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What's next for healthcare in Poland: diagnosis and prognosis

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Introduction

The health protection system is the object of constant pressures and difficulties in mitigating them, and even more so eliminating or at least reducing them. Changes are undertaken under the influence of a one-sided political assessment, the interests of various groups of participants or the protests of successive groups of medical staff. There is no professional and fully documented diagnosis of the system, made by independent experts, which could serve as the basis for a comprehensive health protection reform plan, rather than individual, incidental changes that disrupt the system's already very fragile balance. A well thought-out reform, properly distributed over time, so that at no point does it cause negative health effects. A reform agreed among stake-holders and adopted with understanding of the need for changes, so that it is supported by society. A reform for which there will be funds, institutions and engaged professionals – leaders in health protection. A reform that won't be criticized or changed when the government changes. Such a reform is waiting to be presented and debated. We begin this process by pointing out and presenting the system's main problems.

At the top of the list of issues that must be taken up urgently we place the problem of insufficient resources, but associated with other activities that are essential to achieve higher effectiveness in accomplishing health goals. There is no single miraculous way of balancing and fixing the functioning of the health protection system. This requires both greater financing, qualitatively and quantitatively appropriate staffing, and good institutions. Financial resources are a necessary condition but not a sufficient one – if there is no staff or appropriate institutions, and these are shaped over years.

In this document we present to you four subjects,[1] corresponding to that list of the main issues that must be addressed urgently. We begin with the problem of good governance, meaning achieving a decisive improvement in institutional solutions in health protection. Next we take up the problem of the need for growth in financial outlays, with judicious public and individual responsibility. We strongly accent the need for development in Poland of medical and support staff, presenting the problems of neglect and the deep shortage of professionals, which is currently paralyzing the health service. The final text, though no less important in the group of priority problems in health protection, concerns public health and demands that it be properly valued by treating care for the health of the population as an investment in human capital with a measurable and significant rate of return.

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1 These topics were the subject of presentations and discussion at the mBank-CASE Seminar on May 24 2018. A decade earlier, a similar event was held as part of the BRE-CASE Seminars. The problems presented and the assessments were similar, which demonstrates that over 10 years, little or no improvement has been achieved in the health protection system.

Chapter 1

Stanisława Golinowska

What next for the health system in Poland? Diagnosing the problem, governance in healthcare and reforming the system

Introduction

For many years, the health system in Poland has been the subject of concern and suggestions for improvement. Various concepts of change "for the better" are suggested by a broad range of experts, but for a long time nobody has been working on comprehensive reforms, no improvement programs are being prepared,[1] and the problems are increasing dramatically. They include greatly insufficient resources: personnel, financial and organizational, and poor governance of the health sector.

In this introduction I will address the problem of how institutions operate in the health sector from the point of view of assessing the quality of governance. I will begin with a small glossary, for the purpose of better communication with readers. Then I will address the onditions for a proper diagnosis of the situation in the healthcare system, so that the eternal disputes on "data accuracy" give way to solutions: whether and how to change the situation. A significant portion of the text is a subchapter on the need for the kind of institutions that are prerequisites for good governance. In the final portion I review the reforms being conducted and present recommendations for the directions and priorities of further action. In reforming the health system there is no need for revolutions that destroy institutions; rather, we need improvements and development of what is effective but sometimes has been done too late or incompletely. We need to add the missing bricks to projects that have already been started and introduce new, innovative solutions where they can deliver benefits – both for the healthcare system and for its individual participants.

1.1. Basic categories

In discussions on subjects related to the performance of health activities , various general categories are used to describe the subject we are discussing, such as: , the health system, healthcare, public health, health protection and the health sector. Works on the organization of the health system and health economics (e.g. Wojtczak, 2009 and 2017; Golinowska, 2014) propose maintaining a uniform standard in using concepts, for fuller understanding in interdisciplinary works and discussions. For this reason I will begin with a basic glossary, so that we move from discussing concepts to applying them in good communication, particularly in this discussion.

The healthcare system – the broadest category – comprises the organizational and institutional structure through which an economy makes choices regarding the production, consumption, and distribution of healthcare services.

Healthcare – services of healthcare professionals and their agents, which are aimed at: (1) health promotion; (2) prevention of illnesses and injury; (3) monitoring of health; (4) maintenance of health; and (5) treatment of disease, disorders, and injuries in order to obtain cure or, failing that, optimum comfort and function (quality of life).

1 The document titled *Narodowa Służba Zdrowia. Strategia zmian w systemie ochrony zdrowia w Polsce* (*The National Health Service: A Strategy for changes in the health protection system in Polan*d, Health Ministry, 2016 http://www.mz.gov.pl/wp-content/) does not meet the requirements of a document based on factual justification of reasons for changes and their relation to improved health; doesn't meet the demographic-epidemiological challenges of the immediate future or address the diagnosed failings; and does not meet the requirement of comprehensiveness. It is a version of a political document, used in the election campaign of the victorious party in 2015, in which goals of centralization and of strengthening control over operations in the health sector predominated.

The first and dominant part of healthcare is **treatment**, which requires identification of diseases, applying the appropriate therapies, as well as rehabilitation for the purpose of achieving the required level of well-being.

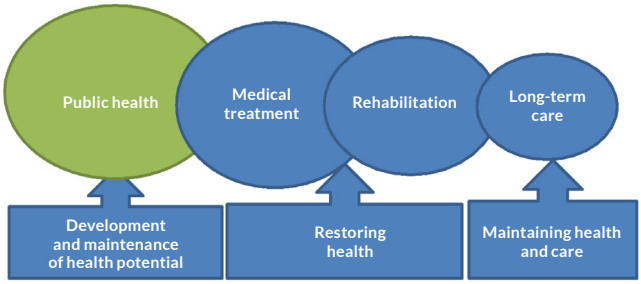
An inseparable part of the treatment process is **rehabilitation**. This consists in restoring functionality after a period of disease and therapy. It is also significant as an action maintaining health in the chronically ill, who are not the objects of urgent medical intervention. Restoring functionality is the healthcare goal that determines its effectiveness, including cost effectiveness, because it restores the ability to work and obviates the need for disability payments.

Achieving civilizational progress of humanity in the form of extending life also leads to a situation in which longer life includes a loss of independence. It requires care, sometimes nursing care if it is related to a chronic illness, or more often with the simultaneous appearance of multimorbidity. Traditionally, the period of lost independence was spent in the family, which ensured care. Today, as a result of changes in the family model and the mobility of family members, it performs the functions of care for older individuals to an increasing limited degree. In the countries with the fastest-aging populations and high levels of modernization of social processes, institutional solutions have arisen that support care for dependent older people. A new sector has emerged: long-term care (LTC), constituting a new branch of the welfare state. This is not always a separate sector; in some countries it is part of the health sector (more often), and in others the social sector.

The significance of **public health** is growing in today's world. As an activity institutionally separate from medical treatment, it emerged in the 19th century along with the development of hygiene for the prevention of infection. Over time, public health activities took control of the threats to health in workplaces, homes and other places where groups gather. Along with the change in trend in the frequency of the major diseases – from infectious diseases to chronic non-communicable diseases known as civilizational diseases – the fundamental activity of public health has become health promotion with health education and primary prevention, directed at limiting the health risk that lies both in health behaviors and in people's living conditions. This direction was officially begun by the Ottawa Charter for Health Promotion (1986). The modern concept of public health thus stresses a healthy lifestyle, countering so-called health risks (smoking tobacco, excessive alcohol use, use of psychotropic substances, sedentary lifestyles, obesity etc.) and good, equal living conditions as the basic determinants of health.

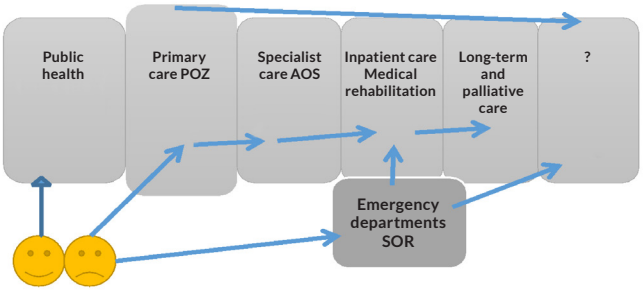
The following figure breaks down the four main actions in the health system.

Figure 1: Main areas of the health system's activity



In the practice of managing **health services**, the term the health sector is used, which covers a set of functions and the institutions that carry them out. This set of institutions is called the health sector, analogous to the education or social sector. The institutional subsets, distinguished based on the organization of health functions, is presented in the following figure.

Figure 2: The health sector and its subsectors



Actions within the health sector are carried out on various levels. At the macro level, the sector is related to other sectors in the context of general macroeconomic categories: GDP, public spending, the labor market (supply of and demand for labor). Sectoral activities encompassing the entirety of health services are the subject of coordinated action by all institutions – those that are organized both vertically and horizontally. We call such actions governance. The micro approach, encompassing the functioning of health service units (facilities) is the object of management .

1.2. Diagnosis

For a doctor it is obvious that any treatment requires diagnosis, and today diagnosis is significantly more comprehensive thanks to new technologies. Meanwhile, when the same doctor becomes the minister of health, or heads a group appointed to reform the health system, most often they do not start from a solid, comprehensive diagnosis of the health system, which of course is complicated. Often they adopt purely political theses, sometimes ideological ones, becoming the defenders of a particular professional group's interests, or influencing the state's financial goals, which in Poland did not sufficiently consider the goal of a healthy population.

The lack of a comprehensive diagnosis of the health system's performance is explained (justified) by the difficulty of making one. In contrast to the obvious approach of basing medical decisions on confirmed facts, in relation to health policy this is incomparably more difficult. Examinations of healthcare activities concern the health of the population, and not medical cases; they take into account the social and regulatory context in which certain situations arise; they require multidisciplinary research teams and a great deal of mass information and statistical analysis. Generalizations concerning the reasons for the appearance of one kind of health outcome or another are thus weighed down by uncertainty and lack of clarity. Overcoming these difficulties requires the proper resources providing support in the area of information and research, which in many countries are an important factor in decisionmaking, described as evidence-based health policy (Dobrow et al, 2004). Such resources have various institutional forms. They include research institutes focused on policy-oriented applied research, think tanks and ad hoc working groups. The reports known from the NHS in the UK and for the Dutch governments conducting health reforms were prepared by specially appointed working groups.[2]

Neither the government nor the health ministry in Poland has the resources it needs to develop and present a comprehensive diagnosis (with prognoses) of the situation in the health system.[3] In this case the question is not information and analysis of an epidemiological situation. This aspect of diagnosis, thanks to the work and analysis conducted e.g. in the National Institute of Public Health – National Institute of Hygiene (NIZP-PZH) and Main Statistical Office (GUS) is more accessible than the financial-organizational one. Descriptions of the financial situation of Poland's health system that are truly more comprehensive have been created, e.g. the Green Paper on Health Protection Financing (Zielona Księga Finansowania Ochrony Zdrowia) and National Health Accounts (Narodowe Rachunki Zdrowia), as well as changes in its organizational design, e.g. the reports from the Health Systems in Transition (HIT) analysis-promoted by the WHO. But they do not constitute a basis for systematic reporting, debate on the merits or proposals for actions by policymakers responsible for the health sector in Poland.

Meanwhile, the issues of healthcare performance are the subject of numerous conferences, which could serve as a method of identifying, discussing and agreeing on positions. But such conferences are dominated by events oriented more toward giving a voice to so-called medical VIPs than to experts capable of preparing the necessary reports.

Diagnosing the performance of the healthcare system should allow a professional (politically independent) and unequivocal assessment of the situation, encompassing:

- a general assessment of the effectiveness of healthcare operations (achievement of its designated goals) and cost-effectiveness;

2 The UK's 1982 Black Report and 1998 Acheson Report are already classics of the approach to operations based on a comprehensive diagnosis of the health situation. In turn, the Dutch documents prepared by the Dekker Commission in 1987 and the Dunning Commission in 1991 are examples of conceptual reports developed for the needs of a social-political debate on reform of the health system.

3 The Health Ministry does not have its own research institute working on issues of the health protection system. The Center for the Organization and Economics of Health Protection (COiEOZ), operating in the 1990s, which started to perform this function, preparing numerous expert studies for the purposes of reform, was transformed in 2000 into the Center for Health Protection Information Systems (CSIOZ). Its mission is limited to issues of creating basic medical information and digitalization. The CSIOZ does not develop analytical functions concerning the assessment of the system's functioning. This role was taken over to a certain degree by the NIZP – PZH, but selectively and without a systematic approach. This deficiency was pointed out in a comparative study by the Netherlands-Polish Chamber of Commerce and the Embassy of the Kingdom of the Netherlands, citing as an example the systematic reports of the National Institute of Public Health and the Environment (RIVM) on the situation in the Netherlands' health protection system.

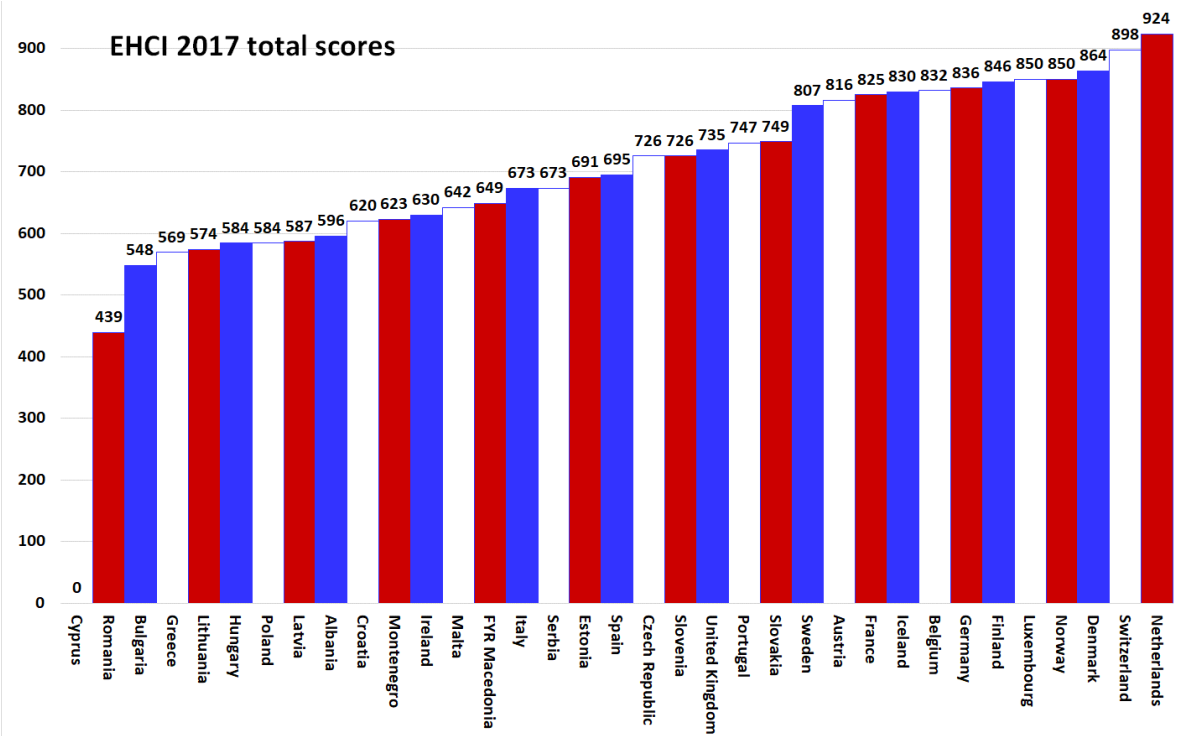
- assessing the effectiveness of management in health-care facilities, taking into account treatment and cost-efficiency goals;
- access and equality in health;
- overalloutcomes: longer, higher-quality life, patient satisfaction.

Assessments of health services from the patient's point of view are provided by the Health Consumer Index (EHCI) established in Sweden, which systematically collects data and announces the results. The index covers six areas: 1) effects of treatment, 2) access to treatment, 3) respect for patients' rights, access to information, e-health, 4) scope and reach of benefits, 5) prevention, 6) medications, defined by 45 indicators (Björnberg, 2018). The results of the consumer index show a ranking, which I present in the diagram below. Poland's position in this ranking is very ow, though it has improved by two places recently. The low position is determined primarily by indicators in the second area, access to health services (time waiting for benefits), and the fourth (range of benefits offered, describing the system's so-called generosity). Both of these areas had the highest number of indicators with unsatisfactory assessments.

The Consumer Health Index also inspired the Polish authors who developed the National Health Performance Index (Kozierkiewicz et al, 2014, 2015 and 2016) for the regions (voivodeships). The index covered 44 indicators (41 in 2015 and 2016) in three groups of problems: use of services (primarily identified with an improvement in health), financial management and assessment of health care. The work provided a great deal of information by region, initially leading neither to the construction of partial indexes, nor a single general index of performance. However, the 2016 edition estimated partial indices and a holistic index (with balanced weightings of 25, 25 and 50 respectively for the groups of problems). Świętokrzyskie voivodeship placed first, both in the holistic index and in the first and third groups. The result is surprising, but the report contains no explanatory analysis.

