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Health system review

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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including

the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site at http://www.healthobservatory.eu.

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This edition was written by a multidisciplinary team of experts on the Polish health care system, representing the following institutions: the Centre for Health Information Systems (*Centrum Systemów Informacyjnych Ochrony Zdrowia* (CSIOZ)), the Jagiellonian University (*Uniwersytet Jagielloński*), the Medical Centre of Postgraduate Education (*Centrum Medyczne Kształcenia Podyplomowego* (CMKP)), the Ministry of Health (*Ministerstwo Zdrowia*), the National Health Fund (*Narodowy Fundusz Zdrowia* (NFZ)), the National Institute of Public Health–National Institute of Hygiene (*Narodowy Instytut Zdrowia Publicznego–Państwowy Zakład Higieny* (NIZP-PZH)), the University of Łódź (*Uniwersytet Łódzki*), and the University of Warsaw (*Uniwersytet Warszawski*). For coordinating the work on particular chapters of the HiT, the European Observatory on Health Systems and Policies is grateful to Paweł Goryński (NIZP-PZH), Iwona Kowalska (Jagiellonian University), Dariusz Poznański (Ministry of Health), Leszek Sikorski (CSIOZ), Alicja Sobczak (University of Warsaw), Krzysztof Sowada (Jagiellonian University), Maria Świderek (NFZ and the University of Łódź), Cezary Włodarczyk (Jagiellonian University) and Iwona Wrześniewska-Wal (CMKP). Ms Wrześniewska-Wal collaborated with the following authors, not affiliated with CMKP: Dorota Karpacka, Jarosław Madowicz, Anna Mądra, Patrycja Trzeciak and Dobrawa Zelwiańska.

It was edited by Anna Sagan (European Observatory on Health Systems and Policies) and Dimitra Panteli (Department of Health Care Management, Berlin University of Technology) and the Research Director was Reinhard Busse (Head of Department of Health Care Management at Berlin University of Technology). A special mention is due to Matthew Gaskins for initiating the report production process.

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8 Conclusion: A Sagan.

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List of abbreviations

AOTM	Agency for Health Technology Assessment	*Agencja Oceny Technologii Medycznych*
CAM	Complementary and alternative medicine	
CARK	Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan	
CIS	Commonwealth of Independent States	
CMJ	Centre for Quality Monitoring in Health Care	*Centrum Monitorowania Jakości w Ochronie Zdrowia*
CSIOZ	Centre for Health Information Systems	*Centrum Systemów Informacyjnych Ochrony Zdrowia*
DRG	Diagnosis-related group	
DPS	Social assistance home	*Dom pomocy społecznej*
EFTA	European Free Trade Association	
EU	European Union	
EU12	EU Member States acceding in May 2004 and January 2007	
EU15	EU Member States before May 2004	
EU27	EU Member States including those acceding in May 2004 and January 2007	
GDP	Gross domestic product	
GUS	Central Statistical Office	*Główny Urząd Statystyczny*
HIV	Human immunodeficiency virus	
HTA	Health technology assessment	
IT	Information technology	
JGP	Homogeneous patient groups	*Jednorodne grupy pacjentów*
KRUS	Agricultural Social Insurance Fund	*Kasa Rolniczego Ubezpieczenia Społecznego*
NFZ	National Health Fund	*Narodowy Fundusz Zdrowia*
NGO	Nongovernmental organization	
NIK	Supreme Audit Office	*Najwyższa Izba Kontroli*
NIZP	National Institute of Public Health	*Narodowy Instytut Zdrowia Publicznego*
NPZ	National Health Programme	*Narodowy Program Zdrowia*
OECD	Organisation for Economic Co-operation and Development	
OOP	Out-of-pocket	

PATH	Performance Assessment Tool for Quality Improvement in Hospitals	
PFRON	State Fund for Rehabilitation of Persons with Disabilities	*Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych*
PiS	Law and Justice Party	*Prawo i Sprawiedliwość*
PLN	Polish unit of currency	*Złoty*
PO	Civic Platform Party	*Platforma Obywatelska*
PPP	Purchasing power parity	
PSL	Polish People's Party	*Polskie Stronnictwo Ludowe*
PZH	National Institute of Hygiene	*Państwowy Zakład Higieny*
RZOZ	Health Care Units Register	*Rejestr Zakładów Opieki Zdrowotnej*
SHI	Social health insurance	
SLD	Democratic Left Alliance	*Sojusz Lewicy Demokratycznej*
SPZOZ	Autonomous public health care unit	*Samodzielny publiczny zakład opieki zdrowotnej*
URPL,WMiPB	Office for Registration of Medicinal Products, Medical Devices and Biocides	*Urząd Rejestracji Produktów Leczniczych, Wyrobów Medycznych i Produktów Biobójczych*
VHI	Voluntary health insurance	
ZOL	Chronic medical care homes	*Zakład opiekuńczo-leczniczy*
ZOZ	Health care unit	*Zakład opieki zdrowotnej*
ZPO	Nursing home	*Zakład pielegnacyjno-opiekuńczy*
ZUS	Social Insurance Institution	*Zakład Ubezpieczeń Społecznych*

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Abstract

Since the successful transition to a freely elected parliament and a market economy after 1989, Poland is now a stable democracy and is well represented within political and economic organizations in Europe and worldwide. The strongly centralized health system based on the Semashko model was replaced with a decentralized system of mandatory health insurance, complemented with financing from state and territorial self-government budgets. There is a clear separation of health care financing and provision: the National Health Fund (NFZ) – the sole payer in the system – is in charge of health care financing and contracts with public and non-public health care providers. The Ministry of Health is the key policy-maker and regulator in the system and is supported by a number of advisory bodies, some of them recently established. Health insurance contributions, borne entirely by employees, are collected by intermediary institutions and are pooled by the NFZ and distributed between the 16 regional NFZ branches.

In 2009, Poland spent 7.4% of its gross domestic product (GDP) on health. Around 70% of health expenditure came from public sources and over 83.5% of this expenditure can be attributed to the (near) universal health insurance. The relatively high share of private expenditure is mostly represented by out-of-pocket (OOP) payments, mainly in the form of co-payments and informal payments. Voluntary health insurance (VHI) does not play an important role and is largely limited to medical subscription packages offered by employers. Compulsory health insurance covers 98% of the population and guarantees access to a broad range of health services. However, the limited financial resources of the NFZ mean that broad entitlements guaranteed on paper are not always available. Health care financing is overall at most proportional: while financing from health care contributions is proportional and budgetary subsidies to system funding are progressive, high OOP expenditures, particularly in areas such as pharmaceuticals, are highly regressive.

