Contextual determinants of cooperation between Poland and European Union in process of health policy making

Kontekstualne determinanty współpracy pomiędzy Polską i Unią Europejską w procesie tworzenia polityki zdrowotnej

Kinga Zdunek, Teresa Kulik

Katedra Zdrowia Publicznego, Uniwersytet Medyczny w Lublinie

Wprowadzenie. Polityka zdrowotna nie jest tworzona w izolacji. Kształtuje się pod wpływem wielu zróżnicowanych determinantów. Pomimo tego, że współpraca pomiędzy Polską a Unią Europejską jest wysoce sformalizowana istotną rolę odgrywają czynniki społeczno-kulturowe.

Cel. Identyfikacja i analiza kontekstualnych determinantów współpracy pomiędzy Polską i UE.

Materiały i metody. W badaniach wykorzystano konstruktywistyczną metodologię teorii ugruntowanej wg K. Charmaz. Aby osiągnąć zamierzony cel przeprowadzono 25 wywiadów swobodnych z zestandaryzowaną listą poszukiwanych informacji wśród polskich ekspertów delegowanych do reprezentowania Polski w gremiach unijnych. Zastosowano celowy dobór próby z elementami kuli śnieżnej. Przeprowadzone wywiady miały charakter kontekstualny i negocjacyjny, dlatego początkowo uzyskiwane odpowiedzi wyznaczały kierunek dalszej rozmowy. Wywiady przeprowadzono w 2010 r. i uzupełniono w latach 2011-2012.

Wyniki. Na postawie przeprowadzonych analiz zaobserwowano, że kontekstualne determinanty w procesie tworzenia polityki zdrowotnej miały charakter systemowy i społeczno-kulturowy. Wśród tych pierwszych wyróżniono czynniki organizacyjne i prawne, podczas gdy w drugiej wskazano na znaczenie kontaktów nieformalnych, grup interesu, a także wpływu mediów oraz aktywność pacjentów i konsumentów.

Wnioski. Sieć stosunków nieformalnych znacząco wpływa na efektywność współpracy pomiędzy Polską i UE, podczas gdy aktywność indywidualnych pacjentów i konsumentów wydaje się mieć najmniej zauważalny wpływ.

Słowa kluczowe: *polityka zdrowotna, kontekst, determinanty, polska, Unia Europejska*

Introduction. Health policy is not made in isolation. It remains under the impact of various determinants. Despite the fact that the cooperation between Poland and the European Union is strongly formalized, an important role is played by sociocultural factors when making health policy.

Aim. To identify and analyze contextual determinants of cooperation between Poland and the European Union in the health matters.

Material & Method. In the research process the constructivist grounded theory approach by K. Charmaz was used. To achieve the main aim we conducted 25 semi-structured interviews with Polish experts representing Poland at expert UE bodies. Purposive sampling with elements of snowball sampling was used. The interviews were of contextual and negotiative character what means that the initial replies directed the further framework of questions during the interview. Interviews were carried out in 2010 and complemented between 2011 and 2012.

Results. Based on the analysis, we observed that in the process of health policy making the contextual determinants were of systemic and sociocultural character. The former group consists of legal and organizational factors, while the latter concerns elements such as: informal relationships, stakeholders and media impact as well as patients' and consumers' actions.

Conclusion. The network of informal relationships significantly affects the effectiveness of cooperation while individual patients and consumers has the least noticeable impact.

Key words: *health policy, context, determinants, Poland, European Union*

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Adres do korespondencji / Address for correspondence
dr Kinga Zdunek
Katedra Zdrowia Publicznego, Uniwersytet Medyczny w Lublinie
ul. Chodźki 1, 20-093 Lublin
tel. +48 81448 6720, e-mail: kinga.zdunek@umlub.pl

Introduction

Health policy is not made in isolation. It remains under the impact of various determinants. Walt and Gilson [1] proposed to consider the process of health policy making through the analysis of actors, context, policy making process and content. This seemingly simplified approach indicates how the complex set of inter-relationships determine the health policy style. The actors remain under the impact of context in which they act, the context is influenced by history, culture and ideology, the policy making process is affected by actors, their position in power structures, their own values and expectations and the content of policy reflects some or all of these dimensions [2].

The context of policy making is changing [3]. 'The policy environment is increasingly populated by a complex of cross-border, inter-organizational and network relationships, with policies influenced by global as well as by domestic actions' [4]. Postmodernist reality together with the technological improvements has facilitated significantly 'communications and relationships, both between government and their advisers as well as between many networks of actors outside of government' [4]. The role of consumer organizations, NGOs and other non-political actors grows in the process of agenda setting and in monitoring the implementation of treaties [3].