Assessments of health systems using indices, adding assessments of selected partial indicators, is undoubtedly a useful cognitive tool. But they cannot replace diagnostic reports assessing the achievement of the tasks assigned to institutions.

Diagram 1: The Consumer Health Index, EHCI 2017



Source: Björnberg (2017)

1.3. Governance

Assessing the process of governance in the health sector is part of the assessment of the governance of the state, for which numerous criteria and yardsticks are indicated. A standard of attributes of good governance was developed by World Bank experts[4] and is universally adopted for comparative reports and rankings of countries by quality of governance. It encompasses six areas: 1) voice and accountability, (2) political stability and lack of violence, 3) government effectiveness (effectiveness of achievement of agreed-upon goals), 4) quality of the regulatory process, (5) rule of law, 6) control of corruption (World Bank 1992, Kaufmann, Kraay and Mastruzzi 2007) . The WHO documents refer to the formulated tasks and content of good governance, extracting specific parameters for the health system (compiled and reworded from WHO 2007 and WHO 2008):

- Formulating health policy and strategic plans for health with basic principles as a guide for the state policies for health;
- Generating intelligence: health information and research on epidemiological situation, health services delivery and use, assessment of collecting funds for health and evaluation and allocative effectiveness of outlays;
- Articulations of health needs, health problems and health priorities in the relevant state documents;
- Regulations and incentives for stakeholders from the institutions of both financial sphere and health.
- Ensuring accountability and responsibility of all the actors in healthcare.

Simultaneously, attention is drawn to methods of good governance for health (Kickbusch, Gleicher 2012), such as:

- collaboration;
- engagement;
- a mixture of regulation and persuasion;
- independent agencies and expert bodies;
- adaptive policies, resilient structures and foresight.

The concepts of good governance for health presented in writings on health policy (Barbazza and Telo, 2014; Chanturidze and Obermann, 2016) carry a great ethical weight. They point to goals of the governance process such as stewardship, the good of the patient, universal health coverage, equality in health etc. This complicates policymakers' pragmatic approach, because the path to use of resources and tools to achieve the goal is difficult to operationalize. So there appear demands to formulate good governance concepts more pragmatically, beginning with evidence-based governance analysis (Saltman and Duran, 2015). Box 1 contains an effort at a less general record of the actions covered by the governance for health process.

Even a cursory glance indicates which governance problems in the health system are not properly represented and institutionalized in Poland. Particularly drastic neglect can be seen in the development of the health workforce: nurses, doctors (including the main specialties related to the demographic-epidemiological transformations of Poland's population) and many healthcare support professions. For years, Poland has been plagued by ineffectiveness in assuring sufficient financing, a lack of satisfactory social dialog, omissions and weakness of institutionalized expert support, limitations in coordination of actions between sectors, and gaps in the integration of successive stages in the medical treatment process. This last problem was taken up recently, initially in relation to cancer treatment (the so-called oncology treatment package).

4 The standard of good governance was presented already in 1992. It was later developed and equipped with measurement standards and indicators that were applied in comparative analyses conducted under the direction of Daniel Kaufmann and Aart Kraay. The World Bank's concept, taking into account criteria whose reference point is a democratic state with a market economy, met with criticism for a global universalism unsuited to the situation of poor countries, particularly African ones (the research of Drake et al, after Collingwood, 2002). This criticism also applied to the question of healthcare (letters to The Lancet in 2008). It appears that this was more a criticism of the World Bank itself than a concept of good governance as a significant development factor of each country, which of course can (and should) develop its own measures and indicators, specific to its stage of development, taking into account the cultural and sociopolitical context.

Box 1: Governance in the health sector – tasks

- developing comprehensive strategic documents and plans, constituting a basis for governance;
- ensuring the development of resources for healthcare , both staff and financial, and for medical services (treatment), as well as public health;
- coordinating processes of allocating resources at various levels of the functioning of facilities providing health services: central, regional and local;
- applying advanced methods of allocation in the process of division of resources, such as assessments of medical technologies, assessments of cost-effectiveness, collective purchasing agreements, innovative delivery methods etc.;
- coordinating processes of resource allocation for various medical specialties according to health needs and epidemiological developments;
- integrating procedures oriented toward treatment of a particular ailment, situated in various health subsectors;
- creating conditions for social dialogue, allowing the expression of opinions and agreement on actions in the area of working conditions and pay for health workers;
- aligning public and private interests in the functioning of increasingly mixed systems of providing health services;
- care for the health infrastructure: keeping it in good condition; up-to-date equipment and planning further development in line with needs;
- encouraging regulations that promote the effective management of facilities providing health services;
- coordinating/integrating actions in the treatment process that are performed within the framework of distinct subsectors of healthcare;
- taking into account the care and social needs of patients through joint action with social services;
- supporting and benefiting from work by health system research institutes and epidemiological and public-health research institutes;
- supporting and directing the education of staff (including life-long learning); supporting research projects and universities in this function;
- creating tools for influencing decisions in sectors other than health that have an influence on the health of the population, according to the motto "health in all policies"
- taking into account patient rights in the treatment process and ensuring equal access to health services, including financial support for the most vulnerable groups;
- cooperation with the education sector, NGOs and the media in the process of health promotion, health education and disseminating evidence-based medical information, supported by research;
- shaping responsibility for health, both individual responsibility and, among professionals and politicians, responsibility for the nation's health, by applying the proper motivational instruments, control systems and administrative and political procedures;
- supporting the professional transmission of knowledge about health and its determinants in a way that is comprehensive and accessible to all (knowledge-brokering) through the appropriate organizations and media.

Source: compiled based on Kickbusch and Gleicher (2012), with modifications and additions

Governance in the health sector requires competences and skills that are not always present. The health minister, and even the deputy ministers, are usually outstanding medical specialists, while very often they do not possess either economic competences or the managerial skills. As a result, they are not suitable partners for other members of the government (even when they are treating them). Additionally, medicine has a hierarchical structure, in which the specialist with the highest qualification stands at the peak, and is also the decider and the one who takes responsibility. Contemporary governance of systems, including healthcare, have flattened structures, with the participation of partners, with numerous compromises and more democratic decisionmaking procedures. For health protection this is a different world, which is difficult to adjust to.

The weaknesses of governance in healthcare are not specific to Poland, but rather universal.[5] The WHO and

5 Quotes from an article assessing the leaders of health protection in the U.S. also apply to the situation in other countries: "Leaders in academic medical centers are ill prepared to lead, but are in a position

many other international expert bodies put forth the concept of leadership for health and organize numerous studies and trainings for gaining competences in the field of health sector governance and its particular elements (WHO, 2007). A model is adopted in which all the attributes of leadership are directed toward the good of the patient: the patient is placed at the center of all activities.

Box 2: Desirable attributes of leadership in healthcare

1. Integrity, consisting in respect for the ethical values of health protection (alignment of behaviors and decisions with values) and the ability to articulate and communicate;
2. Critical thinking, which requires extensive knowledge, the ability to use information and research and to apply them in one's work, as well as striving for perfection;
3. An attitude of service, which requires awareness of actions on behalf of health and the good of the patient; maintaining balance, good contacts;
5. Teamwork, requiring vision, goal setting, planning, motivation, decisiveness, engagement, maintenance of good relations, ensuring resources, openness to innovation and change;
6. Ability to affect social and political groups and local communities, building networks, coalitions and relationships;
7. Forming an attitude of "listening to others" and responsiveness;
8. Broad horizons: understanding various contexts (social, global, historical); understanding the health protection system and the interaction of its elements;
9. Submitting to evaluation and drawing conclusions from it.

Source: compiled based on Arroliga et al (2014) and Hargett et al (2017), with additions

development of governance and management institutions focused on health services. Such asymmetry takes place primarily in countries with low financing of health protection. In that case, analyses of the system's performance compete for funds with the need for medical supplies and compensation for medical professionals, and it is no surprise that they lose out.

For several years, three types of non-medical institutions have been developing in the health sector: financing institutions, health technology assessment (HTA) institutions and public health institutions.

The functioning of the first group of institutions, the financial ones, is based on the model of three financial functions (Mathauer and Carrin, 2010): revenue collection; pooling; and purchasing and provision of services. The institution established to perform the financial function (the function of the payer) in the health sector in Poland since 2004 has been the National Health Fund (NFZ). In addition to this function, the NFZ performs numerous statistical tasks, and informational and training activities. A few years ago (in 2014), its institutional autonomy was limited; it is overseen by the health minister.

In any given health system there can exist many misguided regulations, but also weak compliance with the regulations that are established by law. Additionally, in practice informal rules can take shape as a result of shortages of funds and/or skills. In Poland there is no institution or agency for analysis of how healthcare is financed. Sometimes working „groups are appointed (e.g. the Working Group on Health Protection Financing – Green Paper), or research from international centers is commissioned (e.g. analysis of hospital „indebtedness). But there is still no organization, or properly assigned and fully qualified teams of experts on the economic affairs of the health system.

Beginning in the early 1990s, around the world (or at least in Europe) agencies were developed to assess medical technologies. Like the proverbial mushrooms after a rainstorm, they emerged in one country after another, quickly establishing an international network of

to influence and choose the new generation of leaders… Sadly, most of these leaders never received formal leadership training, but instead learned by observing role models who were accomplished researchers, clinicians, or educators, but were not formally trained leaders." (Arroliga et al, 2014).

information and support in analysis of new medications, procedures and treatment methods. An agency for assessing medical technologies was also set up in Poland (in 2006). In medical circles, the understanding of the need for what it did was initially rather limited. Later it was not allowed full autonomy, while at the same time additional tasks were added related to setting tariffs (described as "prices") for medical services. The agency actually has the status of an institution with legal personality, but it is supervised by the health minister and is only the minister's opinion/advisory body.

The second type of institution is created to carry out research on health and epidemiology, forecasting trends and indicating risk factors of acute illnesses. In Poland there was a tradition of so-called ministry institutes, overseen by cabinet members. In the 1990s, as research and development units they became more independent, but they still operated on a "thematic" basis in the area of a given ministry, carrying out policy-oriented research. The ministers evaluated their operational plans and supervised them at arm's length, e.g. by taking part in the committee that selected the director. In the health sector there were ministry institutes related to epidemiological research on certain infectious diseases (e.g. the Institute of Tuberculosis and Pulmonary Diseases), and sometimes other diseases, and institutes organized by another category structure.[6] The independence of the institutes, which requires project-based work based on grants and commissions, did not deliver sufficient revenues to maintain the laboratories, publishing houses and other scientific/academic structures. These institutions to an increasing degree supported themselves by providing health services. A Supreme Audit Office inspection in 2011 of the Health Ministry's largest research units indicated that revenues from scientific operations account for less than 20 percent of total revenues. Meanwhile, contracts with the NFZ to treat diseases, not including in their costs the research and teaching aspects of the treatments provided, increased the facilities' indebtedness (NIK, 2012). The Health Ministry has never developed a strategy for the system of research institutes essential for running the health system. As a result, supporting this particular set of institutions, rather than other institutes, clinics or centers, did not have a systematic justification; it was more a result of pressure from a certain group of specialists, and sometimes in fact a "struggle to survive" (e.g. the Rheumatology Institute) in the name of its historical accomplishments.[7]

The lack of a base of scientific support for the health system is often seen in poorer countries, but rarely in middle-income ones and almost never in the most wealthy. In 2004 the WHO issued a recommendation report on the need to conduct applied research for identifying and resolving the health problems of a given country and its population, in which it cited the motto of Prawase Wasi, a Thai expert and doctor: "The health research system is the brains of the health system: it is a tool to organize, understand, operate and improve it" (WHO, 2004, p. 59). In Poland this brain of the health system still has shortcomings,[8] even though many institutions employ outstanding scientists.

An additional problem is the transmission of the knowledge acquired into governance practice (Ward et al, 2009). And once again this is a subject that requires institutionalization, both of knowledge transmission methods and of appointing the right people to decision-making positions and testing their competences. Experience in this field, known as knowledge brokering, which serves to overcome the barriers between science and practice (the know-do gap) shows the difficulties and limitations. Overcoming these difficulties requires understanding and recognizing the positions between two worlds, educating people capable of such activities and creating conditions for them to operate.

6 Today the main institutes are the Institute of Psychiatry and Neurology (IPiN); the Children's Health Center (CZD); the Mother and Child Institute (IMiD); the Rheumatology Institute (IR), restructured into the National Institute of Geriatrics, Rheumatology and Rehabilitation (NIGRiR); the Oncology Center-Maria Skłodowska-Curie Institute (COI); the Witold Chodźki Rural Medicine Institute in Lublin; the Jerzy Nofer Occupational Medicine Institute; the Polish Mother Health Center in Łódź (ICZMP) and the Cardinal Stefan Wyszyński Cardiology Institute in Anin (established in 1979).

7 Some epidemiological research, often connected with demographics, is conducted by units of educational institutions. However, scientific careers at universities aren't connected with the country's research needs, but with the universal scientific policy targeted at theoretical-methodological matters with very high publishing demands. American and British journals with the highest impact factors aren't in any hurry to accept for publication the results of research on the unique problems of a single country or region.

8 In 2014 the NIZP-PZH published a study on the research system in the area of public health (Cianciara, 2014). Projects by the KBN, MNiSW, NCN and NCBR were also analyzed. The report confirmed a lack of research priorities, a failure to connect with government documents on health policy in the area or public health and a dominance of medical subjects in projects and publications that were nominally titled as public health issues (Piotrowicz et al, 2014).

The third group of institutions is related to health promotion and the prevention of major diseases. The basic idea, and also the more detailed concept of health promotion, was defined in 1986 at a conference in Canada, where the Ottawa Charter for Health Promotion was adopted by the WHO as a universal declaration. The purpose of health promotion as established in the Charter is "enabling people to increase control over, and to improve, their health." People need to be able to identify actions that make it possible to do so; for this they need knowledge about what supports health, as well as advice, motivation and assistance in gaining the ability to apply this knowledge. It is also necessary for others, including politicians and the media, to work in a similar way. It was established in Ottawa that health promotion is just as important in achieving good health, or perhaps more important, than other services in the health protection sector. Over the 30 years since the declaration, regulations and institutions in the area of health promotion have been set up in many countries around the world. At the start of the second decade of the 21st century there appeared a series of regulations that also took into account care functions in coordination (integration) with other functions on behalf of health.

Poland's first law on public health was passed only on 18 November 2015. In comparison with other countries, that's rather late. The law established the basis for public health activities – not just ensuring safety, which the sanitary inspectorate has been doing for years. The law stresses the need to create the conditions for healthy living at each stage of a person's life, in various places and without regard for an individual's resources, but this is not put into practice. The law did not establish the function of a coordinator for health promotion and prevention in line with the maxim "health in all state policies." It appealed to experiences related to the development of national health programs, in which goals were set for action on behalf of the population's health, and in relation to certain groups (children and, recently, seniors), which acted as a catalyst in the process of setting health priorities and as a guide for the potential executors, though with poor implementation tools (see the chapter by Krzysztof Kuszewski). As a result, in Polish health promotion actions there is still a lack of professionalism; while numerous initiatives are undertaken (particularly by NGOs and the media), there is a lack of research that could confirm the effectiveness of health programs and interventions, and personnel and funding are very limited.

Aside from the aforementioned groups of health sector institutions, **government structures** are significant for the proper functioning of the health system, first and foremost the Ministry of Health.They don't always function as structures appointed exclusively for health; in some countries they also handle social affairs. What departments a health ministry has and what kind of officials it employs in terms of competencies and skills has a significant influence on the quality of governance in the health sector. An analysis on this subject in Poland (KSAP, 2009) indicated that the Health Ministry diverges from the professional standard of this type of central government institution. Its structure is excessively hierarchical, and institutions that are external but supervised by the ministry operate according to established routines and are highly dependent on the ministry's administrative authorities. This dependency is growing, as the parties that have won parliamentary elections are reaching ever lower down the organizational charts to fill positions with "their" people. The spoils system has no established boundaries.

Good institutions, competent people and decent financial resources: These elements are fundamental in the governance process. But it won't operate properly if relationships don't serve to bind them all together. Such relationships aren't just about preventing and mitigating conflicts. There should be cooperation for the common good, while respecting the opinions of all sides. The institutional solution is **social dialogue**, which springs from the tradition of so-called industrial relations, or negotiations between workers and employers on wages and working conditions. One promoter of social dialogue is the International Labor Organization (ILO). Today, social dialogue is well developed in many countries. There are tripartite and multi-sided institutions. In addition to representatives of workers and employers, representatives of the central and local government also take part, along with NGOs and consumer organizations. Social dialogue in Poland had a difficult birth, because the transformation period did not guarantee equal weight of all sides. Initially the abor unions (too pluralistic, and competing with each other) had the advantage, while after more than a decade, together with the development of the private sector in the economy, employer organizations came to dominate.