The health status of the Polish population has improved substantially, with average life expectancy at birth reaching 80.2 years for women and 71.6 years for men in 2009. However, there is still a vast gap in life expectancy between Poland and the western European Union (EU) countries and between life expectancy overall and the expected number of years without illness or disability. Given its modest financial, human and material health care resources and the corresponding outcomes, the overall financial efficiency of the Polish system is satisfactory. Both allocative and technical efficiency leave room for improvement. Several measures, such as prioritizing primary care and adopting new payment mechanisms such as diagnosis-related groups (DRGs), have been introduced in recent years but need to be expanded to other areas and intensified. Additionally, numerous initiatives to enhance quality control and build the required expertise and evidence base for the system are also in place. These could improve general satisfaction with the system, which is not particularly high.

Limited resources, a general aversion to cost-sharing stemming from a long experience with broad public coverage and shortages in health workforce need to be addressed before better outcomes can be achieved by the system. Increased cooperation between various bodies within the health and social care sectors would also contribute in this direction.

The HiT profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems; they describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

Executive summary

Poland is the largest country in central and eastern Europe in both population (38.1 million) and area (312 685 km^2). Since the successful transition to a freely elected parliament and a market economy after 1989, Poland is now a stable democracy with constant economic growth and is well represented within political and economic organizations in Europe and worldwide. It has been a full member of the EU since 2004. In the second half of 2011 it served as the rotating Presidency of the Council of the European Union.

The parliament is divided into a lower house and an upper house, both elected for four-year terms. The president, elected in a general election for a five-year term, appoints the prime minister and the Council of Ministers (cabinet). There are three levels of territorial administration and self-government: at the lowest level is the *gmina* (municipality), followed by the *powiat* (district) and the *województwo* (voivodeship or region).

The transition period of the 1990s saw a considerable improvement in the health status of the Polish population. Average life expectancy at birth reached 80.2 years for women and 71.6 years for men in 2009, but there is still a vast gap in life expectancy between Poland and western EU countries and between life expectancy overall and the expected number of years without illness or disability. Infant mortality has been markedly decreasing, reaching 5.6 per 1000 live births in 2009, a rate which is still higher than the average rate for the EU27 (EU Member States including those acceding in May 2004 and January 2007) and the EU15 (EU Member States before May 2004) but lower than the average for the EU12 (EU Member States acceding in May 2004 and January 2007). Cardiovascular diseases are the major cause of death in both men and women, followed by neoplasms and external causes such as injuries and poisoning. Cardiovascular mortality for both genders has not decreased substantially since the turn of the century but has shifted to the older population, while premature mortality is more frequently attributable to

neoplasms. Tobacco and alcohol consumption are more pronounced in Poland than in western Europe and deaths linked to cirrhosis in young and middle-aged adults have not reduced. Overweight and obesity rates have grown considerably in the adult population and among children.

In 2004, the number of births fell below that of deaths and this, combined with the increase in life expectancy, is projected to lead to a substantial increase in the aged proportion of the population over the next decades. This will have a considerable impact on the health care system both financially, as demand for health services rises, and structurally, as the type of services in demand changes.

The Constitution of 1997 guarantees all citizens the right to equal access to health services financed from public sources: that is, from health insurance contributions as well as from state and territorial self-government budgets. Health insurance contributions are collected by two social insurance institutions, the Social Insurance Institution (*Zakład Ubezpieczeń Społecznych* (ZUS)) and the Agricultural Social Insurance Fund (*Kasa Rolniczego Ubezpieczenia Społecznego* (KRUS)), and transferred to the central health insurance fund, the National Health Fund (*Narodowy Fundusz Zdrowia* (NFZ)). The NFZ is the sole payer in the system, charged with contracting health services with public and non-public providers. Its finances are supervised by the Ministry of Finance (*Ministerstwo Finansów*) and its overall activity by the Ministry of Health (*Ministerstwo Zdrowia*), the key policy-maker and regulator in the system. A number of advisory bodies, some established fairly recently, support the Ministry of Health. For example, the Polish Agency for Health Technology Assessment (*Agencja Oceny Technologii Medycznych* (AOTM)), established in 2005, informs the Ministry's decisions on the inclusion of health care services in the list of guaranteed services and the level and method of their financing.

Certain health care tasks and regulatory functions have been decentralized. For example, monitoring of quality has been entrusted to the Centre for Quality Monitoring in Health Care (*Centrum Monitorowania Jakości w Ochronie Zdrowia* (CMJ)) and monitoring of sanitary standards to the Sanitary Inspectorate. Other tasks, mainly health care promotion and prevention, have been transferred to the territorial self-governments. As the establishing bodies of public health care providers, territorial self-governments also have the right – and under special circumstances, the obligation – to transform these bodies into Commercial Code companies. Since the independence of each level of territorial self-government makes coordination in the health system difficult, there have been calls to increase the role of voivodeships in coordinating health care activities of the lower levels of territorial self-government.

The level and structure of health care financing have undergone substantial changes since 1989, but the share of GDP devoted to health has remained fairly constant. The 1995–2009 period was characterized by an approximately five-fold increase in health care expenditure (from PLN 18.5 billion to PLN 99.0 billion). However, GDP also grew considerably during that period and the percentage devoted to health consequently increased by only 1.9 percentage points, from 5.5% of GDP in 1995 to 7.4% in 2009.

Around 70% of health expenditure comes from public sources. Over 83.5% of this expenditure can be attributed to the universal health insurance, and the NFZ accounted for over 91% of public expenditure on individual health care in 2008. The second most important source of public funds is the state budget, followed by the budgets of the territorial self-governments. Private health care financing plays a larger role in Poland than in most other EU Member States and comes mainly from OOP spending (about 22% of total health expenditure in 2009). Informal payments are widespread but their extent has been decreasing following substantial anticorruption measures. VHI plays a limited role and is mostly provided in the form of medical subscriptions offered by employers in the context of occupational health.

Compulsory health insurance covers 98% of the population and guarantees access to a broad range of health services. The limited financial resources of the NFZ mean that broad entitlements guaranteed on paper are not always available. The NFZ is the sole payer in the system and there is no possibility of opting out. Cost-sharing is limited, with the exception of medicines, medicinal products and auxiliary medical devices, health resort treatments and certain dental procedures and materials. Positive reimbursement lists have been in place since the end of 2009 and are issued periodically by the Ministry of Health.