'Activation' of health policy environment in Poland increases with the regional integration process. Although the impact of the European integration on national healthcare systems has been an increasingly analyzed phenomenon, still very little is known about how the European Union (EU) interacts with health policy and politics of member states [5].

To understand the contextual determinants of the cooperation between Poland and EU in the process of making health policy, it is necessary to concentrate on the systemic and socio-cultural dimensions. Addressing the process of health policy making will require understanding the changing context of policy making and analyzing the health policy environment.

In the present work we display a set of correlations which play an important role in the cooperation between Poland and EU in the field of health. An excessively formalized negotiation path can cause poor control over the outcome. Thus we decided to identify and analyze contextual determinants of cooperation between Poland and EU to inform health policy actors and initiate the discussion on the non-political determinants of the process of health policy making.

Aim

To identify and analyze the contextual determinants of cooperation between Poland and EU in the field of health policy making.

Material and method

Inspired by the constructivist Kathy Charmaz' [6] approach, in the conducted research we applied the qualitative methodology of grounded theory. This inductive perspective is a modified version of the classical, also known as positivist grounded theory created in the 1960s by sociologists Glaser and Strauss [7]. To choose such an approach was justified by the absence of extensive research studies on the impact of the EU on the Polish health policy. 'This constructivist approach allows the application of the method of the consolidated theory in the study of a variety of analytical and substantive problems'[6] and helps in the pursuit of 'a variety of emergent purposes of analysis and focusing on emerging issues' [6]. Choosing such a methodology minimizes the risk of preconceptive exposure of category and allows the spontaneous emergence of important processes, of which the researcher might have been previously unaware. In accordance with Charmaz's conception of grounded theory: a. qualitative data is collected to develop theoretical analyses from the beginning of a project, b. constant comparative method is used where comparisons are made during each stage of the analysis, and c. theories/hypotheses are developed inductively rather than constructed based on existing theories. The conducted research had an exploratory character.

The objective of the conducted research was to identify and analyze contextual determinants of cooperation between Poland and EU within the health policy field. For this purpose we conducted 25 semi-structured interviews with active Polish experts representing Poland at expert UE bodies, such as working groups and the comitology committees of European Commission, preparatory bodies of the Council and Agencies which activities are linked with health issues. The experts were identified via the consultation with the competent governmental authorities who gave permission for conducting the research in the governmental institutions. The respondents specialized in the fields of public health and healthcare systems. An informed consent was obtained from each respondent.

Purposive sampling with elements of snowball sampling was used. The interview questions framework relied on the strengths, weaknesses, opportunities and threats of cooperation between Poland and the EU in the field of health. The interviews were of contextual and negotiative character what means that the initial replies indicated the sequel to the interview. The interviews were carried out in 2010 and complemented between 2011 and 2012.

In accordance with the chosen methodological path the inductive approach was applied. As a consequence the hypotheses were grounded in data and emerged at the end of the research process. With this in mind we adopted the following research stages: a. collecting data by conducting in-depth interviews of contextual and negotiative character, b. conceptualizing data and classifying transcribed text in accordance with the applied methodological approach, what is linked with the identification of emerging processes and determinants of the cooperation between Poland and EU in health matters, c. categorizing collected information using appropriate software, d. coding by applying analytical techniques such as constant comparison of identified processes, e. constructing theory as integrated package of hypotheses.

We registered the material in a 16-hour recording. After making the transcripts, the project team obtained 349 pages of text, which constituted about 750 thousand characters. We collated the material by the use of the NVivo7 program for the qualitative data analysis.

Results

Our data revealed that contextual determinants of cooperation between Poland and EU in health matters were of sociocultural and systemic character. We observed that the sociocultural aspects consisted of elements such as informal networking, stakeholders actions, media impacts and patients' and consumers' attitudes, whereas the systemic ones covered coordination and organization of the cooperation as well as legislative and systemic solutions. In the following work the elements/categories and our findings are explained.

Informal networking

In our study informal networking emerged as a strong channel of impact for the process of health policy making jointly with EU. We observed two types of such: a. informal contacts between representatives of member states and b. working and semi-formal contacts between representatives of member states and representatives of EU.