The health sector, despite its numerous labor conflicts, introduced the institution of social dialogue only in

2005. A social dialogue department was created in the Ministry of Health, which in principle serves the participation of representatives of social partners of the health sector in the Tripartite Committee. In the public sphere, which the health sector is a part of, we face a de facto conflict of interest, because the representative of the employers is the minister of health.[9] However, the minister's authority is limited, especially when not a full party to discussions in the government. It is the prime minister and finance minister who have the executive power, but this level may also be unreliable.[10] The decision--makers' attitude is based on procrastination, including deprecating the parties to the conflict, and when it escalates – to making selective decisions that don't take into account the complexity of the system and increase its imbalances, leading directly to the next conflicts. The number of strikes and striking workers in health services has grown in recent years (Yearbook of Labour, GUS 2017). The strikers based their arguments on the good of society as a whole (primarily the residents during their hunger strike), portraying their group interest as a necessary condition for a general improvement in health outcomes. In 2017, patients were added to the process of building social dialogue in the health system, under the slogan "Citizens for health."[11] Is this a way to improve the situation of health professionals, or just another distraction? After all, patients can't be an equal side in the conflict.

One essential quality of good governance is the **rule of law**, ensured institutionally through procedures of transparency and audit organizations, both watchdog groups and standard administrative supervision, which serve to identify irregularities and prevent corruption. The problem of corruption occurs frequently in the health system, in poorer countries: with weak institutions, and with a society with lower health awareness (Golinowska, 2010). It was present in the communist countries and during their transformation to market economies (Gaal, 2004). The free-of-charge healthcare system balanced its books thanks to informal payments, and gave patients' families a feeling of caring for the sick. When in the middle of the last decade the government launched a quite drastic program of fighting corruption in the health service, under the idea of a "moral cleansing of society," medical circles sought the right for patients to express gratitude for receiving health services. Simultaneously, with greater conviction, they demanded the introduction of privatization and business rules (NPM – new public management) for the functioning of the public sector. A decade after the media outcry over cases of corruption in medicine, formal doctor-patient relationships have been solidified. However, as engaged doctors point out with concern, the nature of corrupt practices has changed: To a great degree they have been shifted to the institutional level, where clientelism and nepotism occur. This is more visible at the regional and local levels.[12] In a situation of shortage, pushing "ordinary" patients (those without connections in medical circles, and with limited abilities to offer benefits in exchange) to the private sector, where prices are constantly increasing, is becoming a basic factor of inequality of access to healthcare in Poland.

9 Shifting the employer function to the level of local government didn't change the essence of the problem, which was the source of financing for health benefits, including compensation for health system workers.

10 In 2008 the "White Summit" was held with the participation of the prime minister. Many necessary actions were agreed upon, along with an increase in contributions to the NFZ. The decisions were not implemented. The global economic crisis that occurred at that time not only justified refraining from implementing them, but also caused the introduction of austerity policies.

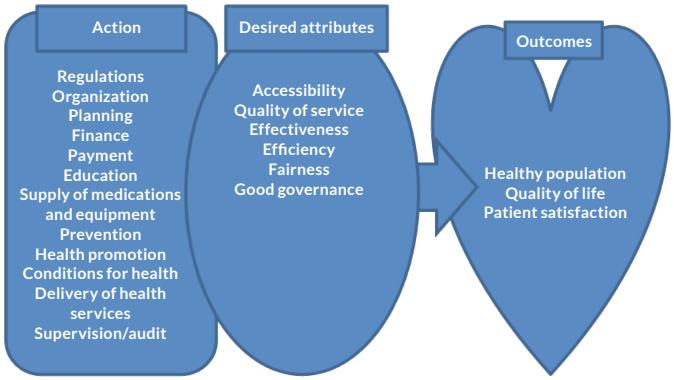
11 Decisions in this area were taken under the influence of the European Commission, which provided funds for social dialogue in health protection.

12 According to the opinion Dr. Marek Balicki expressed on this text.

1.4. Reform

Every reform requires a precise formulation of the goals of the changes, which should be derived both from an assessment of the existing system (the need to react to acute failings) and because of the challenges of the future.[13] It would seem obvious that undertaking a reform of the health system has as its goal an improvement in the health status of the population- longer, high-quality life and effective treatment of the sick. But the goals of health system reform are not always formulated this way. Sometimes the desired characteristics of the system's functioning are treated as the goals of health system reform, e.g. greater cost-efficiency; these are significant in the "production" of health, but they are not first-order goals at every stage of development. At the earlier stages, an obvious improvement in the health system is delivered by general economic and social actions: creating the necessary life conditions, access to primary consumption and universal education. Meanwhile, the desired qualities of the health system (see Figure 3) appear as higher-ranked goals slightly later. They require additional effort: the appropriate institutions for healthcare, and greater resources. With properly functioning institutions and accurate allocation and effective use of resources, they deliver better health outcomes, which in turn become a factor strengthening economic wellbeing (health as a factor of human capital). In Poland we are already at the level of development where for the better health status of the population, it is necessary to achieve the desired attributes of the health system: effectiveness, equality of access to new technologies, the highest possible quality of services and patient satisfaction from their performance. The path that leads from the adoption of reform actions to achieving the stated goal must be evidence-based.

Figure 3: From action to outcome



The reform of Poland's healthcare system was carried out under the slogan of introducing an insurance-based system of financing in place of the tax-financed one, and a so-called internal market mechanism (a regulated market, or quasi-market) as the basis for regulating relations and flows of financial resources between entities. It was accepted a priori that new systemic and institutional solutions would bring positive effects for health. The relationship between the actions undertaken in the specific context of Poland and the health status of the population was not examined. Foreign experts, who visited Polish government bodies in great numbers, concentrated on explaining the solutions from their countries. A health economics textbook by the American economist Thomas Getzen that was translated into Polish was based on examples and practices from the U.S. (!)

The insurance-based reform of the health protection system was partially abandoned after just four years, centralizing the healthcare funds in a single National Health Fund, but leaving the contribution-based financing of the system. The insurance-based nature of the health protection system, taking into account financial autonomy and a certain degree of self-governance by the health sector, did not manage to protect itself from the economic doctrine of reducing taxes and contributions as the basis for development of entrepreneurship and as a factor driving economic growth. Despite the initiation of a systematic method of increasing contributions (0.25 percentage point through 2007) and political promises that this process would continue, decisions on increasing spending were taken only under coercion: from the strikes by nurses (the "white cap rebellions") and other professional groups, and most recently, in 2017, the residents – young doctors receiving specialist education. These decisions, violating the proportions of compensation between various groups

13 In deliberations on the subject of reforming various systems, an incremental approach is often considered, in which changes are made by the method of small steps, without a plan of action imposed from the top down (Lindblom, 1959). This attractive approach does not fit at all with the transformation period in Poland or with the acceleration of global changes under the influence of new social problems new technologies and crises that require reactions – often rescues, prevention or adaptation. This does not mean that we must discard solutions from the past and constantly reinvent the wheel. On the contrary: the roots of the past allow every new structure to be stronger and more enduring.

of medical professions and disturbing the process of advancement on career paths in certain professions, destroyed the motivational systems and are a significant reason for people leaving the medical sector.

Creating an internal market required the preparation of many elements, in line with three categories of market competition: supply, demand and price.

Numerous organizational changes were made in the area of supply. The health sector was divided into relatively autonomous subsectors (see Figure 2), with separate financing methods. The essence of the change was the concept of primary healthcare based on the institution of the family doctor, later developed over many years. The regulation accenting the coordination (and not only gatekeeping) medical function of the family doctor was introduced in October 2016 (Dz. U. Journal of Laws 2017 position 2217). The institutional division of the health sector connected with the process of so-called "autonomization" (and frequently privatization) of healthcare facilities led to a significant disintegration, resulting in a lack of continuity in the treatment process, which today is difficult to correct based on the introduction of the concept of so-called coordinated or integrated care. Another element of institutional changes consisted in the division of the function of purchasing benefits from their provision. The purchaser was initially the regional healthcare fund, and later the centralized NFZ, operating through its territorial branches.

If in the area of supply numerous divisions and organizational changes were made, creating conditions of competition, in the area of demand this process was significantly harder. In the health system we are dealing with the ethically respected need for health, not with demand. There could be no talk of demand competition within public funding (including for dogmatic reasons, when the ex-communist parties took power). But "budget limitations" didn't allow the universal meeting of health needs, which were increasing along with wellbeing, education and longer life. Regulations in the form of access only to a guaranteed services package, or co-payments (or private insurance) were long misunderstood and not accepted, despite the preparation of materials to take decisions, e.g. in the area of the guaranteed benefits package. Meanwhile, work was undertaken on maps of health needs, in the hope that they would be standardized (and rationalized). Contrary to the name, the maps of health needs concerned not analysis of needs, but the available infrastructure resources in the health sector. The lack of territorial coordination in the area of investment for health led to growth in the number of hospitals (growth in the number of hospital beds), with huge regional disproportions. The maps of health needs were to be a tool allowing investment decisions that would equalize access to health services across the country. They could be the basis for forming a nationwide hospital network. A NIK audit (2018) charged that the documents developed were unreliable, and in any case were inventories, not recommendations. It also pointed to the lack of cooperation between the Health Ministry employees preparing the "needs maps" and the research support base (NIZP-PZH), which reduced the quality of the work. However, significant in this undertaking is that a tool that is certainly useful in analyzing, coordinating and auditing the location of inpatient investments cannot replace a tool reflecting the population's health needs arising from an analysis of the health (various types of health balance sheets) and physical soundness of the population.

The regulated market mechanism requires regulated prices (tariffs). The methodological approach based on classification of diagnostic groups (DRG) were prepared immediately after the introduction of the 1999 health reform. This was performed by a team led by Jacek Grabowski. The estimated costs for groups of patients were introduced only in 2008, and in an incomplete fashion.

A market requires freedom of choice as the foundation of competition. Market freedoms in the Polish publicly financed health services boil down to the patient's choice of benefit provider, and equality of providers competing for contracts with the payer, regardless of their ownership status. The liabilities of the health care facilities have led to limitations of both freedoms, applied in the practice of the providers and the payer.

Efforts to identify and estimate the value of the category of the regulated market were made in Poland at different times, independent of one another, without the necessary coordination. The real operation of this "crippled" internal market mechanism was reflected by the system for contracting services. In conditions of strong budget constraints and without the ability to make price adjustments, a deep financial imbalance appeared. This was expressed in the indebtedness of public healthcare facilities known as SP ZOZ, (Sowada, 2008; Golinowska et al, 2012). The reaction to the indebtedness was state debt relief programs at irregular intervals. In 2005–2007

these decisions were made conditional on so-called financial restructuring of hospitals, which meant the need for changes. Because the basic parameters of the internal market did not change, these actions were not excessively intense, and didn't reduce the financial imbalance of the system. In 2011 the conditions for the functioning of public hospitals were tightened. The act on medical activities (Dz. U. Journal of Laws 2015 position 618, as amended) forced hospitals to consider their budgets under the threat of a change in ownership or liquidation. The NIK report (2016) on the effects of this phase of debt reduction pointed out the drastic effects in the area of employment models and conditions of medical personnel (violation of work standards, employment in multiple positions and also temporary work contracts). The situation in health protection became critical. In the following years, work continued in the direction of maintaining an internal market with strong budget constraints, improving certain parameters, such as the internal pricing system. Work was done on defining the guarantee of public financing by creating a nationwide hospital network, which took its final form in 2017. These activities did not reverse the trend of the health system's deepening financial imbalance, and gaps in financing of resources, particularly medical personnel, posed a serious threat to availability of benefits.

In the second half of the previous decade, mechanisms were introduced for so-called new public management (NPM) in health service institutions. From the patient's point of view, reform of hospital management brought worse functioning. Drastic gaps in coordination of the divided system became visible, leading both to a worsening of patient satisfaction and to waste of resources. There were limitations in access to many specialist health services; the quality of care was worsened by the lack of a holistic (integrated) approach to the treatment process and growth was seen in so-called catastrophic spending – the ruin of family budgets in the case of illness, particularly chronic illness (Golinowska 2018).

Awareness of the growing difficulties in the healthcare system was not universal. The situation was often underestimated, due to the lack of a comprehensive diagnosis, and some politicians, talking heads and even journalists accepted the thesis that there are enough funds, they just "flow" to the private sector or straight to the doctors' pockets. So it is no surprise that the cure for healthcare proposed by the new ruling party is centralization of funds for health, elimination of the NFZ and greater control of allocation of financial resources. The first ideas applied to changes in the source of funding: they called for a departure from insurance contributions and a separate fund for healthcare, toward funding from general taxes and pooling the cash flow in the state budget. But it was not pointed out what purpose could be achieved for the population's health and patient satisfaction. Fortunately, other work was begun, improving the operation of certain parts of the system, e.g. the primary care sector (POZ) and the problem of insufficient funds for health care as a real threat to the health services became apparent as a result of the strikes of various groups of medical workers (residents, nurses etc.). A law was adopted to increase spending on health protection to 6% of GDP in 2024, which is not a solution to the problem of lack of resources for the health system in Poland.

Conclusions and recommendations

Undertaking reforms of the health system , either comprehensive or of any part of the sector, requires a professional diagnosis and assessment of the system's functioning. Work of this type should be institutionalized and carried out systematically, which requires assigning these tasks to the proper bodies and entrusting them to competent teams. It should form the basis for annual reporting in parliament. It is high time for a holistic, honest diagnosis and the introduction of annual reporting!

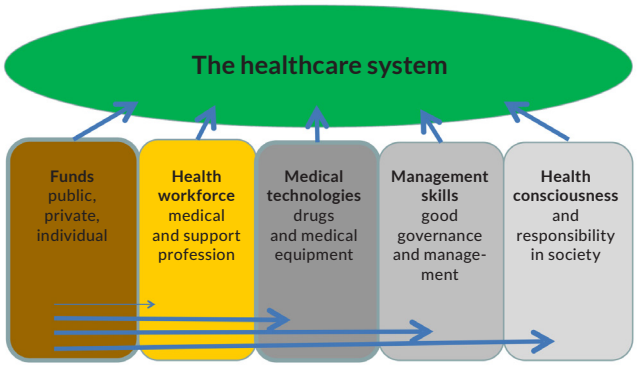
The system's failings should serve as a motivation to develop a program of changes. Their scope should be determined by a health strategy taking into account the challenges of the future, as well as the context of European regulations and the WHO's recommendations.

One threat to the functioning of the health system is relying entirely on programs from the political authorities, whose goals are more related to the struggle for power (winning voter support) than solving acute problems, which in the short term may be perceived as unfavorable (e.g. patient copayments). Another threat, and a waste, are the elements of political platforms that for the purpose of changing personnel or stakeholder groups are aimed at the liquidation/destruction of the institutional body of work built up with great effort over many years. Permanent revolutions instead of improvement procedures

or application of actions based on honest assessments don't deliver benefits for the whole of society.

The purposes of health protection reform at the current stage of the country's development should be more comprehensive and cover these main areas: healthcare (medical care), the health of the population and growth of resources and their efficient management, which is a condition of achieving the goals in the two previous areas: related to treating the sick and caring for the health of the population.

Figure 4: Resources necessary for the proper functioning of healthcare



Comprehensiveness does not mean designating every worthy goal to be achieved simultaneously. Setting priorities for particular stages of reform is another condition of rational action. The current priorities which for several years we have been calling for in our work as the expert group of the IZP at the UJ Collegium Medicum and CASE are:

- Higher staff resources, in both medical and support professions, as a result of adjusting the processes of medical education, health education and public health education to the needs of provision of health services, particularly in areas of shortage and areas related to the new phase of epidemiological development of the aging population – the predominance of non--communicable chronic diseases.
- Defining a research and expert system for health, and the effective functioning of health system institutions; the essential additions to and support of research centers and a system for transmitting knowledge to politicians.
- Development of methods of planning and forecasting labor resources in the health sector at the government (ministerial) level and the ability to use them in the education and hiring process.
- Increasing financial outlays on healthcare as a result of systematically increasing contributions and imposing contributions on all adults; in the case of inability to pay contributions, the obligation is taken up by social assistance services.
- Introduction of the principle of financing public health from the state budget as an action for the benefit of the entire population
- Carving out a new sector: long-term care, defining resources for its development with a defined portion for copayments and ensuring coordination between the medical and social sectors, particularly at the local and service-provider levels.
- Introducing a system of patient participation in the costs of health services (an element of individual responsibility for health) after the final definition of the guaranteed services package and establishment of support for people without the ability to make such contributions.
- Introducing institutional solutions allowing continuity of care, known as integrated healthcare, in relation o dominant chronic diseases of the population. Support is required for the oncology package, introduced with great difficulty, and integrated healthcare solutions being prepared at the moment for ischemic heart disease.
- Requiring the appropriate institutions operating in the health sector, education and public media to provide information on health (information brokering), to conduct health education in schools and public spaces and promotion of good practices, addressed to various groups of people. There should be a ban on advertising of pharmaceutical products and foods without evidence of a positive (or at least neutral) effect on health.
- Institutions for health and medical professionals should undertake work on rebuilding/building trust in medicine and professionalism in their behaviors, comments and public appearances. This is an important task for the professional associations (the doctors' and nurses' chambers), which should be protecting their good name, opposing unethical loyalty in the case of errors and violations.
- Medical professionals should undertake a dialogue among themselves for the purpose of reaching agreement, setting priorities and supporting the implementation process. Competition for prestige and forcing through one's own interest does no one any good, serving neither the professional goals of medical workers nor the patients.