Health insurance contributions take the form of a withholding tax borne entirely by the employee. The state budget covers contributions for vulnerable groups. Up to 86% of contributions paid in a given year can be deducted directly from tax contributions and the contribution rate has risen continually since the early 2000s. Contributions are pooled by the NFZ head office and allocated to NFZ branches (one in each voivodeship). Allocations among branches are based on algorithms defined annually by the government and depend on the number, age and gender of the insured regional population. The branches independently contract health services for the insured and divide their budgets between various types of service. All health care providers meeting certain criteria may compete for contracts with the NFZ. With the exception of primary care services and purchasing of medical devices, contracts can be awarded by

means of competitive tenders or (rarely) negotiations. How much providers are actually paid ultimately depends on the bids submitted to the NFZ – this means that different providers may receive different remuneration, even within the same voivodeship.

Different types of payment mechanism are in place according to both the level of care and, sometimes, the type of service provided. Primary care is financed by capitation, and the fee-for-service principle applies for secondary outpatient care, dental care and certain public health programmes (public health is also financed from the state budget). Since 2008, a DRG-like system has been in place for inpatient care and was extended to certain specialized outpatient services in 2011. Most emergency services are financed on a per diem basis from the state budget.

Mechanisms for paying health professionals include contractual employment (based on the Labour Code), civil law agreements, self-employment and state financing of medical students and trainees. No minimum remuneration for individual professional groups has been established in the health care system.

In 2009, there were 754 general hospitals in Poland, with a total of over 180 000 beds. Approximately 90% of beds were in public hospitals, but the number of non-public hospitals has been rising in the past decade (from 38 in 2000 to 228 in 2009), partially as a result of the transformation of public hospitals into Commercial Code companies. Since private hospitals are not immune from bankruptcy, they are generally more financially stable than their public counterparts. Also, since the majority of private hospitals were established after 1999, the physical condition of their facilities is, on average, better and maintenance is less costly. Most of the ambulatory care provision is in private hands, while the majority of hospital beds are public. Territorial self-governments are the principal source of investment funding for hospitals. Funding from the state budget is also significant and is mainly allocated to the implementation of projects co-financed by the EU. In theory, contracts with the NFZ should also provide hospitals with money for renovations, expansion and replacement of equipment, but after current expenditure is paid, the amounts left for capital investment are negligible.

Although the number of hospital beds per 1000 inhabitants has been decreasing, at 6.7 in 2009 it was still significantly higher than the EU15's average of 5.3. The structure of hospital bed allocation has changed little since the early 2000s and there is a pronounced surplus of acute beds and a deficit of long-term beds. There are significant differences in the geographical

distribution of hospitals, resulting in differences in access to health care – distribution has historic origins and does not necessarily reflect population health needs.

In 2009, 82 900 doctors, 12 100 dentists, 24 200 pharmacists, 200 500 nurses and 22 400 midwives were employed in health care institutions providing publicly financed health care services. Although there are no reliable estimates on the adequacy of staffing levels, available evidence suggests a shortage of health care professionals. The number of health professionals per 1000 population was lower in Poland than in the EU15 on average for all key health professions: 2.2 physicians per 1000 in Poland (compared with 3.5 in EU15), 5.2 nurses (EU15, 9.1), 0.3 dentists (EU15, 0.7) and 0.6 pharmacists (EU15, 0.8). The number of physicians per capita in Poland is lower than in most western European countries and has been decreasing since 2003, mostly because of outward migration, attributable to better remuneration, working conditions and prospects for professional advancement abroad.

A primary care physician is usually the entry point to the health care system, steering patients to more complex care. At each level of care, patients have the right to choose among contracted providers. A referral is needed to access specialist medical care, with the exceptions of certain specialists (e.g. gynaecologist) and certain conditions (e.g. tuberculosis). Ambulatory care (primary and specialist services) is provided by therapeutic entities (clinics or dispensaries) and by medical practices. Provision of dental care within the public sector is very limited and subject to cost-sharing. The most advanced procedures and materials are only available in the private sector. Most hospitals provide health care services in several specialties, and single-specialty hospitals are rare. Day care is not well developed and some less-serious cases could well be treated in outpatient settings. Poland has a long tradition in health resort treatment (*lecznictwo uzdrowiskowe*), which is offered in health resort hospitals and sanatoria. Rehabilitation and long-term care are provided within both the health care sector and the social care sector, but the coordination between the two could be improved. Financial assistance for family caregivers, who constitute the dominant source of care for seniors and persons with disabilities and chronic conditions, is very limited. The network of palliative care units is well developed and the range of available services is broad. Limited financial resources of the NFZ and shortages of medical personnel have negative effects on the access to health care services.

A number of reforms have been implemented since the last HiT country profile for Poland was published in 2005. Major reforms and policy initiatives touched upon many aspects of health care: improving the health care information system, improving access to health care (e.g. regulations on guaranteed benefits baskets), improving organization and financing in the hospital sector (e.g. initiatives to commercialize hospitals), fighting corruption in the health sector, strengthening patient rights, improving health care funding (several failed attempts to introduce VHI), improving reimbursement of providers by the NFZ (introduction of DRGs in various areas of care), improvement of the quality of care (e.g. 2008 Law on Accreditation in Health Care; development of standards of care), and various measures aimed at addressing the shortage and outward migration of health care professionals.

In 2010, the average per capita health care expenditure represented approximately 4.8% of the average household budget, with the figure nearly doubling for pensioners. In 2009, around 8–12% of respondents to a household survey said they did not seek health care when in need because of financial barriers. Paying for medicines prescribed or recommended by doctors was a financial burden for more than half of all households.

The compulsory health insurance financing system can generally be characterized as proportional (contributions form 9% of a given calculation base) with different rules applying to farmers and self-employed individuals. Contributions constitute the main bulk of public health care expenditure, with the rest coming from the state and territorial budgets, which are financing sources of progressive character. Financial shortages, certain unclear regulations, lack of standards and allocation mechanisms poorly adjusted to real health needs have led to relatively high OOP expenditures for households, resulting in private regressive financing, particularly in areas such as pharmaceuticals.

The majority of the population finds it easy to obtain primary care. However, this percentage dropped from 92% in 2006 to 83% in 2008 and it was generally lower for inhabitants of big cities than for residents in rural areas. Access to publicly financed specialist outpatient services was assessed much more poorly. Foregoing the public system in favour of purchasing services in the private health care sector was the most common solution to quickly gain access to specialist outpatient services, while access to hospital treatment is generally well perceived. The general satisfaction with the health care system has decreased and is lower in Poland than in other EU countries.