As we noted such networking facilitates access to practical information which was not easily available and enables to support the group formation. The differentiation between informal and unofficial contacts was made in relation to the level of fraternization. Informality expressed a higher level of fraternization in comparison with unofficial contacts. The respondent stated that: "*sometimes, before the meeting I am receiving the instructions from my bosses to ask, to talk with representatives of particular countries how they solved particular problems, which are important for our department… some instructions e.g., how to prepare for and manage in crisis. And/or they indicate particular countries, e.g.: how Lithuania, Latvia, Germany, Czech Republic… or more general: to collect as much data as I can about particular topic, from all member states*" [expert in crisis management].

The role of networking was highlighted by an interviewee who claimed that: "*sometimes when we receive the EU document, which we have to consult, I write [an] email to my friend from Spain. I ask: Have you seen that? What do you think about that? What is your opinion about that issue. My idea is that…*" [expert in public health]. "*And sometimes, it is worth to discuss in advance the stand with other partners… to make the comments be repetitive. Then, the chances that EU is going to consider them as important increase. Well… if not only one country, but two, three or more member states are proposing similar remark…*" [expert in public health]. The chance to force through the decision is increasing when it is supported by the representatives of other member states. The informal networking was mentioned as a tool which facilitates the cooperation.

The respondents expressed difficulty in working contacts between them and the representatives of the EU institutions as the consequence of lack of considerable experience interpreted as kind of 'multinational work literacy'. Such attitude can be proven by the following opinion: "*We all are only people and we are not always able to express properly in [a] written way, although we should clearly present our stance in writing… Even if it was not successful we should investigate who in [the] Commission is responsible for that particular issue and call, and talk about what exactly do they need, what they expect on next stage, which explanations are necessary… Please, don't get me wrong, I don't mean any pressures such as: Please do not write this in the opinion…*" [expert in international cooperation].

Lightness of the cooperation affects the negotiation path as well as the coordination of the implementation: "*if the person doesn't work in an international environment on regular basis, he or she might have a barrier to communicate by phone, or to call and talk with someone imagined in' this' Brussels, who is working there…nevertheless there is real person, who prepares the opinion for Commission…*" [expert in international cooperation].

Stakeholders actions

In accordance with our analysis the stakeholders actions in the process of health policy making might inspire for change or provoke withdrawal of actions by using 3 types of instruments: a. lobbying, b. defending, and c. supporting.

Lobbying by presenting the products proves that: "*institutions… have a strong position and they are also there presenting their observation, their works… and they can also influence the decisions of experts… They are invited to the meeting and they are presenting their results. They may be familiarized with the national experts opinions and take part in the discussion, but they are excluded from the concluding phase*" [expert in foodstuffs].

When at the EU level the system of categorization of foodstuffs was created, the National Union of Producers of Juices was persuading to include additional products on the list. They were defending the national products. "*For example on that list only the fruit nectar was included. And they, they were insisting to include on the list both fruit and vegetable nectar. This product is very popular on the Polish market, while in the European Union it does not exist. And finally they succeed. The Commission added to the list the nectar made of fruits and vegetables*" [expert in food additives].

The remarks of the industry sector are not always rejected. In many cases, while having strong logical justification, they support the experts as they might be considered as the source of the high level of expert opinion. That was the case of searching common solutions for in the ground of pharmaceuticals. "*Veterinary medical products often are produced in huge packaging. For example: plasma substitutes. They were also packed in quite big containers, and then, when it was coming to the topic of archive samples… it was necessary to provide facilities big enough where those products could be stored for appropriate period of time… Well… The representatives of industry noticed that, and we discussed this issue seriously… Finally all member states decided to accede to industry representatives request and reduce the size of archived samples*" [expert in pharmaceutical inspections].

Coordination and organization

We interpreted coordination and organization procedures by reference to: a. transfer of both knowledge and data between experts itself as well as between experts and decision makers, b. appropriate communication, and c. the level of experience.

With this in mind we concluded that proper coordination helps to avoid controversial debates, thus might be considered as the guardian of the cooperation at institutional level. Transfer of ideas and knowledge, contact with what is happening and relatively regular access to data, which is not easily available help to avoid so called 'first-born mistakes'. "*Thanks to participation in experts groups we got the information from states which had already built the strategy and knew what solutions should be avoided. It is the matter of details such as equipment. What is better? Which tent? Pneumatic or with the aluminum frame?*" [expert in crisis management]. In the respondent opinion the knowledge exchange refers to "*… procedures and way of thinking and doing things in relation to strengthening the number of beds* (in the situation of crisis) *when there is insufficient infrastructure... Now we discuss what to do to be able to help more people in the next 1 or 3 days, especially patients who suffer from traumatic, surgical or toxicological conditions… I am not suddenly asking about very confidential information, but for example how do they organize the support for people with communicable diseases which are particularly difficult to be treated*" [expert in crisis management].

