A., Healthcare Quality Management of the Province of Łódź, wrote under the supervision prof. Romuald Holly and dr Dominika Cichońska.

5.5. Health care benefits' availability[42]

Availability to benefits understood as the criterion for designing the strategy irrespective of the scale (micro, mezo and macro), which is supposed to be implemented, should be always considered in two categories. First one is the possibility of entering the health care system by fulfilling the demand, by the doctor as well as the nurse, depending on the kind of needs. Second criterion of the availability estimation is the possibility of purchasing pharmaceuticals by the consumers, both prescribed and over-the-counter (OTC). Access to OTC drugs does not seem to be a problem, what is proved by the purchase possibility (e.g. analgesic products) in every store regardless its size (from hypermarkets to small neighbourhood shops) and regardless the type of goods offered (groceries, off-licence or even gas stations). Prescribed drugs though are available only in one type of the shop – named pharmacy. Both categories taken into consideration in the availability evaluation and later are used to designing the health care strategy handle with problems impeding the access which are called barriers. Impediments in the access are connected with such aspects as: waiting time, implementation of the contracts with the National Health Fund, gaps in medical staff, information gaps, logistic-geographical barriers (including also concentration of doctors in big urbanized areas), financial and formal-legal barriers. The participation of each barrier is different in various places. That is why asking questions by the regional strategy planning is the most essential conclusion:

– How big is the population?
– What are the population needs?
– How to fulfill them?
– What is the availability (regarding staff and infrastructure)?
– Is it limited and what are the main causes of the limitation?
– If it is unlimited then what to do, considering all barriers mentioned above, to let it be?

The following question is what to do to increase the availability, remembering art. 68 of the Constitution, assuring equal and fair access.

To lead constant and long-term improved availability, to eliminate to the minimum most important and – later – remaining barriers, to monitor permanently the population's health status and availability and to seize the proud first place in the best availability ranking – such a vision seems impossible taking into consideration the heaviness of the problem and the lack of the universal tool which will be checked always and everywhere. The huge commitment from self-government authorities will be required. But this constant, gradual way of improvement will give the best effects for the future, and the wide benefits' availability will project onto a good mark given by the society.

Designing the strategy of the health care and the health policy it is necessary to mainly take on the account such demographic factors as: age, sex, domicile, education, incomes. Very important fact is that each age, socioeconomic, or sexual group has different health needs. Hence the conclusion, that always the health strategy and all action of the health policy should be created basing on demographic data. In order to answer the question what availability in the Lodz province is, one should determine what the population is. There is over 2.5 million of people in the province, including females

[42] This part of text has been prepared by D. Dziurda and T. Posiak on the basis of study of availability to the healthcare products, project on health strategy and health policy for the Lodz region for the period 2014-2020 for the Department of Health Care Policy , Medical University of Lodz. Team responsible for the collecting of the date were composed of following persons: Barbara Dopierała, Paula Szurkowska, Paulina Nowak, Tomasz Posiak and Ewelina Wróbel.
What is important that collecting date for the team took three months, each person was responsible for colecting as many information about health habbits and compliance in each region of Lodzkie province as possible, collecting nearlly 300 questionnaires, that consist necessary information that allowed as to conclude aboute availability to healthcare products.

in 52% of total number. Over 1.6 million of people lives in the urban area[43]. This number includes over 510 thousands – practically 1/5 of the population – is at the age of 65 and more, and 420 thousand constitute the group of inhabitants up to 17 years old. People in an economically productive age are over 1.5 million. Having a reply to the first question we can proceed to determine health needs of the population.

Last year at the Ministry of Health there we works led on a bill about institutions of a health insurance system. The bill was aimed to increase competences of province governors; they will be the ones responsible for establishing health needs in the given province. Why just province governors – since they are keeping a register of curative business units and are gathering the rest of demographic data. Correct estimation of health needs should be based on epidemiological indicators and on their in-depth analysis above all. Unfortunately determining the need will always be on the estimated level, because it is impossible to state how many childbirths in the given year will be or how many people will have appendectomy. The very attempt to determine health needs can be the barrier in the access to benefits (because as every estimated attempt is burdened with the mistake) [Topór-Mądry, 2002].