A series of efforts to improve health care quality has been undertaken. Although no obligatory licensing of health care providers has been introduced to enforce required standards for human resources, equipment or infrastructure, the NFZ does (in the process of contracting) award additional points to providers that have obtained accreditation and/or ISO9001 norm certification. Polish health care providers have participated in an increasing number of international initiatives and programmes on quality improvement, coordinated by the CMJ (e.g. the OECD Health Care Quality Indicators Project, the WHO Regional Office for Europe's Performance Assessment Tool for Quality Improvement in Hospitals (PATH)), and standardized tools for measuring user satisfaction have been developed.

Given its modest financial, human and material health care resources and the corresponding outcomes, the overall financial efficiency of the Polish system is satisfactory. Because of its monopsonistic position, the NFZ can increase and/or change the structure of health care expenditures as well as implement new payment mechanisms and thus modify allocative efficiency. However, there is no needs-based allocation formula to support national, regional or local decision-making with regard to distribution of funds among regions and/or different types of health care service. Poland's performance in human and infrastructural indicators of technical efficiency is low or moderate compared with other EU and OECD countries. The rate of avoidable hospital admissions among patients with chronic diseases was high, as were average waiting times for both outpatient and inpatient care. The NFZ has attempted to increase efficiency by several measures in recent years, mainly by shifting funds to primary care and introducing new payment mechanisms, such as the homogeneous patient groups system (*jednorodne grupy pacjentów* (JGP)), which is a DRG-type system. As a result, a modest decrease in the average length of stay in hospital has been observed, but the average cost of hospitalization has increased as well.

Extensive reform efforts have taken place since the start of political and economic transformation in 1989, including the first systemic changes in the health sector. Initial reforms were haphazard, and shifts in the composition of the government have so far resulted in little continuity in reform efforts. However, following the electoral success of the same political party in the parliamentary election in 2011, one can assume that the general direction of the reforms will be continued. Many existing challenges still need to be resolved and the world financial crisis, which has so far had a limited impact on the Polish economy, may yet pose challenges to the health care sector.

Limited financing seems to be the greatest barrier in achieving accessibility and good quality of health care services and in improving patient satisfaction with the system. VHI has been often proposed as a source of additional financing but, despite the substantial share of private health expenditure, all initiatives in this area have so far failed. Nevertheless, measures have been put in place to improve allocation of NFZ financing between various types of care in order to better reflect their actual costs. If complemented by measures regarding, among other things, the allocation of resources to the NFZ regional offices, this may translate into improved and more equitable accessibility of care. Increased cooperation between various bodies within the health and social care sectors could also greatly contribute in this direction.

Privatizing public hospitals as a solution to inefficient management and accumulated debt has been strongly opposed and politicized, but privatization of health care institutions has been taking place and the 2011 Law on Therapeutic Activity encourages territorial self-governments to commercialize hospitals. Time will show how commercialization of hospitals impacts on the accessibility, affordability and quality of care in Poland.

Substantial measures have been undertaken in the area of quality control, including health technology assessment (HTA) and the introduction of accreditation standards for hospitals and primary care, but such initiatives are still lacking in many areas of care. The increasing shortage of health care personnel also endangers service provision and may require complementing the ad hoc interventions practised so far by a more strategic approach.

1. Introduction

1.1 Geography and sociodemography

The Republic of Poland is the largest country in central and eastern Europe in both population (38.1 million) and area (312 685 km^2). It is also the largest country among the 12 new Member States admitted to the EU in May 2004 and January 2007. Poland shares a border with Lithuania, Belarus and Ukraine to the east, the Czech Republic and Slovakia to the south, and Germany to the west. The Baltic Sea delimits Poland in the north, except for a small area in the north-east, where it borders the Russian enclave of Kalingrad (Fig. 1.1).

Fig. 1.1
Map of Poland

Source: United Nations, 2004.
Note: The meaning of 'district' in this figure is different from the one used in the rest of the text (see section 1.3 for more information).

Polish territory was first settled by Slavic groups in the 6th and 7th centuries AD, and the Polish State was founded in 966. It has had a turbulent history of repeated invasions, but between the 14th and 17th centuries, it was a strong and prosperous country with a flourishing culture. By the end of this period, however, it had ceased to be a great power. In the 18th century, Poland was further weakened by the War of the Polish Succession and was finally annihilated when Austria, Russia and Prussia partitioned and occupied the country for a period lasting 123 years. Between the First and Second World Wars, Poland was again an independent country, but in September 1939 it was invaded by Nazi Germany and later by the Soviet Union, and from 1945 it came under the Soviet sphere of influence. The country was devastated during the war, its capital was completely ruined, and one-fifth of the population was killed, including virtually all its Jewish population. The German army was expelled in 1945 and the State of Poland was re-established, but Communists strongly supported by the Soviet Union dominated the Polish Government, taking over completely in 1947 and establishing a people's republic. In 1989, Poland was the first country among the central and south-eastern European countries to re-establish democracy after 44 years of Communist rule.

Since achieving political independence in 1989 and after a successful transition to the market economy, Poland is now a stable democracy with a constantly growing economy and is well represented within political and economic organizations in Europe and worldwide. It is a member of the United Nations, the Council of Europe, the OECD, the European Free Trade Association (EFTA) and the Central European Initiative. Likewise, in March 1999, Poland became a full member of the North Atlantic Treaty Organization, and on 16 April 2003, it signed the EU Accession Treaty in Athens, which forms the legal basis for Poland's EU membership. Since 1 May 2004, Poland has been a full member of the EU, and in 2009 it signed the Lisbon Treaty. On 1 July 2011 it took over the rotating Presidency of the Council of the European Union from Hungary.

