# Doctors as „poverty managers” in Poland’s health care system

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## Intro

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First: an apology. Initially, I intended to conduct a pilot study with junior doctors. The Covid-19 pandemic affected both my research plans and, more importantly, the social reality I wanted to look into. While I remain convinced that my questions regarding the lived experience of economisation are still relevant, they would now be detached from the immediate preoccupations with crisis management.

Thus, I decided to postpone the research phase and present instead my questions, hypotheses and conceptual reference points.

## Abstract

Since 1998, a series of reforms was introduced in Poland's health care system, ostensibly aiming to prevent profligacy and secure quality care for patients. The economisation, however, failed to deliver on its promise. In the context of persistently underfunded and understaffed public health care system, hospital management do increasingly become „poverty managers,” burdened with the task of balancing between conflicting medical and financial expectations. Some researchers went as far as framing this as a situation where a „financial diagnosis” precedes, and sometimes even replaces the medical one (Charkiewicz 2009). A series of practices of resourcefulness have beeen reported aiming at improving the financial condition of hospitals while maintaining their basic function of providing care. They range from clearly unethical conducts (unnecessary hysteroscopy) through ambiguous ones (keeping patients in beds over the weekend) to apparently benign ones (diagnosis optimisation).

My aim in this paper is to explore the perception and everyday attempts to resolve such dilemmas on the part of junior doctors. I will do it with a series of IDIs. The choice of junior doctors as my group of respondents is based on the hypothesis that this one of few categories within the system that combines genuine on-the-ground knowledge of its workings with the critical gaze of a newcomer. This is also one of few categories of health care employees whose protests combine short-term demands based on self-interest with long-term demands based on a vision of public good.

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## The promise and failures of economisation

The promise of economisation:

to provide good medical care for less money, preventing systemic profligacy and giving value for taxpayers’ money.

The actually existing economisation:

→ the system ignores "the extent to which the course of disease and the behavior of patients and health professionals are governed by noneconomic factors" (Mechanic 1990)

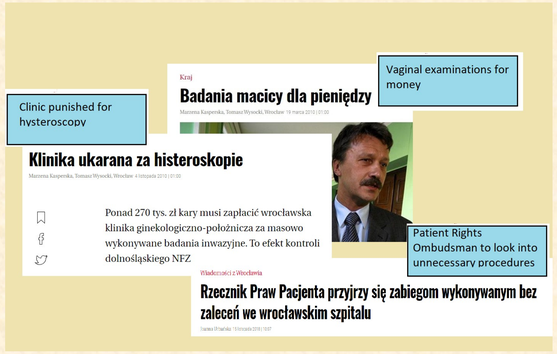
→ "financial diagnosis" precedes, and sometimes even replaces medical diagnosis (Charkiewicz 2009)

**Frugality failures?**

| Cost-saving measures… | …and (some of) their impacts |
|---|---|
| Competitive procurement | Unnecessary equipment acquired to fulfill requirements |
| Caps on procedures | Equipment staying idle for some part of every year |
| GPs as gatekeepers | Late diagnoses, high rate of hospitalisation |
| Postponed hospitalisation | Less efficient and more costly therapies, higher risk for patients |
| Outsourcing services (medical & other) | Lower quality, more iatrogenic diseases |
| Junk contracts for nurses, opt-outs for doctors | Lower quality, more iatrogenic diseases |
| Private providers competing with public ones | „Creaming” |
| Fee-for-service | Unnecessary procedures |
| Diagnosis-related groups | Keeping patients hospitalised over the weekend, „diagnosis optimisation” |

## Adaptive resourcefulness: a case

*„He came once to the staff meeting and said that we were in the red. He told us to make histeroscopy before every planned operation. And so it began”...*




In 2007, in a hospital in Wrocław approx. 1000 hysteroscopy examinations were conducted, most of them without any medical need. At the time, hysteroscopy enjoyed attractive pricing.The hospital was subsequently punished, and the use of **fee-for-service** was limited.

In 2008, **diagnosis-related groups (DRGs)** were introduced to decide how much a hospital should be paid for the services provided to a patient. The idea was to calculate, on empirical basis, the adequate levels of payment and prevent unnecessary procedures.
As a result:

- hospitals tend to keep well-priced patients over the weekend without doing any procedures;
- a market for the IT enabling „diagnosis optimisation” emerged.

## Are doctors in public health care „poverty managers”?

The concept of **„poverty management”** was first introduced in feminist sociology to give a fair account of work done mostly by women in poor household simply to get by. Instead of blaming the poor for their alleged „lack” of management skills it shed light on the many skills needed to survive.

Can this concept be useful for understanding actions of doctors in persistently underfunded and understaffed public health care?

## Frugality failures – what’s the point?

While various cost-saving measures adopted since 1998 have never stopped to disappoint, they are consistently pursued by decision makers? Is it a case of what Raymond Boudon called **„adverse effect”**, or is there a hidden agenda, better grasped through the lenses of David Harvey’s concept of the **„accumulation by dispossession”**?

## What moral economy for the health care?

While health care system designers neglect the **„moral economy”** of health care services, but still resort to moral panic whenever adaptive resoursefullness of health care providers leads to some unexpected consequences, what is the actual moral economy of the heatlth care and how is it changing?