We considered issues of appropriate communication and the level of experience as supplementary. Our data demonstrate that communication channels were often disturbed by notional fuzziness which can be the consequence of linguistic abilities of an expert. This supported by insufficient knowledge of English can affect significantly the way health policy is made. "*Poland, very often, like many other countries did not take part actively in some discussions… We are here only some years, too short… we do not feel so comfortably at the EU level… There is also the need to know English quite well…*" [expert in pharmaceutical policy]. Moreover our data revealed a communication and organizational gap between experts and decision makers. "*Between national experts and decision makers there are many levels. Sometimes I have the feeling that my report, with highlighted need of change in particular issue or recommendation for action or preparation any legislative act, is lost in the office of the decision maker…*" [expert in environmental food contamination]. From a technical point some respondents claimed that "*there should be more people who are taking part in such meetings. Usually one person is participating in 2 or 3 meetings which can take place parallel*" [expert in nutritional toxicology] but also stressed that "*… even though we are young member state we are already finishing the phase of studying… obtaining new experiences is a great process because we can see how others are maintaining, we can study and make conclusions*" [expert in pharmaceutical policy].

Media

The role of media in the process of health policy making is bilateral. On the one side they can hasten the process, on the other side, slow it down. "*Polish and European media are interested in slightly different issues. Look into the newspaper… how much they were writing about the flu before. It does not mean that the problem does not exist now, it is, and soon it will come back…*" [expert in public health]. Media in accordance with the respondents' opinions are the driver of action. They demonstrated intensive activity "*during the debate about the possibility of introducing new law on plain unbranded cigarette packaging. Informal declaration of Poland on considering the possibility of introduction of new law from political point of view was not binding, nevertheless political and propaganda noise was significant*" [expert in public health]. Our data show that Polish media by its lack of interest may contribute to the passive scheme of health policy making. That was the case when at the EU level the issue of food additives was discussed. "*This topic was in UK on the front page, highlighted, it was main news in all media, in newspapers and TV. In Poland it was written in small print, it went unnoticed… Research which is so important was ignored by Polish media. In UK there was a special meeting on the national level, debates, how to solve the problem, and in Poland it went unnoticed…*" [expert in food additives].

Legislation and system

The determinants of meaningful importance in opinions of respondents were legislative and systemic measures applicable on the Polish ground. At this point

it is appropriate to invoke the case of the purchase of the vaccine against pandemic flu. Poland was opposed to the rules of the transaction, as in accordance with Polish law they were illegal. "*The difference between Poland and other countries was the result of the fact that Poland wanted the vaccine to be available in pharmacies for patients who want to buy the vaccine in accordance with the doctor's orders. Other countries had a slightly different system, that is why they did not understand what it meant to make the vaccine available in the so called – free circulation – wolny obrót*" [expert in crisis management].

The systemic differences were exemplified by reference to the European law on cross-border healthcare, in accordance with the article 168 in the Treaty on the Functioning of the EU [8]. The Union action shall respect the responsibilities of the Member States for the definition of its health policy and for the organization and delivery of health services and medical care. The Polish stand was that the so-called 'patients' rights directive' infringes on the autonomy of Poland in the organization and delivery of health services and medical care. "*A bone of contention was if the directive will regulate the right of reimbursement of the costs of treatment sought abroad in public and non-public provider. Poland did not want to support the measures, which are opposed to the organization of the Polish health system. Poland had to raise an objection to those proposals, as the Polish system is based on two types of providers: those who have contracted the services with the national payer and those who have not*" [expert in health insurance].

Patient & consumer attitudes

Amongst all of the channels of impact on the process of health policy making the impact of the patient and consumer was least noticeable. The interests of patients are represented mainly by institutionally formalized stakeholders. One of such was the Federation for Woman Family Planning (FEDERA) which claimed that the 'patients' rights directive' would facilitate the access to abortion for Polish woman. In their opinion it was limited by the fact that Polish doctors often rejected the service in reference to the conscience clause [9]. Abortion services in Poland are prohibited except for the following conditions: a. threat for mother's life, b. fetus' malformation c. 'the pregnancy is a result of a criminal act with the proviso that it does not exceed the 12th week of pregnancy'. The representatives of the Federation stressed that in reality the doctors on purpose are 'extending the time of procedures, what blocks access to abortion, even in cases where it is legally allowed'[10].