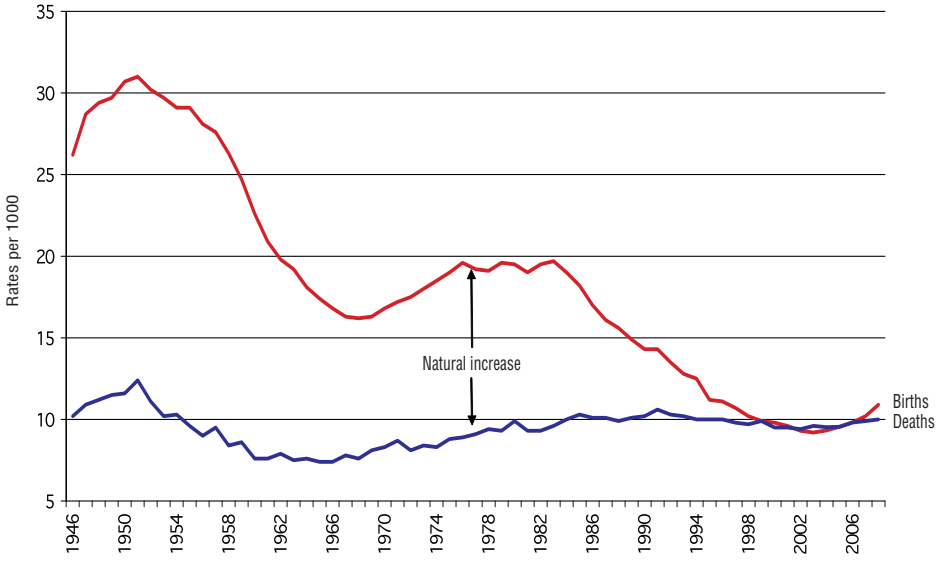
In 2009, 61% of the total population lived in urban areas. Warsaw, the capital, has a population of 1.7 million. In terms of ethnicity, language and religion, Poland is more homogeneous than most countries in the region. Poles make up 97.5% of the population, with Belarusian, German, Lithuanian and Ukrainian minorities accounting for the remainder. Polish is the official language and is spoken by 36.6 million people. German (500 000), Belarusan (220 000),

Ukrainian (150 000) and several other languages are also spoken, while English and German are taught as second languages at school, having recently displaced Russian. Ninety-five per cent of the population is Roman Catholic, with the main religious minorities being Orthodox, Protestants, Old Catholic, Jehovah's Witnesses and several other small groups (GUS, 2010c).

In 2004, the number of births fell below that of deaths, resulting in negative natural population growth, as in many other EU countries (Fig. 1.2). Because of the population decline, it is estimated that by 2050 there will be 31.9 million inhabitants in Poland, or 6.2 million less than in 2009. However, this projection may need to be revised if the slight reverse trend in the birth rate (which increased in the 2006–2009 period) continues. The proportion of people over the age of 65 years, which was 13% of the total population in 2009 (Table 1.1), is projected to increase to 37.9% by 2025 (European Commission, 2006b).

Fig. 1.2

The pattern of natural movement in the population, 1946–2008



Source: NIZP-PZH,2010.

Table 1.1
Trends in population/demographic indicators, 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
Total population (million)	35 578	38 119	38 588	38 458	38 165	38 150
Population female (% of total)	51	51	51	52	52	52
Population aged 0–14 years (% of total)	24	25	23	19	16	15
Population aged 65 years and more (% of total)	10	10	11	12	13	13
Population aged 80 years and more (% of total)[a]	1.4	2.0	2.2	1.9	2.5	3.1
Population growth (annual %)	1	0	0	–1	0	0
Population density (people per km^2)[b]	114	122	123	122	122	122
Fertility rate, total (births per woman)	2	2	2	1	1	1
Crude birth rate (per 1 000 population)	20	14	11	10	10	11
Crude death rate (per 1 000 population)	10	10	10	10	10	10
Age dependency ratio[a]	52	54	51	46	42	40
Urban population (% of total)[b]	58	61	61	62	61	61
Single-person households (% of total)	n/a	18.3[c]	n/a	24.8[d]	n/a	26.9[e]
Population aged 25–64 years with an upper secondary or tertiary qualification (% of total)[a]	n/a	n/a	n/a	79.8	84.8	88.0

Sources: [a]European Commission, 2011a; [b]WHO Regional Office for Europe, 2011b; [c]1988 GUS estimation; [d]2002 census; [e]2008 GUS estimation.
Notes: The age dependency ratio is the ratio of the combined child population (aged 0–14) and the elderly population (aged 65+) to the working age population (aged 15–64); n/a: not available.

1.2 Economic context

The Polish economy has traditionally been dominated by industry and agriculture. However, the services sector is rapidly growing and in 2010 accounted for 72% of the country's GDP, compared with 25% for industry and construction, and 3% for agriculture (GUS, 2011b).

After independence was achieved in 1989, Poland experienced a brief but intense period of economic decline. The transformation from a centrally planned to a market economy was accompanied at the outset by a severe downturn, with a considerable fall in GDP, and inflation reaching 70% a year. The Polish Stabilization Programme, implemented in 1990, entailed far-reaching consequences for the country's economy, including heavy social costs with rising poverty levels. However, by the mid-1990s, the economy showed signs of recovery, with GDP growth at 7%. Inflation also declined steadily, dropping to 1.9% in 2002, which is comparable to rates observed in western Europe. Growth continued until 2001 (Table 1.2), but with the recession in the global economy in 2001 and 2002, GDP levels stagnated, as in most European countries. Unemployment was also a serious problem during this

period, manifested by a three-fold increase in the registered unemployment rate (which underestimates real unemployment) compared with the early 1990s. This figure reached 18% in 2005, before declining to 8% in 2009 (Table 1.2).

Table 1.2

Macroeconomic indicators, 1990–2009 (selected years)

	1990	1995	2000	2005	2009
GDP (current US$), billions	59	139	171	305	431
GDP, PPP (current international $), billions	208	286	404	526	722
GDP per capita (current US$)	1 547	3 604	4 454	7 963	11 288
GDP per capita PPP (current international $)	5 459	7 420	10 513	13 784	18 926
GDP growth (annual %)	n/a	7	4	4	2
Cash surplus/deficit (% of GDP)	n/a	n/a	n/a	–4	–6
Tax wedge on labour cost (%)[a]	n/a	43.6[b]	37.0	37.5	33.2
General government gross debt (% of GDP)[a]	n/a	49.0	36.8	47.1	50.9
Industry, value added (% of GDP)[a]	50	35	32	31	30
Agriculture, value added (% of GDP)[a]	8	8	5	5	4
Services, etc., value added (% of GDP)[a]	42	57	63	65	66
Labour force (total), millions	18	17	17	18	17
Unemployment rate (% of labour force)	n/a	13	16	18	8
At-risk-of-poverty rate	n/a	n/a	16	20.5	17.1
Gini coefficient[a]	n/a	n/a	30	35.6	31.4
Real interest rate (%)	n/a	–5	12	4	n/a
Official exchange rate (LCU per US$, period average)	1	2	4	3	3

Sources: World Bank, 2011; [a]European Commission, 2011a; [b]Data for 1996.
Notes: The Gini coefficient is a measure of absolute income inequality; the coefficient is a number between 0 and 1, where 0 corresponds with perfect equality (where everyone has the same income) and 1 corresponds with perfect inequality (where one person has all the income, and everyone else has zero income); LCU: Local currency unit; n/a: not available.