The Lodzkie province has 69 hospitals, dealing with the health needs. Together they are equipped with 12 931 beds, the rate of a hospital for 10 thousand inhabitants is 51.2, what classifies the Lodzkie province on 3 for place in the country. Used beds amounts to 69%, expressed in days gives the rate of 1 bed filled by 252 days, and the patient spends average 5.2 day at the hospital. Presented supply of hospital beds in the province gives the clear picture that the barrier connected with the waiting time for the hospital treatment in the Lodzkie province is not the main problem. In Lodzkie province there are over 1337 curative entities, registered in the Register of Curative Business Entities led by the province governor. To receive full reply to the question about the availability, the number of doctors working in the Lodzkie province is still needed. The absolute number of working doctors in the province is 10 801, what makes the rate to 10 thousand inhabitants of 42.8 and classifies the province on the 2nd place in the country in terms of accessibility to doctors. There are 3105 dentists working, the rate to 10 thousand inhabitants is 12.3, what gives also the 2nd place in general classification in the country. As recalled at the beginning, the access to the pharmaceutics also influences the availability in the Lodzkie province. There are 2389 pharmacists working, what is the highest number in Poland to 10 thousand inhabitants – 9.5. The number of nurses and midwives working is 23 984 (95/10 thousand) and 3085 (12.2/10 thousand) respectively, what also gives the highest number of working nurses in Poland.[44]

A question should be asked, if there is no problem with the lack of personnel limiting the availability, then what causes so negative opinion of availability by Poles [Pączkowska, 2009]. There can be a lot of reasons, for instance an inborn tendency to complaining, some negative experience from the past, however the most accurate statement seems to be that the society doesn't know where to search for information about the possibility of obtaining of the treatment. The awaiting lists are conducted by every branch of National Health Fund on their web pages, but not everyone, in particular people in the advanced age, are able to use web resources. Therefore a helpline was established where seniors can obtain the answer about the availability. The next question is if the financial barriers in our system are the mainspring. Generally speaking they are, but they do not concern the hospital treatment, but they are the main obstacle in purchasing the pharmaceuticals, However the main barrier in the access to benefits are the very patients which are not-obeying the prevailing principle of the social solidarity, putting self-interests over other which were

[43] Biuletyn Statystyczny Ministerstwa Zdrowia, Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa 2013.

[44] Biuletyn Statystyczny Ministerstwa Zdrowia, Centrum Systemów Informacyjnych Ochrony Zdrowia, Warszawa 2013: 23-25.

before them, enrolling in more than one doctor to the visit within the same week is a general phenomenon. Such behaviour does not facilitate the decisions concerning the strategy and the realistic evaluation of the availability on account of patients of the spectre. So the conclusion is that reforming the health care should begin with the reform of the patient, rather than the system.

6. CONTEXTUAL ISSUES

Regardless of the two leading research trends recommended in this work, one cannot omit some crucial contextual matters, such as the issue of dialectic relationship between a concept and regional policy, and the idea of integrity, convergence and harmonization. Strengthening the relationship seems to be the best way for regions to prevent alienation, toxic influence of separatist and nationalist movements, aggravated by economic crises on the one hand, and on the other, by depreciation of the concept of the country. The idea of a "tiny motherland" should find such an interpretation that would best serve the transformation of EU structures, so that separate modules could be, not only mutually compatible ("cohere", or at least, not interfere), but also to a large extent complementary (i.e. complement and support one another, creating a synergy effect). This can be fully achieved only on a regional level, and particularly pertains to the organization and securing social and health coverage.

It should be stated here that our two-year studies and analyses that induced reflections discussed here, have also led to a negative verification of many calls for better functioning of regional health care, which, despite all hopes, turned out to be futile. The call for rationalization of health care within the region was one of the most disappointing. It turned out that the concept of rationalization will be just a complementary notion. All policies seem to express and execute particular interests, which are seldom rationally justified, or are a result of unbiased reasoning. Moreover, any project, regardless of how rational it is, first refers to some values and resulting goals and objectives. Only later, does it involve logic, in order to prove the objectives and devise methods of effective implementation. On the other hand, understanding values is always a result of their interpretation motivated by particular interests. Therefore, it seems difficult to talk about an entirely "neutral" rationalization of political activity. However, actions conducted in correlation with praxeological guidelines, as well as the "good job" procedure, regarded as a process of achieving particular goals, may be perceived as politically neutral. This may occur, however, only when the goal itself is politically neutral. In social activity it is rarely neutral, though. Similarly to a machine gun, which is itself, neither good nor bad, but can be used for a good or bad cause.

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