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Chapter 2

Christoph Sowada

Financing health system in Poland: spending levels and allocation of funds

Introduction

Among the many ills that plague health protection in Poland, the issue of insufficient funds is usually ranked the highest. Shortages of personnel (doctors, nurses, other medical professionals), technical infrastructure that doesn't meet the needs of contemporary medicine, limitations on access to state-of-the-art drug therapies may be and often are presented as a result of budget limitations. But the statement that spending on health protection in Poland is too low is true to the same degree as it is trivial and oversimplifying. The fundamental problem arises from the attribution to funds (resources) of absolute causative power, as if everything were just a question of money. And that's not how it is. In reality, what's decisive is access to real resources, and these are always limited. This in turn means that it's impossible to fully meet all needs, of all people, at every time and place, either health needs or the other needs each of us has.

Limitations on real resources are an empirical fact. Without such resources, money becomes a worthless piece of paper. But on the other hand, we can increase the quantity of available real resources by buying them sufficiently far in advance. The more money we have for health protection, the more we will be able to amass real resources, employ medical professionals and good managers, buy high-tech diagnostic and therapeutic equipment. And thus the higher the chances that the health protection system will meet the health needs of society to a higher degree, and provide it a feeling of greater security. But even so, not all needs will be fully met. The system certainly won't meet all the subjective aspirations of the citizens (shaped first and foremost by the natural human tendency to compare one's own situation with that of other people, e.g. the residents of the rich countries of Western Europe), and it won't even meet "only" the health needs already objectively identified.

Increasing the chances of constructing a more patient--friendly and effective health care system with higher financial ressources also doesn't mean that these opportunities will be taken. Resources, even very large ones, can be wasted. Much, but not all, depends on what financial resources we have. Equally important is their effective use. In a sector as crucial both to society and its individual members as health care is, efficiency of allocation of monetary and real resources takes on particular significance: economic (the goal is the optimization of the relation of results to costs), but also, and primarily, ethical: wasting resources in the sector that saves human life and health is worthy of particular condemnation.

2.1. Expenditures on health protection in Poland compared with other countries

Expenditures on health, defined in international statistics as current spending (not including investment spending or spending on training staff) more than doubled in 2006––2016 in nominal terms (from PLN 57.5 billion to PLN 121 billion), and in real terms by almost 69% (taking into account price growth in the health sector). Growth by source of funding is presented in Table 1. Seventy percent of total current spending is covered from public funds, the remaining 30% from private funds, of which about three quarters is financed directly by households (from the patient's own pocket), and one-fourth by private health insurers and employers.

Table 1: Spending on health protection in Poland, 2013–2016

		2013	2015	2014	2016*
Current spending on health	PLN m (current prices)	105635	107458	114142	121069
	% of GDP	6,45	6,33	6,3	6,5
Public current spending on health	PLN m (current prices)	74639	75929	79887	84554
	% of GDP	4,56	4,47	4,41	4,45
	% of current spending on health	70,7	70,7	70,0	69,8
including: mandatory insurance**	PLN m (current prices)	64106	65912	69334	72452
	as a % of GDP	3,91	3,88	3,83	3,90
	as a % of total current spending on health	60,7	61,3	60,7	59,84
– state budget	PLN m (current prices)	6102	5957	5936	
	% of GDP	0,37	0,35	0,33	
	% of current spending on health	5,8	5,5	5,2	
– local government budgets	PLN m (current prices)	4432	4060	4617	
	% of GDP	0,27	0,24	0,25	
	% of current spending on health	4,2	3,8	4,0	
Private spending on health	PLN m (current prices)	30996	31529	34256	36515
	% of GDP	1,89	1,86	1,89	1,96
	% of current spending on health	29,3	29,3	30,0	30,16

* estimated levels

** according to NRZ methodology, this also includes spending other than health insurance from mandatory insurance contributions, e.g. private liability insurance obligations, if this spending is related to healthcare. But the share does not exceed 1% of total spending by mandatory insurance.

Source: GUS (2017a and b)

In comparison with the majority of EU countries, Poland doesn't spend much on health care: It has one of the lowest indicators of current spending on health in GDP, and also very low spending per capita (total, and as of so-called mandatory schemes (or state expenditures and expenditures from mandatory insurance) hereinafter, for the sake of simplicity, referred to as public spending – see Table 2).

Table 2: Spending on health in selected EU countries, 2016

	Share of current spending in GDP (%)	Share of financial spending as part of government/ mandatory programs (%)	Total spending on health, USD (PPP at constant prices, OECD 2010)	Total spending by government/ mandatory programs, USD (PPP at constant prices, OECD 2010)
Czech Rep.	7,3	6,0	2 207,0	1 819,0
Estonia	6,7	5,1	1 763,2	1 341,2
France	11,0	8,7	4 087,9	3 222,4
Germany	11,3	9,5	4 851,8	4 103,7
Greece	8,3	4,8	1 969,8	1 148,3
Hungary	7,6	5,2	1 862,7	1 271,5
Latvia	5,7	3,2	1 300,7	734,2
Luxsemburg	6,3	5,3	6 245,7	5 183,4
Netherland	10,5	8,5	4 857,7	3 927,0
Poland	6,4	4,4	1 622,2	1 118,8
Portugal	8,9	5,9	2 423,3	1 605,3
Slovania	6,9	5,5	1 996,0	1 592,3
Slovania	8,6	6,1	2 473,5	1 776,4
UK	9,7	7,7	3 758,8	2 976,7

* Current expenditures, which also includes private spending

Source: the authors, based on OECD (2018)

The particularly low ratio of health expenditures to GDP in comparison to other countries is often cited as an argument for growth of monetary outlays on health protection in Poland. This argument is also one of the most important reasons why the Sejm on November 24 2017 amended the law on healthcare benefits financed from public funds, to call for gradual growth in the share of public expenditures (defined here as spending from the state budget and the NFZ) on spending in GDP to a level of at least 6% in 2025 (now in 2024). Even though the share of spending on health in GDP is one of the most commonly cited indicators in various expert opinions and comparative analyses, formulating concrete financial recommendations on its basis must be recognized as an error. First of all, a higher ratio does not at all ecessarily mean fuller meeting of society's health needs, or the achievement of better health indicators. Secondly, the share of health expenditures in GDP in and of itself does not say anything about the level of available financial resources, because they also depend on the level of GDP itself.1 In the end, all spending related to the engagement of real human and capital resources for the provision of health services is regulated in monetary units, in złotys or in euros.

Unfortunately, expenditures per capita on health in Poland is also much lower than in the majority of European countries. This was noted by the creators of the aforementioned law of 24 November 2017, stressing that growth in the share of public spending on health also means growth in the monetary sum designated for this purpose. For example, then-Health Minister Konstanty Radziwiłł gave assurances that the act meant that health protection over 10 years (2018–2027) would receive PLN 500 billion more than if it were not adopted.2 In turn, in a May 17, 2018 report by the information service Rynek Zdrowia (Health Market), relating the European Economic Congress in Katowice, one can find a comment from Wojciech Kozłowski (from the law firm Dentons), that thanks to this law in 2024 alone health protection will receive PLN 85 billion more (Rynek Zdrowia, 2018). The author's own calculations indicate that keeping the Health Ministry's promises would require the Polish economy to achieve an annual GDP growth rate over the next 10 years of 14.3%, while Kozłowski's forecast could come true if from 2018 to 2024 Polish GDP grew by about 19% (by comparison: the cumulative six years nominal rate of GDP growth in 2011–2017, was 26.5% (GUS, 2018)). Achieving such (nominal) GDP growth rates is theoretically not ruled out, but this is possible only with an annual inflation at a level of at least 10%. But with such inflation, the real value of the health minister's declared additional PLN 500 billion would be just a fraction of that amount. Meanwhile, as was said earlier, it is the real value, not the nominal value, of financial resources that determines whether it will be possible to fix health protection in Poland. Assuming optimistically that it will be possible to maintain real annual GDP growth of 3% over the next 10 years,3 growth in the share of public spending on health in GDP may generate additional PLN 230 billion over that period. This is also a large amount of money (2.7 times public spending on health in 2016), and we must do everything possible to use these funds well. But at the same time it must also be pointed out that growth in public spending is not identical to growth in total expenditures for health. Growth in public spending may lead to (partial) substitution of sources of financing and reduction of private expenditures. It appears that such substitution is even expected by the legislature, which stressed in point 2 article 131d of the law that the additional funds are to ensure access to guaranteed benefits, taking into account waiting lists for services. In the area of the services that at the moment have the longest waiting lists, patients most often seek opportunities to get help by financing them from their own pockets. If increasing public expenditures actually leads to an improvement in access to guaranteed services, private financing won't be necessary. Regardless of the positive-normative evaluation of such a result, from the accounting point of view a switch in financing sources doesn't mean growth in spending.

2.2. Effective allocation of financial resources in the health protection sector

Maintaining an efficient and effective system of health care requires serious engagement of financial and real resources. But growth in financial outlays, increasing

1 E.g. Luxembourg, one of the richest countries in the EU and the world, has a lower share on health expenditures in GDP than Poland (6.3% of GDP in 2016), and in fact to meet health needs it has per capita an amount four times greater than Poland.

2 Comment on TVP public television news program Wiadomości, November 24 2017.

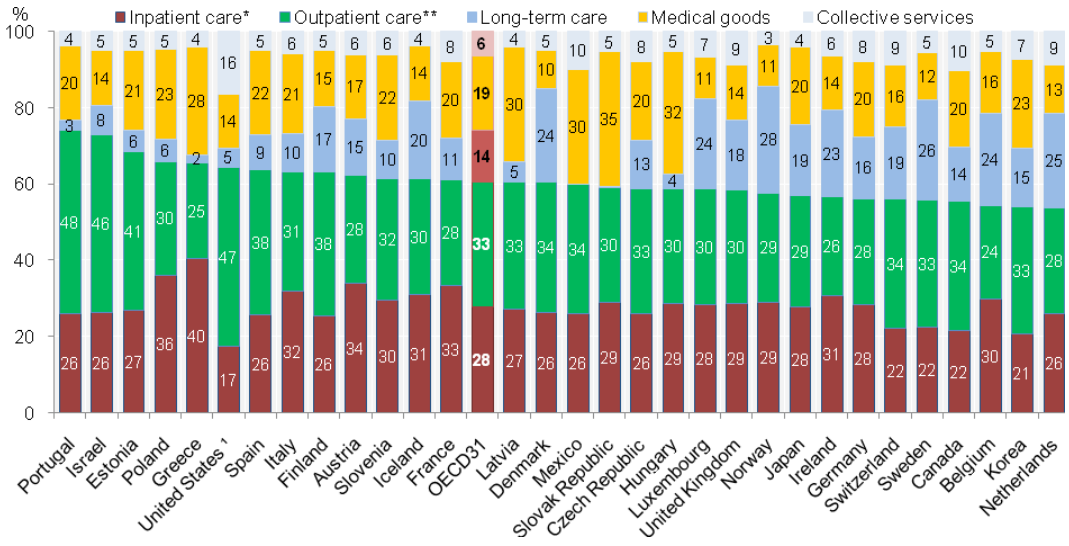
3 Optimistically, as in recent months (as of spring 2018 -ed.) signs are multiplying of a growing likelihood of another global crisis or at least an economic slowdown.

the share of health expenditures in GDP or expenditures per capita, cannot be treated as the goal of health policy, because money will only ever be one of the tools needed to improve the situation in health. Poorly spent money not only doesn't improve health or strengthen the feeling of security, but actually provides further grounds supporting the "leaky bucket" hypothesis, which says the health protection system is capable of taking in any amount of funds, with no result. It is this hypothesis that opponents of increasing public spending on health refer to, although experience teaches that market solutions are also far from the economic effectiveness of the model of perfect competition. The health outcomes achieved in the U.S., which builds its health care system to a large degree on the basis of private health insurance, are the best evidence of this.

Unfortunately, the allocation of very limited (as has been shown) monetary and real resources in Polish health care system cannot in any way be judged effective, it means supporting the maximization of health outcomes. Due to financial regulations, the healthcare sector in Poland has undergone fragmentation. The establishment of separate budgets and separate processes for contracting services for particular parts of the sector: primary care, outpatient specialist care, inpatient care etc. has led to the fragmentation of diagnostic and therapeutic processes, harming patients themselves and the system's cost--effectiveness. Patients in each part of the sector are treated as carriers of funds on the one hand, and costs on the other. If the costs only exceed the revenues, service providers have a motivation to "toss" the patient to another part of the sector, e.g. from primary care (POZ) to outpatient specialist care (AOS), or from AOS to a hospital, even when there is no medical need for doing so. The lack of coordination of care and benefits isn't just a threat to patient health; it also leads to the waste of already modest resources.

Particular cases of ineffectiveness of resource allocation include neglect of preventive actions and health promotion (the generally low level of public health, discussed further in Krzysztof Kuszewski's text), and hospital-centric allocation of funds in medical treatment. Among the OECD member countries included in Figure 1 below, only Greece directs greater financial resources to the most expensive part of the system – hospitals. Polish hospitals absorb 36% of current health expenditures on health, compared with an OECD average of 26%. Slovakia and Hungary designate 29% of spending for this purpose, and the Czech Republic 26%. Even greater "hospital-centricity" in spending in the Polish health care

Figure 1: Financing of health protection by function in selected OECD countries, 2015:



"Collective services" include prevention, public health and system administrative costs

Source: OECD (2017) Health Statistics 2017, WHO Global Health Expenditure Database

system can be seen in the NFZ budget (see Table 4). In 2004–2017, the share of hospital treatment in NFZ expenditures grew from 43.4% to more than 50%. Of course, this growth came mainly at the cost of a declining share of NFZ spending on medication refunds. But there is no doubt that the outpatient sector, and in particular primary care, which treats patients often equally effectively, or even more effectively and so at significantly lower costs, does not play (not only for financial reasons) the role in the Polish system that is assigned to it in significantly richer (and thus better able to bear higher costs) Western European systems, e.g. in the Netherlands or France.

Table 3: NFZ expenditures by type of health benefit, 2004–2017 (PLN million and % of total)

		2004	2010	2014	2016	2017
Primary healthcare	mln PLN	3507.6	7248.8	7701.4	9461.5	10209.2
	%	11.5	12.8	12.2	13.4	13.39
Specialist outpatient care	mln PLN	2032.9	4196.9	5431.7	5800.6	5635.0
	%	6.7	7.4	8.6	8.2	7.39
Hospital treatment (including therapeutic and drug treatments)	mln PLN	13241.2	26905.7	31214.9	35036.6	38682.4
	%	43.4	47.5	49.4	49.5	50.73
Psychiatric care and addiction treatment	mln PLN	1026.3	1953.8	2319.4	2468.9	2662.3
	%	3.4	3.5	3.7	3.5	3.49
Medical rehabilitation	mln PLN	814.6	1768.9	2100.4	2235.7	2384.2
	%	2.7	3.1	3.3	3.2	3.13
Nursing and other care services as part of long-term care, and palliative and hospice care	mln PLN	466.8	1163.5	1479.9	1753.9	2148.5
	%	1.6	2.1	2.3	2.5	2.82
Dental treatment	mln PLN	909.1	1689.3	1729.1	1769.2	1776.0
	%	3.0	3.0	2.7	2.5	2.33
Spa treatment	mln PLN	324.2	536.6	599.2	627.7	635.4
	%	1.1	1.0	1.0	0.9	0.83
Urgent care, medical transport and emergency medicine	mln PLN	881.7	35.8*	43.5	44.9	45.7
	%	2.9	0.1	0.1	0.1	0.06
Preventative health programs (financed from the NFZ's own funds)	mln PLN	0	130.9	159.7	162,4	172.9
	%	0.0	0.2	0.3	0.2	0.23%
Separately contracted health benefits	mln PLN	771.7	1385.8	1737.7	1947.9	2134.8
	%	2.5	2.5	2.8	2.8	2.80
Orthopedic equipment, assistance devices and technical devices	mln PLN	386.4	589.9	803.7	946.3	1021.4
	%	1.3	1.0	1.3	1.3	1.34
Drug refunds	mln PLN	6118.4	8546.3	7550.3	8087.6	8267.1
	%	20.1	15.1	11.9	11.4	10.84
Cost of benefits provided abroad	mlnPLN	6.2	228.1	348.7	493.5	476.4
	%	0.0	0.4	0.6	0.7	0.62
Total	mln PLN	30487.4	56643.9	63219.6	70836.7	76251.3
	%	100	100	100	100	100

* since 2007, pre-hospital emergency medicine is financed by a state budget subsidy

Source: based on NFZ financial statements for 2004, 2010, 2014–2017

Conclusions

Poland's health system is underfinanced, although this conclusion cannot be justified by pointing only to spending in other EU and OECD countries. The point of reference for the argument for growth in health expenditures should be unmet health needs and health policy goals, expressed in health indicators.