By 2009, the GDP per capita was more than three times greater than in 1990, reaching US$ 18 926 purchasing power parity (PPP). Although other central and south-eastern European countries admitted to the EU at the same time as Poland have achieved substantially higher GDPs per capita, including the Czech Republic (PPP US$ 25 565), Hungary (PPP US$ 20 276) and Slovakia (PPP US$ 22 877) (World Bank, 2011), Poland fares better in terms of the Human Development Index. In 2007 it improved its ranking and was placed 41st, coming sixth among the central and south-eastern European countries, ahead of Latvia and Lithuania (UNDP, 2010).

1.3 Political context

The Constitution of 1997 stipulates that the Republic of Poland is a democratic state ruled by law. The Polish Parliament is divided into a lower house (*Sejm*) with 460 seats and an upper house (*Senat*) with 100 seats, and members of both chambers are elected for four-year terms. The president is elected in a general election for a five-year term, with a maximum two-term limit. The president appoints the prime minister with the consent of the *Sejm*, and members of the Council of Ministers (the cabinet) are proposed by the prime minister, appointed by the president, and approved by the *Sejm*. The president has veto power over laws passed by the parliament, although the veto can be overturned by the parliament with a three-fifths majority vote in the presence of at least half of the statutory number of members of parliament. The president may also direct draft laws to the Constitutional Tribunal, which verifies their compatibility with the Constitution (draft laws approved by the Tribunal can no longer be vetoed by the president).

Economic turmoil throughout the 1980s led to the rise of a strong independent trade union, Solidarity (*Solidarność*), which forced elections in 1989. A year afterwards, with the re-establishment of democratic rule, Lech Wałęsa was elected president, and the first fully democratic parliamentary election was held in October 1991. Parliamentary elections in 1993 saw a swing to the left, with the post-Communist Democratic Left Alliance (*Sojusz Lewicy Demokratycznej* (SLD)) receiving the majority of votes. Subsequent parliamentary elections saw little continuity in the composition of the government. After the 2001 parliamentary elections, SLD had to form a coalition with two other parties (the Union of Labour (*Unia Pracy* (UP)) and the Polish People's Party (*Polskie Stronnictwo Ludowe* (PSL)) to achieve majority in the *Sejm* and after the 2003 parliamentary election it formed a minority government with the UP. The nationalist conservative Law and Justice Party (*Prawo i Sprawiedliwość* (PiS)) formed a minority and later a majority coalition government after the 2005 parliamentary election (in the same year, Lech Kaczyński from the PiS was elected president). After the 2007 parliamentary elections, the liberal-conservative Civic Platform Party (*Platforma Obywatelska* (PO)) formed a coalition government with the PSL.

The most recent parliamentary election took place on 9 October 2011. The 100 *Senat* seats were divided as follows: PO 63, PiS 31, PSL 2 and independent candidates 4. In the *Sejm*, out of 460 seats, the PO won 207 (45%), PiS 157 (34.1%), Palikot's Movement (*Ruch Palikota*) 40 (8.7%), PSL 28 (6.1%), SLD 27 (5.9%) and German minorities 1 (0.2%). Donald Tusk, appointed prime minister

in 2007, was re-appointed and is thus the first prime minister to serve two consecutive terms since the fall of communism. The last presidential election took place in July 2010, following the death of President Kaczyński on April 10, 2010. Bronisław Komorowski (PO) was elected president.

Since 1999 there have been three levels of territorial administration and self-government in Poland. The principal unit of administrative division with territorial self-government status, established in 1990, is the *gmina* (often translated as commune or municipality). It is followed by the *powiat* (often translated as county or district) and the *województwo* (voivodeship, or area governed by a voivode; also translated as region), which form the second and third level of administration and territorial self-government, respectively. At the end of 2010, there were 2478 *gminas*, 314 *powiats*, 65 cities of *powiat* status and 16 voivodeships[1] (until 1999 there were 49 voivodeships). The last are administrated by the voivode (*wojewoda*), who is appointed by the central government, and the voivodeship marshal (*marszałek województwa*), who is elected by the regional elected assembly (*sejmik wojewódzki*).

There is a dual nature of administration in the voivodeships: the voivode fulfils the representation of the central government (thus being responsible for taxation, military and statistical administration, for example), while the self-government component of the voidvodeship is responsible for regional strategy and policy for socioeconomic development and the functioning of certain regional public services (e.g. higher education, specialized health services). Apart from certain health care functions, *powiats* are mainly responsible for the local provision of secondary education, certain social services, and consumer protection, whereas the activities of the *gminas* cover areas such as public transportation, primary education, social care and cultural services and physical resources planning (see also section 2.4). They are financed partly from local budgets and partly from the central budget. *Gminas* cover an average population of 2400, although their size varies considerably. The legislative and controlling body of each *gmina* is the council, which is elected to represent the local population. Administrative offices of *gminas*, divided into urban, rural and urban–rural, exercise local self-government administration, and *gmina* councils are elected every four years.

Poland had a Corruption Perceptions Index of 5.3 in 2010 (compared with 4.6 for the Czech Republic, 4.7 in Hungary and 4.3 in Moldova) and ranked 41 out of 178 countries scored. Poland's Corruption Perceptions Index has been

[1] Dolnośląskie, Kujawsko-Pomorskie, Lubelskie, Lubuskie, Łódzkie, Małopolskie, Mazowieckie, Opolskie, Podkarpackie, Podlaskie, Pomorskie, Śląskie, Świętokrzyskie, Warmińsko-Mazurskie, Wielkopolskie and Zachodniopomorskie (see Fig. 1.1)

increasing steadily (and perceived corruption, therefore, decreasing) since 2005, a trend opposite those in many other eastern European countries (Transparency International, 2010).[2]

1.4 Health status

The transition period of the 1990s saw a considerable improvement in the health status of the Polish population. This may be related, on the one hand, to the economic and social changes that took place and, on the other, to increased health promotion and public health activities as well as the reorganization of health service provision.