The patients' rights were defended by the Polish Chamber of Physicians and Dentists as well. In the open letter directed to Donald Tusk – the then Prime Minister of Poland – they were calling on adaptation of health services to „patients' rights directive' referring to the patients' rights [11].

Discussion

The health policy environment is constantly changing and it affects the way health policy is made. The changes are accompanied by the process of reconfiguration of powers what may lead to paradigm alterations. Such shifts are supported by: a. the process of proliferation of actors involved in the inter-organizational activities on health matters, b. the emergence of contextual drivers playing the important role in the theatre of health policy. On the one side an increased role of stakeholders is noticeable, media shapes the policy and often steers the behavior of 'empowered' patients and consumers. On the other side, the increased role of drivers such as informal networks, legislative and systemic context as well as coordinative and organizational procedures affects the health policy styles.

The increased importance of networking might be considered as a step in reshaping the way health policy is made. The influence of informal networking at the EU level was stressed by Hajer and Wagenaar. By reference to Wallace they pointed out that 'specialists have characterized EU as an experiment in finding alternative forms for developing public policy' [12]. Lundberg said that 'public media are irreplaceable as a mechanism for moving a problem to a solution'. Otten highlighted that 'policymakers get their first information on a problem or its urgency from the press – even if the press is not itself digging up the information but simply conveying it from an advocacy group, a research organization, or the general public' [13]. Baeten pointed the role of stakeholder groups which are using the EU measures to push for the realization of their aspirations [5].

Although in the literature on the subject some attention was given to the determinants analyzed above, still very little is known about the inter-relationships between them in different contexts. Therefore we would like to propose to consider the observed elements which influence the process of health policy making in the Europeanized reality as the pyramid of contextual determinants. Such structure depicts the intensity of each determinant. We proposed the triangle where the top layer means the "least" weighty determinant based on the analysis of the intensity of determinants emerging during each interview. It broadcasts the hierarchical relationship among the concepts. A different background is reflected by the geographical localization, socio-cultural environment and political situation. With this in mind we would like to propose the structure of a pyramid illustrating the determinants of the process of health policy making jointly with EU for Poland which consists of elements such as: informal networking, stakeholders,

coordination and organization, system and law, media and patient and consumer actions (Fig. 1).

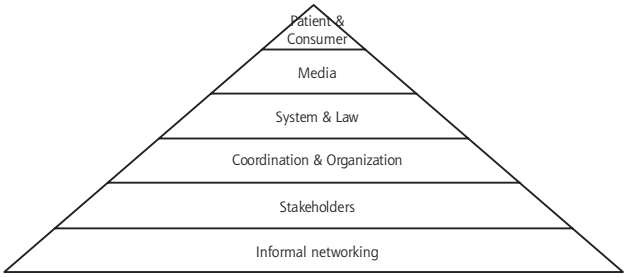

Fig. 1. Determinants of process of health policy making in Europeanized reality

Conclusion

Based on the results of our analysis, we concluded that the process of health policy making jointly with EU is influenced by a range of formal and informal factors. Amongst all contextual determinants the least mentioned by respondents were attitudes of patient & consumer and the most often – the network of informal relationships, as it was barely mentioned during conducted interviews. Our study provides the insights into the cooperation between Poland and EU on the field of health by demonstrating the shape of the pyramid of contextual determinants. An identified set of correlations provides diagnosis of mechanisms which influence the process. The key points emerging from our data can be defined as following:

- The process of health policy making in cooperation with EU is determined by a range of factors.
- One of the most influential ones is context.
- In the process of the Europeanisation the contextual determinants were of systemic and sociocultural character.
- The structure of the pyramid of context might vary due to different socio-cultural and systemic infrastructure.

Additionally in the Polish case:

- One of the strongest contextual determinants of the process was informal relationships.
- The patient and consumer were the least involved parties in the process of health policy making.
- The network of informal relationships affects the effectiveness of cooperation.
- International experience of an expert as well as their qualifications determine the quality of the cooperation.

Further steps and practical implications

With this in mind we diagnosed further steps. The newly structured contextual determinants of cooperation between Poland and EU needs to be analyzed more in depth in order to characterize the direction of potential influence. Particularly it remains to be shown how the network of informal relationships can shape the tendencies in the process of health policy making jointly with EU.

An extended analysis should be conducted in the field of media and stakeholders impact. Knowledge about the mechanisms which control different ways of response to the EU measures will make the cooperation more effective and efficient. Our analysis leads to the conclusion that it is needed to reinterpret the position and involvement of the patient and consumer in the process. Their limited interest in the European issues is worrying and brings the risk of policy separated from the needs of population.

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