A mobilization of various sources of health care financing is needed, both public – growth in insurance premiums for the NFZ, broadening the base on which they are calculated, imposing percentage premiums on farmers, growth of budget subsidies, growth of excise taxes on unhealthy consumption and shifting revenues from these taxes directly and fully to health system – and private: growth of private health insurance, introduction of patient co-payments, which have a motivational effect (as described in Marzena Tambor's text).

Growth in health expenditures in and of itself will not guarantee an improvement in health indicators, growth in the feeling of security or an improvement in patient assessments of the system's functioning. Also essential are decisive steps toward effective and efficient allocation of resources. Particularly necessary is the creation of a system of coordinated healthcare, going beyond the medical sector, both in the pre-disease direction (health promotion and disease prevention) and post-disease (rehabilitation, nursing and palliative care).

A holistic view of the person as potential patient, patient and former patient requires a change in the organizational paradigm of health care, overcoming its fragmentation, and

renewed integration (including financial integration) of its individual elements.

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Chapter 3

Marzena Tambor

On patient copayments: examples, opportunities and limitations

Introduction

Growing health needs and simultaneous limitations on the ability to meet them, constitute a significant challenge for healthcare systems, and encourage the search for ways to limit healthcare costs, as well as for alternatives to public health care financing. Patient cost-sharing for publicly financed healthcare is a widely used tool for increasing the financial stability of healthcare systems (Ros, Groenewegen i Delnoij, 2000; Tambor et al., 2011). By increasing patients' responsibility for financing services, cost-sharing might limit negative consumer behaviors such as the excessive use of services (moral hazard), which appears when services are provided to patients free of charge (S. Golinowska, 2015; Mwabu, 1997; Zweifel and Manning, 2000). Thus, patient cost--sharing provide an opportunity to improve the efficiency of healthcare resource use. Additionally, patient cost--sharing constitutes a source of revenue for the healthcare system or particular providers, which makes them an attractive tool in countries with under-financed healthcare systems.

3.1. Copayments in Europe

In the majority of Western European countries, patient cost-sharing for outpatient or inpatient healthcare services was introduced in response to growing public spending on health (Abel-Smith i Mossialos, 1994; Tambor et al., 2013; Tambor et al., 2011). Only a few countries (the UK, Denmark, and Spain) have not decided on this step, which was to a large degree dictated by the principle, deeply rooted in those countries' systems, of equal access to healthcare benefits, which could be violated by the introduction of patient cost-sharing. In Central and Eastern European countries, patients commonly contribute to the costs of medicines, but more rarely copay for healthcare services in the public system, though informal or quasi--formal payments (payments illegally introduced by providers) are widespread (Stepurko et al., 2010). As a result, despite the lack of formal patient cost-sharing for services, the share of household out-of-pocket expenditure in healthcare financing in these countries is significantly higher than in Western European countries (WHO, 2018).

Looking at the experience of European countries, we can observe very dynamic changes in the policy on patient cost-sharing for healthcare services (Tambor et al., 2011). Over the past decades, many countries have introduced patient cost-sharing, but later gave up on this tool. But while in the countries of Western Europe the abandonment of cost-sharing is often based on an assessment of the policy and results from the limited effectiveness of cost-sharing policy in achieving its goals, in Central and Eastern European countries cost-sharing policies are rarely based on evidence, and its withdrawal often has a political basis. Table 1 presents examples of countries where significant changes in patient cost-sharing policy have taken place in recent decades.

Table 1: Changes in patient cost-sharing policy in selected European countries

Netherlands: patient cost-sharing for specialist outpatient services and inpatient services was introduced in 1997, and withdrawn in 1999, when the system turned out to be relatively untransparent and did not fulfil its goals, i.e. increasing patient awareness of the costs of healthcare and limiting unnecessary use. In 2006 patient cost-sharing was restored in a different form (deductibles).
Germany: patient cost-sharing for inpatient services was introduced in 1990. In 2004 obligatory cost-sharing for out-patient services were introduced (EUR 10 for the first visit in each quarter), though it was abandoned in 2013 in light of the positive financial condition of the public insurance system. Providers expressed opposition to patient cost-sharing, considering fees a financial burden on low-income patients and unnecessary bureaucracy for doctors.
Hungary: formal patient cost-sharing was introduced in 2007 in a situation of widespread informal payments. Copayments aroused much discussion and were abolished in 2008 after a referendum where voters expressed opposition to formal copayments.
Slovakia: patient cost-sharing was introduced in 2003 in the face of a high deficit of the public system. The law was questioned on constitutional grounds, but upheld (with the copayments recognized as administrative fees) until the change of government in 2006. Still, providers continued to collect payments from patients. In 2015, a regulation was introduced banning such practices.
Czech Republic: patient cost-sharing for inpatient and outpatient services was introduced in 2008. The copayments were politically divisive, controversial and unpopular. Some local governments (controlled by the opposition) refunded patients' copayments. By a 2013 decision of the Constitutional Tribunal, the daily copayment for hospital care (EUR 4) was abolished beginning in 2015. In that same year, a new governing coalition also withdrew mandatory copayments for outpatient services.

Source: Based on Alexa et al., 2015; Stafford, 2012; Tambor et al., 2013.

The systems of patient cost-sharing for healthcare services in European countries vary widely.[1] This diversity applies both to methods of payment and its levels, as well as to the range of services and the segment of the population covered by cost-sharing. The most widely applied and simplest method is fixed payments (co-payment) for doctor visits or hospital stay days. In Central and Eastern Europe these payments are relatively low (less than EUR 5). Higher levels apply in richer countries, e.g. up to EUR 35 in Sweden for consultations with specialists, and EUR 9 per day for hospital stays.

In several European countries (France, Belgium, Austria, Luxembourg, Slovenia), patients are obligated to pay a fixed percentage of the costs of services (co-insurance), e.g. in France, patients cover 30% of the costs of outpatient care and 20% of the costs of hospitalization. It is not difficult to imagine that the amount the patient must pay can be significant. Thus, in most countries where this form of cost-sharing is applied, a market for private health insurance has developed, and voluntary insurance coverage is widely purchased by consumers. Yet, the access to private insurance is difficult for the poor and chronically ill, which requires support from the state. It must also be noted that allowing private insurers to cover the costs of patient payments significantly reduces the influence of cost-sharing on excessive use of services, though the fiscal effect, i.e. relieving the burden on the public purse, can still be achieved.

Another form of patient cost-sharing, which exists in the Netherlands and Switzerland, is deductibles. Under this mechanism, the patients cover the entire cost of services until they pay a certain level in a year, e.g. in the Netherlands, the annual deductible is EUR 385.[2] Thus, the patient receives a bill for the full cost of the first visits in a year, but in later visits they may reach the level of the deductible, and further services in that year will be free of charge. This form increases awareness of the costs

1 A review of patient contributions for healthcare benefits in 27 EU countries is presented in Tambor et al., 2011.

2 Dutch insurers may voluntarily increase the deductible to a maximum of EUR 500 in exchange for payment of lower health insurance premiums.

of services, and can significantly influence demand at the beginning, i.e. when the patient decides to use care for the first time in a given year.

All of the above mentioned methods are direct patient cost-sharing mechanisms. There is also indirect form of cost-sharing, known as indemnity or extra billing, where the patient voluntarily pays fee by selecting higher-priced services. The level of this payment is the difference between the price of the service and the amount refunded by the public insurer. This form of cost-sharing gives consumers the possibility to choose higher-quality services. However, it must be borne in mind that this method requires a clearly defined scope and standard of services within the public system which are available free of charge for patients. Moreover, improvements in quality of care for paying patients should not happen at the expense of patients using the free of charge, basic range of care. The experience of France, where some outpatient care providers may charge higher fees for their services above the reimbursed amount, also indicates the risk of significant growth in the price of services, not always justified by its costs (Chevreul et al., 2015).

Despite the introduction of patient cost-sharing, certain services, due to their significance for population health, may be exempted from cost-sharing obligation and provided free of charge. In European countries these are often prevention services, maternity care and emergency care (Tambor et al., 2011). Sometimes primary healthcare is excluded from the cost-sharing system (the Netherlands, Estonia), in order to ensure its accessibility to all patients. Additionally, certain population groups are exempted from cost-sharing obligation, or have their payments reduced. The most commonly protected groups are children, the elderly, low-income people, people with certain health problems (the chronically ill and disabled). But there are also exemptions that are not justified by higher needs or lower ability to pay, e.g. medical professionals in Bulgaria. The share of population that is exempt from copayments may be significant, e.g. 60% in Portugal (Simoes et al., 2017). Upper limits on copayments are also frequently used (e.g. the total level of cost-sharing in a year, or the number of inpatient days subject to payments), particularly in countries where the level of the one-time charge is significant, and payments may constitute a financial burden for the people who are forced to frequently use health care services.

Diversity in countries' patient payment systems, and the characteristics of a given health system or population's socioeconomic situation, affect the effectiveness of cost-sharing policies, though the scientific evidence in this area is limited. Countries' experiences indicate the effectiveness of patient payments in reducing the use of healthcare services, but this is often burdened with negative consequences in the form of limitation of access for high-risk groups. Adverse equity effects were observed e.g. in Germany (Rückert et al., 2008) and France (Lostao et al., 2007)2007. The reason for failures of protection policy may be gaps in the mechanisms applied, or their untransparency, which leads to patient not exercising their rights to be exempt or pay lower fee.

Patient cost-sharing does not seem to constitute a significant source of revenues for healthcare systems, e.g. in Germany the EUR 10 fee for the first doctor visit in each quarter, which existed until 2013, generated net income in the amount of about EUR 2 billion a year, the equivalent of about 1% of public insurance spending on health (Stafford, 2012). At the micro level, for the individual healthcare provider, patient cost-sharing may be a more significant source of revenues. For this reason, the healthcare providers in less prosperous countries are often supporters of patient payments, perceiving them as a source of increased income (Tambor et al., 2015). Nevertheless, the fiscal capacity of the cost-sharing system is often limited due to the relatively low level of payments, which are set so as not to constitute a barrier to access for the majority of consumers, as well as due to the exemptions or fee reductions for selected social groups. It must also be borne in mind that net revenues are reduced by the costs of administering the system, which are higher the more complicated the system is.

3.2. Premises and barriers for the introduction of patient cost-sharing in Poland

The introduction of mandatory patient payments for healthcare services in Poland is often raised in discussions on the need to rationalize the healthcare system, but also on its underfunding and the need for additional sources of revenue. Looking at indicators of healthcare spending, it can be seen that the funds designated for healthcare in Poland are lower than in the majority of European countries (WHO, 2018). This relationship occurs regardless of whether we are discussing total health expenditure or only public spending; expenditure per capita or expenditure relative to gross domestic product (GDP).

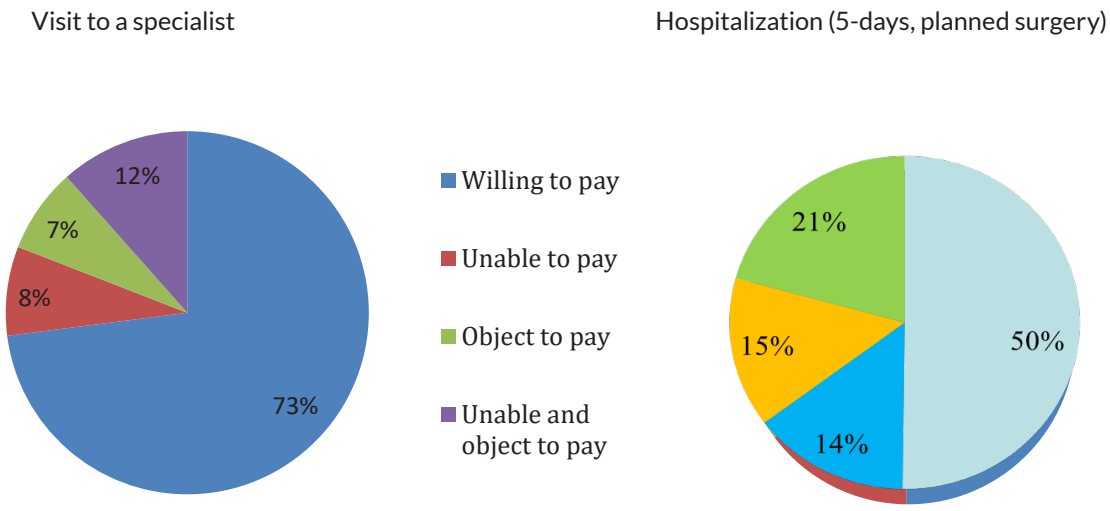
There is also a widespread conviction that some healthcare services are overused by patients in Poland, though it is hard to find evidence documenting the scale of excessive use of care.

Meanwhile, there is evidence indicating patients' willingness to pay for healthcare services of good quality and quick access. This evidence is provided by research carried within the international project ASSPRO CEE 2007.[3] In a study on a representative group of residents of Poland, willingness to pay for publicly financed outpatient specialist services of high quality and accessi

bility was expressed by 73% of respondents, while 50% respondents were willing to pay for hospitalization (see Figure 1). However, willingness to pay for services is more common among younger people, with higher incomes and better health (Golinowska and Tambor, 2012; Tambor et al., 2014).

The willingness of consumers to pay for better access of care is also reflected in the use of private healthcare services in Poland. According to GUS, 38% of those who use outpatient specialist care (excluding dental care) use these services in the private sector (2016 data; GUS, 2018).

Figure 1: Willingness of Polish consumers to pay for healthcare services of good quality and quick access * (percentage of respondents), 2010.



* High quality and quick access were defined as: modern medical equipment, renovated healthcare facilities, and polite staff with good reputation and skills, max. 30 min travel time to the healthcare facility, max. 10 min waiting time in the outpatient facility, max. 1 month waiting time for planned surgeries.

Source: Results of the ASSPRO CEE 2007 project, www.assprocee2007.com

3 The ASSPRO CEE 2007 project (Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe) was an international research project in the 7th Framework Program, carried out in 2008–2013 in six Central and Eastern European countries under the leadership of Maastricht University in the Netherlands. The purpose of the project was to supply scientific evidence to form policies in the area of patient contributions to treatment costs in the countries of Central and Eastern Europe. Project website: www.assprocee2007.com

The above mentioned arguments might indicate a certain need, as well as space for introducing patient payments. Nevertheless, there are also significant barriers, which must be taken into account when developing a patient cost-sharing policy. The first is the financial burden on patients imposed by existing payments for healthcare. The share of household out-of-pocket expenditure in total health spending in Poland is already 23%, compared with a WHO recommendation of 15% (WHO, 2018). Households pay primarily for medicines both for prescription drugs, where cost-sharing exist, as well as over-the--ounter medicines, consumption of which in Poland is at one of the highest rates in the EU (Eurostat, 2018). Another significant item in household health expenditure is spending on dental care, which is largely not financed from public funds. The burden of healthcare spending on households is significant; about 9% of households are affected by catastrophic spending, i.e. expenses so high that they limit the ability to meet other needs (Tambor and Pavlova, 2018). Additionally, some people forego using healthcare because of inability to pay. According to GUS data, in 2016 about 6% of people for whom medicines were prescribed did not buy them due to financial barriers (GUS, 2018).

Another significant barrier that, as shown by the experience of other Central and Eastern European countries, may prevent the implementation of patient cost-sharing, is social opposition. Despite quite significant willingness to pay for high-quality and accessible services, consumers in Poland do not consent to mandatory patient payments for services in the public system. Qualitative research carried out as part of the ASSPRO CEE 2007 project indicates that patient opposition results from the low quality and accessibility of services in the public system, and simultaneously a lack of confidence that copayments could improve this situation (Golinowska et al., 2010). At the basis is consumers' conviction that the system is mismanaged and public funds from insurance premiums are not used efficiently. Thus, patients perceive obligatory fees as paying twice for the same thing (once as insurance premiums, once as cost-sharing). Consumers would acceptance patient cost-sharing if a better quality of healthcare was ensured. More acceptable for consumers would be a cost-sharing system that contributed toward a general improvement in the quality of care for all patients, than a system that would allow voluntary payments in exchange for better quality or availability of care (particularly in the case of quality of purely medical services, and not e.g. better standards for hospital rooms).