More specifically, after a period of no substantial improvement with slight annual fluctuations during the 1970s and 1980s, average life expectancy at birth began to increase in 1993 (Table 1.3 and Fig. 1.3), reaching 80.2 years for women and 71.6 years for men in 2009. It is worth noting that life expectancy at birth in Poland since 1991 has developed in parallel with the average of other new EU Member States. Nevertheless, there is still a vast gap in life expectancy between Poland and western EU countries, which had widened considerably between 1975 and 1991 and has only recently started to narrow (Fig. 1.3). It is important to note that a considerable gap exists between life expectancy overall and the expected number of years without illness or disability, measured, for example, by healthy life-years and disability-adjusted life expectancy, respectively (Table 1.4). Another interesting phenomenon is that the increasing trend observed in life expectancy overall is not apparent when looking at healthy life-years.

Table 1.3
Mortality and health indicators, 1980–2009 (selected years)

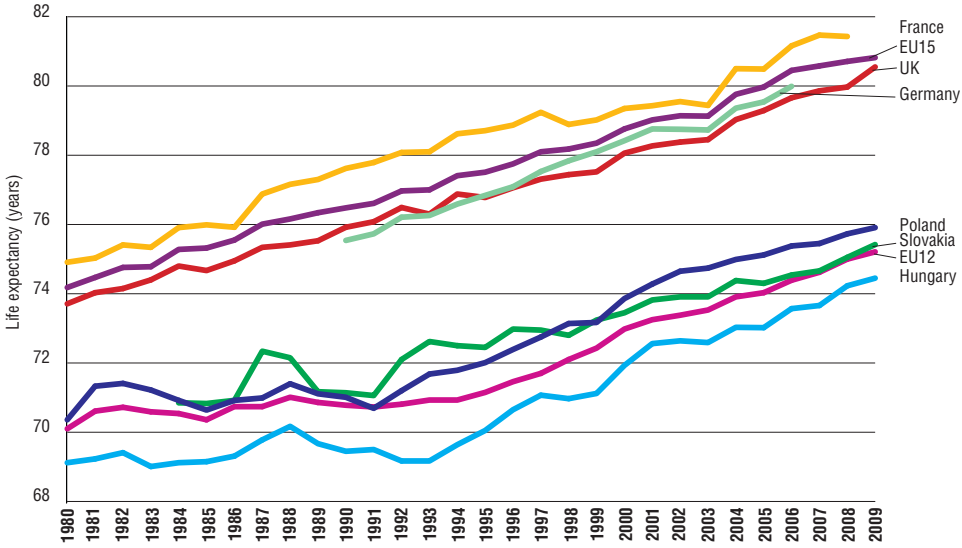
	1980	1990	1995	2000	2005	2009
Life expectancy at birth, total (years)	70.4	71.0	72.0	73.9	75.1	75.9
Life expectancy at birth, male (years)	66.1	66.6	67.7	69.6	70.8	71.6
Life expectancy at birth, female (years)	74.7	75.6	76.5	78.1	79.4	80.2
Crude death rate per 1 000 population, total	9.8	10.2	10.0	9.6	9.7	10.1
Crude death rate per 1 000 population, male	10.9	11.3	11.0	10.5	10.7	11.1
Crude death rate per 1 000 population, female	8.8	9.2	9.1	8.8	8.7	9.2

Source: WHO Regional Office for Europe, 2011b.

[2] The Corruption Perceptions Index ranks countries based on how "clean" (10) or "corrupt" (0) the public sector is perceived to be.

Fig. 1.3

Average life expectancy at birth in Poland compared with selected EU countries and regional averages, 1980–2008



Source: WHO Regional Office for Europe, 2011b.

Table 1.4

Healthy life-years and disability-adjusted life expectancy, 2000-2009 (selected years)

	2000	2001	2002	2005	2006	2007	2008	2009
Disability-adjusted life expectancy, total[a]	64.3	64.3	65.8	n/a	n/a	67.1	n/a	n/a
Disability-adjusted life expectancy, male[a]	62.0	62.1	63.1	n/a	n/a	64.1	n/a	n/a
Disability-adjusted life expectancy, female[a]	66.5	66.6	68.5	n/a	n/a	70.2	n/a	n/a
Healthy life-years at birth, male[b]	n/a	n/a	62.5	61[c]	58.2	57.4	58.4	58.1
Healthy life-years at birth, female[b]	n/a	n/a	68.9	66.6[c]	62.5	61.3	62.6	62.1

Sources: [a] WHO Regional Office for Europe, 2011b; [b] European Commission, 2011a.
Notes: [c]Break in series; n/a: not available.

Since the transition to democracy, infant mortality has been markedly decreasing, although the rate of improvement has slowed somewhat in recent years. The improvements in living conditions and the decline in environmental pollution as well as initiatives to improve maternal and child health contributed to this change. In 2009, the infant mortality rate was 5.6 per 1000 live births, which is still higher than the average rate for the EU27 and the EU15 (4.3 and 3.7, respectively), but lower than the EU12 average (6.3).

Crude mortality rates for all ages, by comparison, have been stable (Table 1.5). As in other industrialized countries, cardiovascular diseases are the major cause of death in both men and women, followed by neoplasms and external causes such as injuries and poisoning. As with other health status indicators, important decreases in mortality rates took place beginning in the 1990s and were indicative of the third phase of epidemiological transition, in which an overall reduction in mortality rates could be attributable mainly to a fall in the number of deaths from lifestyle diseases, in this case mainly cardiovascular disease (Zatoński, McMichael & Powles, 1998). The decrease in cardiovascular mortality can be attributed primarily to the substantial change in population diet as a result of the market transformation, which allowed for a higher consumption of vegetable oil (Zatoński et al., 2008). Central and western Poland have higher mortality rates overall and from cardiovascular disease specifically (both for men and women), while mortality rates attributable to neoplasms are higher in the north-west. As pointed out in a recent report on men's health by the European Commission, cardiovascular mortality for both genders has not decreased substantially since the early 2000s but has shifted to the older population (aged 65 and above), while premature mortality is nowadays more frequently attributable to neoplasms (White, 2011). Overall, while women are more likely to die of cardiovascular disease, men have a higher rate for neoplasms and external causes of death, the latter attributable most probably to the high rate of traffic accidents among men (Golinowska & Sowa, 2006).