In discussions on the introduction of patient cost-sharing, the question on the provisions of the Polish Constitution, as a factor that makes it impossible to implement obligatory patient payments, is also raised. Article 68 of the Polish Constitution states that „Equal access to health care services, financed from public funds, shall be ensured by public authorities to citizens, irrespective of their material situation." The article does not speak directly of free healthcare, but of equal access. Thus, it can be assumed that if a cost-sharing system was accompanied by various mechanisms protecting access to healthcare for vulnerable groups (unable to pay for services), the constitutionality of such a system could be preserved. The experiences of other European countries where the constitutionality of patient cost-sharing was questioned also indicate variations in how patient payments are defined. Patient fees can be regarded as patient participation in the costs of treatment, in which case their constitutionality may be questioned (as in the Czech Republic, see Alexa et al., 2015). Yet, they might but also defined as an administrative fee (as in Slovakia, see Szalay et al., 2011), or a payment for food and accommodation in the hospital, which to a lesser degree can be recognized as violating the principle of equal access to healthcare services.

Summary

Patient cost-sharing for publicly financed healthcare services is one of the available tools to improve the sustainability of healthcare system. However, its potential is limited, and its implementation is burdened with the risk of negative effects on patient access to necessary health care services.

The potential of patient cost-sharing to generate additional funds for health care system is small, as indicated by the experiences of European countries. Thus, patient payments would not be able to eliminate the problem of healthcare system's underfunding, particularly if we speak of fixed, relatively low copayments, which at the moment appear to be the administratively possible solution in Poland. Looking also at indicators of healthcare spending in Poland and its structure (the relatively high share of household out-of-pocket spending), the efforts should be made to rather increase public funds for healthcare. Patient cost-sharing, meanwhile, could be a tool for increasing patients' responsibility and their awareness of health care costs, and more rational use of services. However, the implementation of patient payments requires developing protective mechanisms, to ensure access for vulnerable population groups. Such mechanisms should be targeted first and foremost at people with lower financial ability (the poor) and people with higher healthcare needs. The system should be also administratively simple to introduce, and transparent for consumers. The space for introducing patient cost-sharing for services in Poland is today significantly limited by the presence of patient payments, mainly for medicines, which also requires intervention by the state.

Introducing patient cost-sharing for services in Poland is also a politically difficult task due to existing public opposition. As research in this area indicates, the acceptance of patient payments could be higher if patient expectations of better quality and accessibility of care were met. This is a difficult task if we take into consideration the low fiscal potential of patient cost-sharing. The experiences of other countries in our region have shown that the cost-sharing policy did not contribute to a significant improvement in service quality, and thus it was doomed to failure. Thus, it is essential to introduce other mechanisms, including provider-side measures, which will contribute to a general improvement in health care for patients.

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Chapter 4

Alicja Domagała

Health workforce: personnel shortages and ways to overcome them

Introduction

The problem of labor resources for the healthcare sector has for more than a decade been one of the key areas of strategy and actions by the most important international organizations that work on health issues. In the 2006 World Health Organization report *Human resources for health in the WHO European Region*, it was stated that the majority of countries are facing a medical staff crisis, whose main challenges are problems related to education and professional training, ensuring a satisfactory level of compensation and employee retention (WHO, 2006a).

A significant initiative at the EU level, in response to the crisis in labor resources that has been diagnosed, was the preparation of the document titled European Commission Green Paper on the European Workforce for Health (European Union, 2008). It defined the key challenges facing European healthcare systems in the context of health workforce, and proposed actions at the EU level that would help resolve the most important problems without exerting a negative influence on healthcare systems outside the EU. Designating the issues of medical staff as priorities also resulted in the adoption, at the international level, of many other initiatives, including: the compilation on a global scale of an atlas of knowledge about healthcare workers (WHO Global Atlas of the Health Workforce, 2009), the development of a code of conduct in the recruitment of employees from abroad (the WHO Global Code of Practice on the International Recruitment of Health Personnel, 2010) and the creation of a platform of collaboration for joint action against the medical staff crisis, the Global Health Workforce Alliance (WHO, GHWA 2006b).

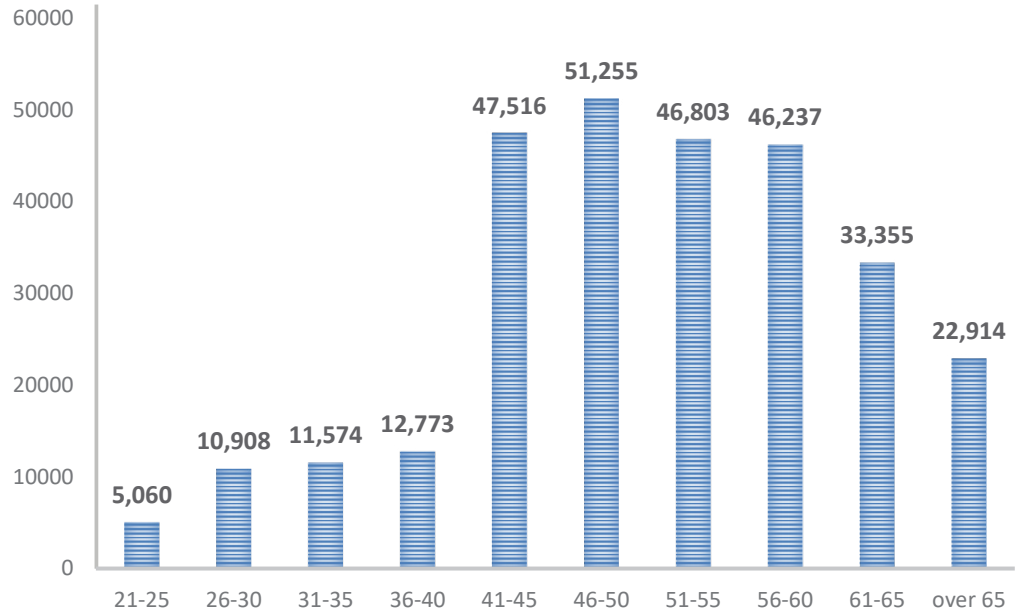
The current medical staff problems, particularly the intensifying shortages, have been driven by many factors, of which the most important are inappropriate management of human resources and a lack of a rational human resources policy; failure to adjust the structure of employment to the nature and scope of services provided; lack of planning or inappropriate planning in the education system; and in many countries also insufficient financing of the healthcare system. The most important challenges for the majority of countries today are: training a sufficient number of medical personnel prepared to address the growing health needs of the population; ensuring a satisfactory level of compensation; and recruiting, motivating and retaining employees (Włodarczyk and Domagała, 2011). Additionally, the problem of staff shortages is magnified by the continued aging of the population and the increase in chronic diseases, which leads to growth in demand for medical services, and thus growth in the need for qualified medical workers from particular professional groups.

According to current WHO forecasts, the healthcare system's labor shortages on a global scale will reach about 18 million medical employees in 2030 (WHO, 2016). In turn, estimates prepared by EU experts and published in the document EU level Collaboration on Forecasting Health Workforce Needs, Workforce Planning and Health Workforce Trends indicate that shortages of medical staff in healthcare systems at the EU level already in 2020 will reach about 1 million employees, including shortages of doctors forecast at 230,000, nurses at 590,000, and shortages of dentists, pharmacists and physical therapists totaling 150,000 (European Union, 2012).

4.1. Shortages of Polish medical staff – current level and scale of the shortage

For Poland it is difficult to make a real assessment of the scale of the shortage of medical staff. There is a lack of formal structures for planning and forecasting health workforce, which results in a lack of systematic analysis and strategy in this area. The available forecasts are fragmentary and don't take into account epidemiological and demographic trends in the population (Domagała and Klich, 2018). But we must stress the key significance of initiatives in this area undertaken by medical professional associations. The Polish Chamber of Nurses and Midwives (NIPiP) prepared a forecast of the number of registered and employed people in those professions through 2035, which confirm that the shortage of nursing staff in Poland is alarming (NIPiP, 2013). According to these forecasts, the number of nurses employed per 1,000 residents, currently one of the lowest rates in the EU at barely 5.2 (compared with an OECD average of 9.0) may drop to 3.65 in 2035. A decline to such a low level, accompanied by growth in demand for nursing and care services, poses a significant threat to the continuity of patient care, and a serious challenge for decisionmakers and organizers of healthcare. According to data from the NIPiP, the most numerous age group of professionally active nurses (33.5%) is the 46-55 age group, and the smallest is people under 35 (16%) (NIPiP, 2017). The average age of nurses working in Poland at the moment is as high as 51, and as the data in Figure 1 show, this indicator will grow steadily. Such an age structure among nurses leads to the problem of a "generation gap," meaning a lack of ability to replace older age groups by younger people entering the system. According to NIPiP estimates taking into account the current age structure, the forecast deficit in 2030 will be about 169,000 nurses and midwives (NIPiP, 2017).

Figure 1: Age structure of Polish nurses



Source: Central Register of Nurses and Midwives, www.nipip.pl

Similarly disadvantageous is the condition of the physicians workforce, both in quantitative terms (the lowest number of doctors per capita among European OECD countries) and in demographic ones (the rising average age of this professional group), which over the next few years may cause a further intensification of the problem of access to healthcare. Data published in the OECD report Health at a Glance 2017 indicate that Poland is characterized by the lowest number of doctors per 1,000 residents among EU member states (OECD, 2017). The average for all OECD countries in 2015 was 3.4 doctors per 1,000 residents, and for Poland barely 2.3 per 1,000. Among European countries the highest number of professionally active doctors per 1,000 residents is found in Greece (6.3), Austria (5.1) and Portugal (4.6). An analysis of this indicator over the years shows that Poland is one of a few OECD countries for which the number of doctors over the past 10-20 years has not

increased. Most countries preparing for the forecast increase in the need for doctors significantly increased the supply of doctors, e.g. in Sweden the indicator rose from 3.0 in 2000 to 4.2 in 2015; in Denmark, from 3.0 to 3.7; and in the UK from 2.0 to 2.8. But it must be pointed out that these countries have a high share of immigrant doctors among employed doctors (e.g. in the UK, the level is as high as 28.7%), which means that the growth in the employment indicator was achieved not only through increasing the number of doctors educated, but also by employing doctors from other countries.

The Polish Chamber of Physicians (NIL) has for many years been pointing out the problems of the doctor shortage and the unfavorable age structure (NIL, 2015). According to NIL data, the most numerous group of working doctors is people aged 46–60, while the least represented are the age groups of 31–35, 36–40 and 66–70. More than 60% of practicing specialists are over 50. The average age of a doctor working in their profession in Poland is almost 50 today, and the average age of a specialist is as high as 54.5 years. That means that in the group of doctors, similarly as in the case of nurses, we are facing a "generation gap," i.e. an inability to replace the older age groups with younger people joining the labor market (NIL, 2015).

Also noteworthy are expert analyses concerning forecasts for ensuring medical services for the population over the next few years. One such forecast was developed on the basis of the methods used in the NEUJOBS project (Golinowska et al 2013). According to the results of this forecast, demand for medical staff for inpatient care will rise by 9,500 doctors and 17,200 nurses by 2030.

A valuable initiative is the preparation of forecasts of the need for medical staff in the area of oncological and cardiological care, prepared within the framework of the Map of health needs (Ministry of Health, 2015). On the basis of these forecasts, estimates for shortages of doctors in 2030 were calculated, reaching 389 oncologists and 655 cardiologists. We must hope that this forecasting will be continued to create further maps of health needs, and that it will be broadened to the remaining medical specialties.

The information presented above and the disturbing forecasts in this area have been confirmed by the Supreme Audit Office (NIK), in a report titled Formation and professional preparation of medical staff in Poland (NIK, 2016), which states that the method of educating medical staff does not ensure a sufficient number of specialists, adjusted to changing health needs. It also points out the lack of a comprehensive strategy of ensuring medical staff, taking into account demographic and epidemiological trends. Additionally, the lack of solid, reliable information on the subject of emigration of medical personnel was pointed out; this makes it impossible to counteract the trend. In the conclusions of its audit, NIK warned that attempts to eliminated the multi-year backlog by speeding up the process of educating doctors carries the risk of an inability to maintain the quality of education (e.g. elimination of post-graduate internships in medical education, opposed by professional organizations).1

4.2 Issues in planning medical staffing

Shortages in medical staff have for many years been treated as a priority by European and global health organizations. Various approaches to moderating the effects of the shortage are proposed, but these actions require cross-sector cooperation and the support of contemporary health policy by proper management, as well as planning of medical staffing. One of the solutions proposed by experts is an increase in limits on admissions to medical studies, as well as the number of places for specialist education, financed from the state budget. Still, according to NIL the limit on admissions for full-time medical studies in Poland do not even ensure the maintenance of the current number of doctors, particularly in light of the problem of the generation gap. 2 Factors that hinder an increase in admissions to medical education include finances, as medicine is one of the most important fields of study, and the costs of educating a medical student are very high. The limits on admissions to full-time medical studies have for years been maintained at a relatively stable level. The Supreme

1 The 13-month post-graduation internship was eliminated in 2011, to speed up the path of educating doctors and their entry to the labor market. However, in the end the internship was restored in 2016.

2 Each year the health minister (in consultation with the minister responsible for higher education) issues an ordinance setting the number of students who can begin medical and dental studies in that academic year. When setting the limits of acceptances, the criteria described in Article 8 paragraph 4 of the *Act of 27 July 2005 – Law on Higher Education* are taken into account, as are the capabilities of he educational institutions and the need for graduates of these fields of study.

Audit Office points out that the limits on admissions to medical studies are set by universities, guided by their own analysis, mainly financial (NIK, 2016). A significant change in the limits on admissions to medical studies was made in the 2015–2016 academic year, when they were increased by 394 places for professional degree studies, conducted full-time in Polish, and by 183 places for part-time study. Since then, the limits on admissions to medical studies have increased systematically: In the 2018–2019 academic year, they totaled 7,816 places, including 5,966 for Polish-language studies.[3] Additionally, since 2015 the number of specialist places financed from the state budget (residencies) has increased, particularly in priority fields with the greatest shortages.[4] But it must be pointed out that medical education is a long-term process; the period from enrollment in studies until the completion of a specialization generally lasts 10–20 years. Thus, decisions in this area should be taken in a considered fashion, based on honest analyses and forecasts, taking into account both demographic-epidemiological needs and differentiation in particular regions of the country.

The analyses and prognoses prepared by the NIPiP of the number of registered and employed nurses and midwives in 2016–2030 indicate the following problems: systematic growth in the number of registered nurses and midwives with pension rights; the constant growth in the average age of employees; the clear lack of intergenerational replacement arising from the disadvantageous age structure; a further reduction in the number employed per 1,000 residents (NIPiP, 2017). In light of the seriousness of these problems and their consequences for the healthcare system, the Strategy for the development of nursing and midwifery in Poland was developed, and – significantly – this was done with the participation of key entities engaged in shaping how nursing and midwife services are ensured (MZ, 2017).

An important area of activities toward ensuring appropriately educated and motivated medical staff is ensuring the proper level of compensation, which will ensure employees remain in the system. An analysis of wage policy in our country (see Figure 2) shows that actions in this area are mainly ad hoc, and in general are a response to a wave of strikes and protests. The points shown on the time axis relate to strikes and protests, and their size reflects the scale of the protest. Analysis also clearly indicates a lack of planning in the sphere of financing labor resources, even though personnel costs account for the greatest share of medical facilities' operating costs.[5] Additionally, agreements and decisions in this area concluded at the central level are often unrelated to securing the necessary financial resources to implement them at the level of the healthcare facility[6] The consequences of these decisions mean that managers of healthcare units, carrying out the financial obligations to employees placed on them by statute without acquiring sufficient financing, generated debts for their facilities.

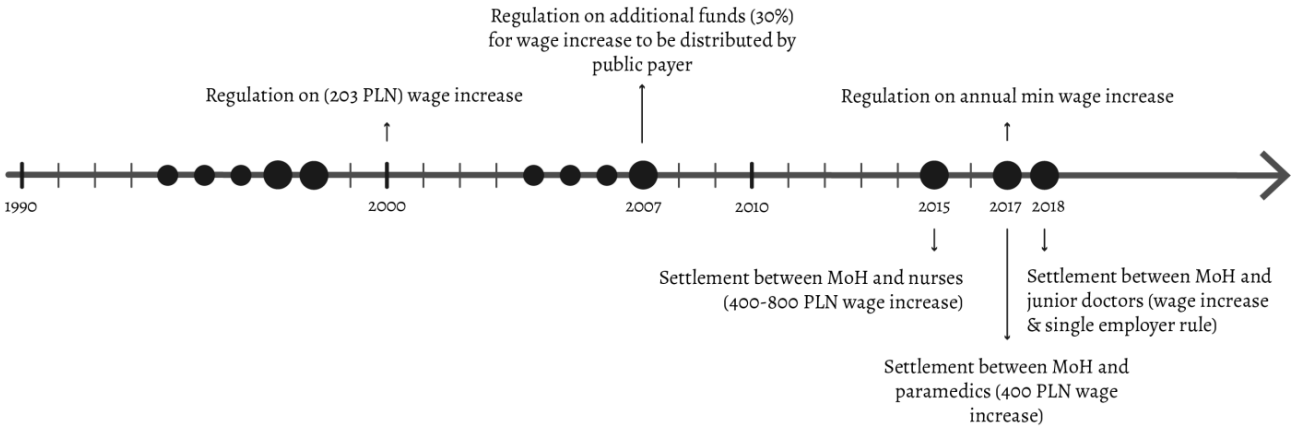
3 Comprising 4,678 for full-time study and 1,277 for part-time studies; the remaining 1,861 are places for students studying in languages other than Polish, who will not work in the Polish healthcare sector in the future.

4 Health Ministry ordinance of December 20 2012 on defining priority medical fields, Dziennik Ustaw (Journal of Laws) 2012, position 1489.

5 The costs of employing workers are a key item in the budgets of healthcare facilities, generating from 50% to 80% of total operating costs depending on the particulars of the facility (of this, costs of medical staff constitute 60–80% of personnel costs).

6 "Act 203" – the Act of December 22 2000 amending the act on the negotiating system for steering the growth of average compensation in private businesses and amending certain acts on healthcare facilities, Dziennik Ustaw (Journal of Laws) No. 5 position 45, 2001. Under this law, workers in Public Healthcare Facilities (SPZOZ) were entitled from January 1 2001 to increases in average monthly wages of at least PLN 203 (pro rata for part time work), based on growth of all components of compensation.

Figure 2: Analysis of the introduction of legal regulations in the area of growth of compensation in the healthcare system as a response to medical workers' strikes and protests



Legend: • (the dots) designate strikes and protests, and their size reflects the size of the protest

Source: Dubas-Jakóbczyk K., Domagała A. Impact of the doctor deficit on hospital management in Poland – a mixed methods study, International Journal of Health Planning and Management, 2018.

4.3. Consequences of the medical staff shortage

The current condition of medical staffing in Poland is alarming, and the consequences of personnel shortages are visible in various areas of the healthcare system's operation. Taking into account forecasts of the number of medical workers, it must be expected that the problems in the healthcare sector will only intensify. Patients have limited access to medical services; waiting times for services (both inpatient and outpatient) are growing. Satisfaction with the quality of medical services is falling, with a simultaneous decline in patients' health security. In the latest ranking by the Euro Health Consumer Index, Poland ranked 31st of 35 countries (Health Consumer Powerhouse, 2017).[7]

The negative consequences are also clearly being felt by employees. Excessive burdens arising from the lower staffing, worse working conditions and long-term stress lead to effects including burnout – a serious problem, particularly among nurses. As a result, the worsening working conditions have a direct effect on reducing job satisfaction, and on frequent resignations from work in the healthcare system.

In turn, the mass resignations from labor contracts by workers from various medical professions that have been observed in many hospitals in recent months are posing a real threat to the stability of healthcare facilities' functioning. The pressure on the managers of medical facilities and the pay demands often leave them no room for negotiation, and the rejection of these demands may result in failure to fulfil the conditions under which the National Health Fund (NFZ) contracts for medical services, and thus the need to suspend the operations of individual departments, or even the entire facility. In total, and from the perspective of the system, this leads to growth in the operating costs of the healthcare system.

7 The only countries ranked lower than Poland are Albania, Bulgaria, Montenegro and Romania.

4.4. Key challenges/possible methods of overcoming the crisis

Finding, training and retaining medical specialists is currently a key challenge both for the government and politicians responsible for healthcare, and for managers of medical facilities. One of the key factors shaping the supply of personnel is the number of graduates from medical schools. Thus, it is important, when planning education and forecasting the employment of various groups of medical workers, to introduce accurate analyses, taking into account health needs. So it is worth participating actively in international initiatives, such as The Joint Action on Health Workforce Planning and Forecasting, whose purpose is exchange of experiences, mutual support for member states, dissemination of proven tools and good practices in the area of staff planning, and taking common actions to improve labor resources in the healthcare sector (EU, 2016).

Another significant issue is putting compensation and promotion policy in order. As the analysis illustrated in Figure 2 shows, decisions to increase compensation are on the whole taken at the central level after waves of strikes and protests, often without reliable cost analysis and long-term forecasts, and most of all without ensuring the appropriate sources of financing that would allow the implementation of planned raises at the level of particular healthcare facilities without the need for those facilities to go into debt. The lack of complex planning means that poorly thought out decisions from the central level generate debt for individual healthcare facilities.

The NIK audit (2016) indicates that in Poland there are no effective mechanisms monitoring migration. High budgetary outlays on educating medical workers are directed at ensuring a sufficient number of qualified medical personnel in the future. But in combination with the globalization of the labor market, migration of qualified medical professionals seems inevitable. Thus it is essential to define a migration policy (for both emigration and immigration) in relation to medical workers.

One opportunity to relieve the burden on medical workers of the growing administrative and organizational tasks seems to be the introduction to the system of support professions (e.g. medical assistants/secretaries, coordinators/organizers and health promoters). One of the groups of specialists that could provide effective support in this are public health specialists, whose interdisciplinary knowledge and targeted preparation for work in the healthcare system means they perform very well in roles such as coordinators of oncological treatment packages.

An attempt to mitigate the negative effects of the personnel shortages and a correction of actions in this area is not possible without close and responsible cooperation of all levels and all organizations engaged in the development of health workforce (i.e. planning, educating, employing and managing) at all levels of the healthcare system.

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Chapter 5

Krzysztof Kuszewski

(Public) Health as an investment

Introduction

Health protection is usually presented as two parallel but complementary actions: 1) building and 2) improving the health of the population. In light of lengthening life expectancy and the desire to ensure older people can continue to function, maintaining the good health and independence of this group, through rehabilitation and an active lifestyle, is continually gaining in importance.[1] For almost four years, the growing significance of building health, regardless of people's health status, age and social situation, has been stressed. Treatment and rescuing human life (medicine) is still ranked very highly, but it will be easier and less costly when public health institutes are in operation. People's quality of life, their well-being, will be higher when we take care for their health and support it, not excluding anyone from the life of society. We describe this building of health as investment. In this work we focus on one of the actions present in building health: creating and implementing national health programs (NHPs).

5.1. On investment in health – briefly and in economic terms

Investing in health was described as one of the actions making it possible to carry out the Agenda for sustainable and long-term growth (UN 2015; Hamelmann et al 2017). It ensures benefits for all of society and supports the growth of the economy, of all its sectors, with an estimated 400% return on each invested dollar. Following the new UN document on development around the world, the WHO's Health Evidence Network (HEN) was set up; its reports strengthen the idea of treating health protection as an investment (Dyakova et al, 2017). Nota bene, this thesis has been present for many years in the WHO's expert reports and recommendation documents. It has now also entered the document presented in Poland.[2]

Better health strengthens social capital and ensures a higher level of well-being, contributing simultaneously to better macroeconomic indicators and sustained growth. This is also why spending on public health should be perceived and justified as an investment, and not, as is traditional, as a cost. The investment approach to health was also seen in the European Union strategy for innovative development, Europa 2020, in which the health of the population and health services are a productive factor of growth and employment.[3]

1 Supporting the health and functioning of chronically ill people who have growing limitations on their activities is separated out as a third type of action in health protection, and is connected with social operations (Golinowska et al 2017)

2 Health as an investment in the context of the Action plan for implementing the Agenda for sustainable development 2030 and Health 2020: A study for political decisionmakers. WHO, Warsaw 2018.

3 https://ec.europa.eu/health/funding/programme

The high returns on investment in public health activitiest based on an analysis by the *Health Evidence Network*:

- Limiting the influence of environmental threats brings relatively high returns even from a modest scale of investment.
- Ensuring housing and healthy living conditions supports health and does not exclude people from social life.
- Reducing road accidents reduces treatment costs and limits disability.
- Improving spatial planning respecting the standards of a healthy environment and social integration is a condition of healthy life.
- Getting people to move more, making them more physically active (walking, riding bicycles) is a condition of a healthy lifestyle.
- Building links and social activity in local communities limits loneliness and depression.

Source: Dyakova i in., 2017

5.2. National Health Programs

The concept of investing in health is made operational by national health plans (NHPs). Even though the idea of treating health spending as an investment was present in various plans for many years, we are dealing with practical plans to implement it when in 1977 at the World Health Assembly the slogan "Health for all by the year 2000" was heard, and institutionally established a year later in declarations from Almaty. The WHO member countries were obligated to develop national strategies for health for all. In the 1990s, the idea of health for all was confirmed in WHO European documents with a horizon of 2020 (per Wojtczak, 2017).

One significant idea for the construction of an NHP was another important thesis: "health in all policies." This concept was presented by Finland during that country's EU presidency (Stahl et al, 2006), and later included in the WHO agenda (the Malta resolution and the Agenda WHO 2013).

Since the time of the system transformations in the 1990s, National Health Programs in Poland were basic documents defining the national policy on public health. Already in 1990, at the initiative of the Health Ministry, the first National Health Program was developed, adopted for implementation of a decision of the Social--Economic Committee of the Council of Ministers. Its strategic goals were related to preventing the threat of high mortality in Poland, primarily due to circulatory system diseases, injuries and poisoning, infectious diseases that can be eliminated and infant mortality (per Włodarczyk, 1998 and Wojtczak, 2009). In the implementation layer, this was a program directed at cooperation among ministries and between the central and local governments. Building new state institutions in those times did not support planning and coordination (Włodarczyk, 1998) and the program did not have a sufficient effect on decisionmaking. In 1993 it was changed, and the stress was placed on citizens' responsibility for making their own decisions. Rafał Halik wrote that despite the WHO's very warm reception of the Polish initiative, the first NHP was weak in terms of the institutional strengthening and implementation tools; it was de facto more of a declaration (Halik, 2014).

Next there were developed two long-term strategies, one for 10 years and one for eight (1996–2005 and 2007–2015), which were executed with varying effects. The next strategy, a mid-term one for five years (2016–2020) is being carried out now. All programs were prepared according to a uniform model: they begin from defining strategic goals, then set operational goals and subordinate them to tasks. It is of course assumed that progress toward achieving the goals will be monitored.

Table 1: National Health Programs in Poland – strategic and operational goals

Program	Strategic health goals	Operational goals
1996–2005 mproving health and related quality of people's lives	(1) Creating conditions and shaping motivation, knowledge and skills for a healthy lifestyle, and taking actions for one's own health and that of others. (2) Shaping an environment for life, work and education that supports health (3) Reducing differences in health and access to health benefits	1. Increasing people's physical activity 2. Improving people's eating habits and the health quality of food. 3. Reducing the spread of tobacco smoking. 4. Reducing alcohol use and changing its structure, and reducing harm to health caused by alcohol. 5. Limiting the use of psychoactive substances and related harm to health. 6. Increasing the effectiveness of health education in society and actions in the area of health promotion. 7. Promoting mental health and preventing the occurrence of psychogenic disorders. 8. Reducing exposure to harmful factors in the life and work environment. 9. Improving sanitation. 10. Reducing the frequency of accidents, particularly road accidents. 11. Increasing the quality and effectiveness of emergency care during sudden threats to life. 12. Increased accessibility and improved quality of primary healthcare. 13. Preventing the occurrence and effects of premature birth and low birth weight. 14. Improving early diagnosis and active care for people at risk of developing ischemic heart disease. 15. Improving early diagnosis and increasing the effectiveness of treatment of malignant tumors of the cervix and breast. 16. Creating conditions allowing disabled people to join in or return to active life. 17. Increasing the effectiveness of prevention of infectious diseases. 18. Intensification of prevention of tooth decay and periodontal diseases in children, youth and pregnant women.

Table 1: National Health Programs in Poland – strategic and operational goals

Program	Strategic health goals	Operational goals
2007–2015 Improvement in Poles' quality of life	(1) Reducing morbidity and early mortality caused by heart and circulatory disease, including strokes. (2) Reducing morbidity and early mortality caused by malignant tumors. (3) Reducing the frequency of injuries resulting from accidents and limiting their effects. (4) Preventing mental disorders through preventive-promotional actions. (5) Reducing early morbidity and limiting the negative effects of chronic diseases of the osteoarticular system (6) Reducing morbidity and early mortality caused by chronic respiratory disease. (7) Increasing the effectiveness of prevention of infectious diseases and infections (8) Reducing social and territorial differences in the state of public health.	Operational goals concerning risk factors and actions in the area of health promotion: 1. Reducing the spread of tobacco smoking. 2. Reducing alcohol use and changing its structure, and reducing harm to health caused by alcohol. 3. Improving people's eating habits and the health quality of food, and reducing the incidence of obesity. 4. Increasing people's physical activity. 5. Limiting the use of psychoactive substances and related harm to health. 6. Reducing exposure to harmful factors in the life and work environment and their health effects, and improving sanitation. Operational goals concerning selected populations: 7. Improving healthcare for mothers, newborns and small children. 8. Supporting physical and psycho-social development and health, and preventing the most common health and social problems of children and youth. 9. Creating conditions for healthy and active life for older people. 10. Creating the conditions for the disabled to lead an active life. 11. Intensifying the prevention of tooth decay in children and youth.
2016–2020	(1) Extending Poles' healthy lives. (2) Improving health-related quality of life (3) Limiting social inequalities in health.	(1) Improving people's eating habits, food quality and physical activity. (2) Preventing and resolving problems related to the use of psychoactive substances, behavioral dependencies and other risky behaviors. (3) Preventing problems of mental health and improving the psychological well-being of society. (4) Limiting the health risk resulting from physical, chemical and biological threats in the external environment and places of work, residence, recreation and education. (5) Promoting a healthy and active lifestyle during old age. (6) Improving reproductive health.

Source: the author, based on NHP documents

Developing a strategy is the first step. Implementation has run into problems related to establishing responsibility and ensuring the necessary funds. The long-term strategies exceeded the political responsibility of the ruling political groups, lending even greater significance to the institutions of the conceptual and analytical support base of the Health Ministry and the authority of experts in the area of public health.

Table 2: Institutionalization and monitoring of the NHP

NPZ	Responsibility		Monitoring
	creating the program	Implementing the program	
1996 –2005	Initially, the Expert Writing Team for Updating the National Health Plan, and from 2008, he Inter-ministerial Coordinating Team directed by the prime minister	Province governors' representatives for the NHP	Państwowy Zakład Higieny, PHZ, National Institut of Hygiene – P. Goryński, B. Wojtyniak, K. Kuszewski Monitoring of expected effects of the National Health Program 1996–2005 (2004 and 2005)
2007–2015	PZH; Coordination-writing team: Krzysztof Kuszewski, Paweł Goryński, Bogdan Wojtyniak, Rafał Halik	local governments	PZH – Monitoring team K. Kuszewski, R. Halik).
2016–2020	Health Ministry	Local governments and other public institutions	Health Ministry

Source: the author

The 1996–2005 NHP

Already during the creation of the initial National Health Program in 1990, the rules were established for inter-ministerial coordination in appointing the Inter--Ministerial Coordinating Team under the direction of the prime minister. This approach was repeated in 1996 during work on the long-term, open NHP (with the participation of experts and activists) for 1996–2005. In comparison to the 1990 program, the operational goals were broadened. Screening research was added, related to the early diagnosis of certain cancers. The program set the direction of regional decentralization before independent provinces were created, and the principle of subsidiarity was applied. It seems that these lofty, democratic ideals ran into the barrier of politicians' unpreparedness to cooperate, and society's low awareness of health. But it must be recognized with satisfaction that local governments, once they had the right legal basis, started to independently implement hundreds of local and regional health programs.

The 2007–2015 NHP

The program was prepared in PZH by a large, interdisciplinary team of experts. It was introduced with a two-year delay (related to a change of government). Its main goals resulted from an epidemiological analysis of the country and concentrated on preventing the main diseases in the population, beginning from ischemic heart disease. The program included, first of all, preventing non-infections chronic diseases, but it did not ignore infectious diseases. One of the goals was to reduce regional differences in health. The operational goals were divided into two types: those oriented toward limiting the risks of the main diseases and those aimed at the health problems of groups deserving of particular concern: children and youth, the disabled and older people.

Implementation of the NHP was mainly a matter for the local governments. For them, the program was to constitute a type of guide in directing actions for the health of the local community. The local governments quickly understood the sense of decentralization, and without worrying about the central government, ran hundreds of local programs (Cianciara et al, 2014). These programs, sometimes prepared in an insufficiently professional manner (Bandurska et al, 2016) were a social movement for health, which made it possible to identify local health problems and difficulties in implementing the programs.

Indicators were built into the NHP, making it possible to monitor implementation. The monitoring process didn't work right away; it improved significantly starting in 2010, when monitoring of the NHP covered all provinces. Here it must be mentioned that uniform monitoring of the NHP was not obligatory for local governments. In 2010 a total of 1,878 local governments at various levels were reported on, and in 2011 the number of local governments that

filed reports on subjects related to actions as part of the NHP rose to 2,368. The results of the monitoring of NHP implementation were also used by the administration in analyzing health and social policy in the territory of the provinces. In 2011–2012 all province governments organized conferences to sum up the results of NHP monitoring, which were held with the participation of regional decisionmakers in the area of health.

The National Health Program for 2007–2015 was the last document that clearly defined goals and ways to meet them, with indicators of implementation that could be monitored.

The 2016–2020 NHP

The preparation of the next NHP coincided with a change in government. A document was prepared for a shorter, five-year period. The creation of the Program was assigned to different teams than before, and supervision over the program's content was assumed by the Health Ministry, entrusting work to officials, not experts. The Inter-ministerial Coordinating Team met increasingly rarely, and representatives of ministries came from lower and lower levels.

The 2015–2020 NHP referred to the act on public health passed in September 2015.[4] The strategic goals were formulated very broadly, and in light of the short implementation period, they sound like particularly empty slogans. It is difficult to subordinate them to concrete operational goals, and even more so tasks. A new operational goal was introduced to the Program, related to reproductive health, which has an ideological context. Actions were announced related to aging and environmental threats. A leading position among the operational goals was taken by the fight with obesity and addictions (primarily from alcohol and narcotics). The main health threats, such as circulatory system disease, cancer, injuries and accidents, were not indicated as the main health problems requiring the state's concern, and the fight against them was consigned to the activities of medical specialists and scientific societies.

5.3. New health threats

Recent years have brought new threats to health, which should have been taken into account in the 2016–2020 NHP, but were not. They constitute a challenge for public health institutes, particularly for the Main Sanitary Inspectorate. An anti-vaccine campaign has broken out, and there is an acute problem of access to and use of designer drugs (bath salts), mixtures of various substances of unknown composition, that cause deep neurological change and often death. The problem of air pollution has intensified, and along with it the threat of circulatory-system disease, which is particularly true of large cities and their suburbs which are heated by coal of abysmal quality. This is the result of a policy of maintaining unprofitable coal mines to win over the mining vote. What's worse, in 2016 the development of wind electricity was legally restricted. This disrupted the implementation of the rule "health in all policies."

Final remarks

Investing in health requires the existence of institutions responsible for it, a long-term, monitored program and decentralization in its implementation. In accordance with the European Health 2020 policy, each health program should emphasize cooperation between the central administration, local government and other entities, and concentrate on restricting health inequalities and strengthening inter-ministerial actions for health.

Experience teaches that reforms in social policy, part of which is health protection, take root slowly and shouldn't be subjected to sudden changes when the government changes. The four radical reforms from the end of the 1990s didn't take root, and in essence, other than the local-government reform, their implementation has been partly or fully reversed. Health protection, as a complicated system, with numerous relationships between its elements, and a sensitive one, with a high impact on society, requires evolutionary changes (some of them incremental ones). Additionally, it involves a huge number of participants and stakeholders, whose cooperation is necessary for the system to work. Rather than evolutionary

4 The tasks written into the act on public health are almost a copy of a report by the American Centers for Disease Control and Prevention) from 20 years ago, and total just 1.5 pages. In the later, broader section, the Polish law announces the appointment of a public health council, and then gives the methods of financial settlement. The act does not indicate a coordinator of implementation of the listed public health tasks placed in the area of responsibility of many ministries. This was pointed out by panelists at a September 8 2017 conference (Zeszyty Naukowe Ochrony Zdrowia. Zdrowie Publiczne i Zarzadzanie No. 4/2017).

changes, at a certain moment centralization and a return to micromanagement began in Poland, without deliberation or discussion. Paradoxically, this happened during a period when in the area of health policy sophisticated studies were appearing, containing concepts of systemic solutions in health protection (Golinowska, 2014 and 2017; Włodarczyk, 2014; Cianciara, 2014; Wojtczak, 2017) and the results of comprehensive, evidence-based research. The latter allows an assessment of the effectiveness of methods of eliminating threats and diseases (in particular: Kuszewski and Gericke, 2005; NFZ, 2012; the systematic research by the duo of Goryński and Wojtyniak and their collaborators).

Increasingly often, people without the proper scientific background and practical experience in public health are appointed as top officials and experts. This situation was particularly disadvantageous for the creation of professional health programs and establishing them over the longer term. Additionally, complete overhauls of staffing for administrative positions in the health sector (and not only there), and changing health policy as a result of priorities imposed by successive political groups, delay and even reverse non-political solutions that have been decided on. Health protection is an element of social security and confidence in the state; it cannot be used for political battles.

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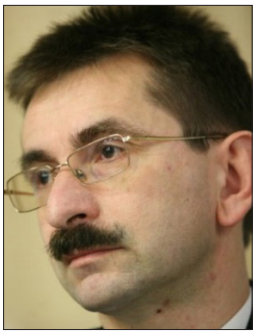

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14. Etyka biznesu
15. Perspektywy bankowości inwestycyjnej w Polsce
16. Restrukturyzacja finansowa przedsiębiorstw i portfeli trudnych kredytów banków komercyjnych (podsumowanie skutków ustawy o restrukturyzacji)
17. Fundusze inwestycyjne jako instrument kreowania rynku finansowego w Polsce
18. Dług publiczny
19. Papiery wartościowe i derywaty. Procesy sekurytyzacji
20. Obrót wierzytelnościami
21. Rynek finansowy i kapitałowy w Polsce a regulacje Unii Europejskiej
22. Nadzór właścicielski i nadzór bankowy
23. Sanacja banków
24. Banki zagraniczne w Polsce a konkurencja w sektorze finansowym
25. Finansowanie projektów ekologicznych
26. Instrumenty dłużne na polskim rynku
27. Obligacje gmin
28. Sposoby zabezpieczania się przed ryzykiem niewypłacalności kontrahentów. Wydanie specjalne: Jak dokończyć prywatyzację banków w Polsce
29. Jak rozwiązać problem finansowania budownictwa mieszkaniowego
30. Scenariusze rozwoju sektora bankowego w Polsce
31. Mieszkalnictwo jako problem lokalny
32. Doświadczenia w restrukturyzacji i prywatyzacji przedsiębiorstw w krajach Europy Środkowej
33. (nie ukazała się / was not published)

34. Rynek inwestycji energooszczędnych

35. Globalizacja rynków finansowych

36. Kryzysy na rynkach finansowych skutki dla gospodarki polskiej

37. Przygotowanie polskiego systemu bankowego do liberalizacji rynków kapitałowych

38. Docelowy model bankowości spółdzielczej

39. Czy komercyjna instytucja finansowa może skutecznie realizować politykę gospodarczą państwa?

40. Perspektywy gospodarki światowej i polskiej po kryzysie rosyjskim

41. Jaka reforma podatkowa jest potrzebna dla szybkiego wzrostu gospodarczego?

42. Fundusze inwestycyjne na polskim rynku – znaczenie i tendencje rozwoju

43. Strategia walki z korupcją – teoria i praktyka

44. Kiedy koniec złotego?

45. Fuzje i przejęcia bankowe

46. Budżet 2000

47. Perspektywy gospodarki rosyjskiej po kryzysie i wyborach

48. Znaczenie kapitału zagranicznego dla polskiej gospodarki

49. Pierwszy rok sfery euro – doświadczenia i perspektywy

50. Finansowanie dużych przedsięwzięć o strategicznym znaczeniu dla polskiej gospodarki

51. Finansowanie budownictwa mieszkaniowego

52. Rozwój i restrukturyzacja sektora bankowego w Polsce – doświadczenia 11 lat

53. Dlaczego Niemcy boją się rozszerzenia strefy euro?

54. Doświadczenia i perspektywy rozwoju sektora finansowego w Europie Środkowo-Wschodniej

55. Portugalskie doświadczenia w restrukturyzacji i prywatyzacji banków

56. Czy warto liczyć inflację bazową?

57. Nowy system emerytalny w Polsce – wpływ na krótko- i długoterminowe perspektywy gospodarki i rynków finansowych

58. Wpływ światowej recesji na polską gospodarkę

59. Strategia bezpośrednich celów inflacyjnych w Ameryce Łacińskiej

59. (a) Reformy gospodarcze w Ameryce Łacińskiej

60. (nie ukazała się / was not published)

61. Stan sektora bankowego w gospodarkach wschodzących – znaczenie prywatyzacji

62. Rola inwestycji zagranicznych w gospodarce

63. Rola sektora nieruchomości w wydajnej realokacji zasobów przestrzennych

64. Przyszłość warszawskiej Giełdy Papierów Wartościowych

65. Stan finansów publicznych w Polsce – konieczność reformy

66. Polska w Unii Europejskiej. Jaki wzrost gospodarczy?

67. Wpływ sytuacji gospodarczej Niemiec na polską gospodarkę

68. Konkurencyjność reform podatkowych – Polska na tle innych krajów

69. Konsekwencje przystąpienia Chin do WTO dla krajów sąsiednich

70. Koszty spowolnienia prywatyzacji w Polsce

71. Polski sektor bankowy po wejściu Polski do Unii Europejskiej

72. Reforma procesu stanowienia prawa

73. Elastyczny rynek pracy w Polsce. Jak sprostać temu wyzwaniu?

74. Problem inwestycji zagranicznych w funduszu emerytalnym

75. Funkcjonowanie Unii Gospodarczej i Walutowej

76. Konkurencyjność sektora bankowego po wejściu Polski do Unii Europejskiej

77. Zmiany w systemie polityki monetarnej na drodze do euro

78. Elastyczność krajowego sektora bankowego w finansowaniu MSP

79. Czy sektor bankowy w Polsce jest innowacyjny?

80. Integracja europejskiego rynku finansowego – Zmiana roli banków krajowych

81. Absorpcja funduszy strukturalnych

82. Sekurytyzacja aktywów bankowych

83. Jakie reformy są potrzebne Polsce?

84. Obligacje komunalne w Polsce

85. Perspektywy wejścia Polski do strefy euro

86. Ryzyko inwestycyjne Polski

87. Elastyczność i sprawność rynku pracy

88. Bułgaria i Rumunia w Unii Europejskiej Szansa czy konkurencja dla Polski?

89. Przedsiębiorstwa sektora prywatnego i publicznego w Polsce (1999–2005)

90. SEPA – bankowa rewolucja

91. Energetyka–polityka–ekonomia

92. Ryzyko rynku nieruchomości

93. Wyzwania dla wzrostu gospodarczego Chin

94. Reforma finansów publicznych w Polsce

95. Inflacja – czy mamy nowy problem?

96. Zaburzenia na światowych rynkach a sektor finansowy w Polsce

97. Stan finansów ochrony zdrowia

98. NUK – Nowa Umowa Kapitałowa

99. Rozwój bankowości transgranicznej a konkurencyjność sektora bankowego w Polsce

100. Kryzys finansowy i przyszłość systemu finansowego

101. Działalność antykryzysowa banków centralnych

102. Jak z powodzeniem wejść do strefy euro

103. Integracja rynku finansowego po pięciu latach członkostwa Polski w Unii Europejskiej

104. Nowe wyzwania w zarządzaniu bankami w czasie kryzysu

105. Credit crunch w Polsce?

106. System emerytalny. Finanse publiczne. Długookresowe cele społeczne

107. Finanse publiczne w krajach UE. Jak posprzątać po kryzysie (cz. 1)

108. Finanse publiczne w krajach UE. Jak posprzątać po kryzysie (cz. 2)

109. Kryzys finansowy – Zmiany w regulacji i nadzorze nad bankami

110. Kryzys fiskalny w Europie – Strategie wyjścia

111. Banki centralne w zarządzaniu kryzysem finansowym – Strategie wyjścia

112. Gospodarka nisko emisyjna – czy potrzebny jest Plan Marshala?

113. Reformy emerytalne w Polsce i na świecie widziane z Paryża

114. Dostosowanie fiskalne w Polsce w świetle konstytucyjnych i ustawowych progów ostrożnościowych

115. Strefa euro – kryzys i drogi wyjścia

116. Zróżnicowanie polityki fiskalnej w trakcie kryzysu lat 2007–2009 i po kryzysie

117. Perspektywy polskiej gospodarki w latach 2012–2013

118. Problemy fiskalne w czasach malejącego popytu i obaw o wysokość długu publicznego

119. Kondycja banków w Europie i Polsce. Czy problemy finansowe inwestorów strategicznych wpłyną na zaostrzenie polityki kredytowej w spółkach–córkach w Polsce

120. Zmiany regulacji a rozwój sektora bankowego

122. Dlaczego nie wolno dopuścić do rozpadu strefy euro

123. Unia bankowa – skutki dla UE, strefy euro i dla Polski

124. Procedura restrukturyzacji i uporządkowanej likwidacji banku doświadczenia światowe, rozwiązania dla UE i dla Polski

125. Ład korporacyjny w bankach po kryzysie

126. Sektor bankowy w Europie. Co zmienił kryzys?

127. Austerity Revisited, czyli ponownie o zacieśnieniu fiskalnym

128. Polityczne korzenie kryzysów bankowych i ograniczonej akcji kredytowej

129. Długofalowe skutki polityki niskich stop i poluzowania polityki pieniężnej

130. Kryzysy finansowe w ujęciu historycznym i co z nich dla nas wynika / Lessons learned for monetary policy from the recent crisis

131. Skutki niekonwencjonalnej polityki pieniężnej: czego banki centralne nie uwzględniają w swoich modelach? / The effects of unconventional monetary policy: what do central banks not include in their models?

132. Czy w Europie jest za duzo banków? / Is Europe Overbanked?

133. Transformacja gospodarcza w Polsce w perspektywie porównawczej / The Polish Transition in a Comparative Perspective

134. Jak kształtowała się konkurencja w sektorze bankowym w Polsce i w Europie przed kryzysem i w okresie kryzysu / On Competition in the Banking Sector in Poland and Europe Before and During the Crisis

135. Ćwierć wieku ukraińskich reform: za mało, za późno i zbyt wolno / A quarter century of economic reforms in Ukraine: too late, too slow, too little

136. Korporacyjny rynek papierów dłużnych w Polsce: aktualny stan, problemy, perspektywy rozwoju / Corporate debt securities market in Poland: state of art, problems, and prospects for development

137. Unia Bankowa - gdzie jesteśmy / The Banking Union: State of Art

138. Bezpośrednie i pośrednie obciążenia polskich banków AD 2015. Próba inwentaryzacji i pomiaru niektórych z nich / New publication: An assessment of direct and indirect liabilities of Polish banks AD 2015

140. Stan i perspektywy rozwoju rynku funduszy private equity w Polsce / The condition of and prospects for the private equity funds market in Poland

141. Co dalej z systemem Euro? / Rethinking the Euro system (w przygotowaniu)

142. Problem nieściągalności VAT w Polsce pod lupą / VAT non-compliance in Poland under scrutiny

143. Polityka gospodarcza i rozwój sytuacji makroekonomicznej na Węgrzech, 2010—2015 / Economic policy and macroeconomic developments in Hungary, 2010—2015

144. O wzroście gospodarczym w Europie, czyli niepewna perspektywa rozwoju krajów zachodnich / On Economic Growth in Europe, or,

The Uncertain Growth Prospects of Western Countries

145. The Catalan economy: Crisis, recovery and policy challenges / Katalońska gospodarka: kryzys, odbudowa i wyzwania dla polityki gospodarczej

146. Economic policy, the international environment and the state of Poland's public finances: Scenarios / Polityka gospodarcza i otoczenie międzynarodowe, a stan finansów publicznych w Polsce. Scenariusze

147. Jak Komisja Europejska i kraje europejskie walczą z oszustwami VAT / How the European Commission and European countries fight VAT fraud

148. Kapitalizm oligarchiczny w Rosji: stagnacyjny ale stabilny / Russia's Crony Capitalism: Stagnant But Stable

149. Znaczenie imigracji zarobkowej dla gospodarki Polski / The Influence of Economic Migration on the Polish Economy

150. More for less: What tax system for Poland? / Więcej za mniej: jaki system podatkowy dla Polski

151. The Stupendous US Record Gets Suppressed / Zdumiewające karty amerykańskiej historii pozostają w ukryciu

153. Will Ukraine Be Able to Establish Real Property Rights? / Czy Ukraina będzie w stanie wprowadzić rzeczywiste prawa własności?

154. Thinking about pension systems for the 21st century: A few remarks based on the Polish example / Rozważania o systemie emerytalnym w XXI wieku: Kilka uwag na podstawie polskiego systemu

156. Co dalej z ochroną zdrowia w Polsce – stan i perspektywy

157. Is a Fiscal Policy Council needed in Poland? / Czy Rada Polityki Fiskalnej jest potrzebna Polsce?