Gender differences are also apparent in lifestyle choices that affect health. A 2007 survey found that 34% of men were daily smokers compared with 23% of women, while the general decrease in smoker numbers slowed down in the mid-2000s (WHO, 2009). An alarming increase in smoking initiation in those aged 13–15 years was also observed in the 1990s. A government action plan to curb the "tobacco epidemic" in Poland was launched in the 1990s. Combined with multifaceted tobacco control legislation it contributed to the reduction in the share of daily smokers in the population (WHO, 2009). Premature alcohol-attributable mortality in Poland was twice as high as the EU15 average in 2002, and an overall boom in alcohol consumption was observed after 2003 with a peak in 2008 (9.58 litres of 100% alcohol per capita). The excise tax increase implemented by the government at that point led to a 0.5 litre per capita decrease in 2009. The only health indicator that did not improve in the 1991–2008 period was cirrhosis-related deaths in young and middle-aged adults (Zatoński et al., 2008). There was a parallel increase in the consumption of spirit alcohol (as opposed to wine or beer) combined with relatively high alcohol consumption

Table 1.5

Main causes of death (all ages, per 100 000),[a] 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
Communicable diseases						
Infectious and parasitic diseases	16.8	8.9	6.9	6.5	5.7	6.3
Tuberculosis	10.4	4.7	3.7	2.9	2.0	1.7
HIV/AIDS	n/a	n/a	0.0	0.3	0.3	0.2
Noncommunicable diseases						
Diseases of circulatory system	577.5	589.2	532.2	446.2	384.2	356.3
Ischaemic heart disease	108.6	121.0	107.1	141.8	114.4	96.9
Cerebrovascular disease	77.0	73.1	78.8	104.2	87.4	72.4
Malignant neoplasms	194.8	212.8	215.4	217.2	211.5	201.8
Trachea/bronchus/lung cancer	39.3	51.4	53.1	52.0	51.4	49.5
Malignant neoplasms of the female breast	20.5	22.6	22.9	21.5	21.4	20.3
Cervical cancer	11.8	10.4	9.8	9.3	7.8	7.3
Diseases of the digestive system	41.2	34.5	34.9	37.7	39.1	37.0
Chronic liver disease and cirrhosis	14.4	11.4	13.6	14.6	15.0	16.0
Diseases of the respiratory system	63.0	44.9	35.9	46.4	42.3	41.9
Mental disorders and diseases of the nervous system and sensory organs	17.4	14.0	14.8	13.3	15.7	15.2
Diabetes	14.3	16.6	13.6	13.0	12.2	13.7
External causes						
External cause injury and poison	80.7	82.5	77.0	66.4	62.6	57.6
Suicide and self-inflicted injury	n/a	13.8	14.6	15.0	15.0	15.8
Motor vehicle traffic accidents	n/a	22.4	18.5	15.9	13.0	10.7

Source: WHO Regional Office for Europe, 2011b.
Notes: [a]Standardized death rates; n/a: not available.

among the youth (PARPA, 2011). Research shows that overweight and obesity rates have increased considerably in the adult population (particularly in men), a trend generally observed in eastern Europe after the economic transition (Jarosz & Rychlik, 2008). An alarming increase in obesity rates in children aged 6–13 years, particularly among boys living in urban areas, has also been recorded (Bac et al., 2011).

Maternal mortality has decreased substantially since the 1980s, as have pre-, peri- and neonatal deaths, as well as infant birth rates (Table 1.6). Although Poland currently has a limited ban on abortion in place, the number of terminations increased more than three-fold between 2000 and 2008.[3] Immunization rates are high for all childhood diseases as well as for tuberculosis with almost universal coverage, as is the case for most EU12 countries and particularly for the Czech Republic and Hungary. In the 2007 Innocenti Report

[3] A bill to ban all abortions is currently under consideration, after the *Sejm* voted against a motion to stop the legislation on 1 July 2011.

Card 7, Poland ranked below the OECD average with regard to the health and safety of children (and lower than the Czech Republic but higher than Belgium, Hungary, Greece, Ireland and Austria) (UNICEF, 2007).

Table 1.6

Maternal, child and adolescent health indicators, 1980–2009 (selected years)

	1980	1990	1995	2000	2005	2009
% of all live births to mothers, age under 20 years	6.4	8.0	8.0	7.3	5.3	4.9
Abortions per 1 000 live births	n/a	n/a	n/a	0.36	0.62	1.2[a]
Infant deaths per 1 000 live births	21.2	16.0	13.6	8.1	6.4	5.6
Neonatal deaths per 1 000 live births	13.3	11.5	10.1	5.6	4.5	4.0
Perinatal deaths per 1 000 births	18.6	16.0	10.5	6.7	5.3	4.0
Postneonatal deaths per 1 000 live births	7.9	4.4	3.5	2.5	1.9	1.6
Probability of dying before the age of 5 years per 1 000 births	24.3	18.3	15.3	9.3	7.5	6.4
Maternal deaths per 100 000 live births	11.6	12.8	12.7	10.8	3.0	1.9

Source: WHO Regional Office for Europe, 2011b.
Notes: [a]Data for 2006; n/a: not available.

Poland is at the lower end of the EU27 range for hospital admissions for mental and behavioural disorders. However, as pointed out by White (2011), the incidence of depression is one of the highest in the same group of countries, indicating that the low number of hospitalizations may not necessarily be representative of the presence of the condition in the population.

The state of dental health is relatively poor in the Polish population and is reflected by high levels of dental caries. According to a recent *Eurobarometer* study (European Commission, 2010), only 28% of Poles reported having all their natural teeth (compared with an EU27 average of 41%, Czech Republic 43% and Slovakia 29%, but also Hungary 19%). In the same survey, the citizens of Poland and Hungary topped the list of most frequent confectionary consumers, with 22% of respondents in both countries declaring that they eat sweets frequently. The reasons behind this are limited access to publicly financed dental care and low awareness about dental hygiene in both mothers of young children (Szatko et al., 2004) and adolescents (Ganowicz et al., 2005).

Overall, the fall in the birth rate combined with the increase in life expectancy is projected to lead to a substantial increase in population ageing over the next decades. This will have a considerable impact on the health care system both financially, as demand for health services rises, and also structurally, as the type of services in demand changes.

2. Organization and governance

2.1 Overview of the health system

Before the start of gradual public sector devolution in 1989, the Polish health system was strongly hierarchical and predominantly funded from the central budget. In the course of the political and economic reorganization that followed the collapse of communism, the strongly centralized system based on the Soviet model of health care (the so-called Semashko model) was replaced with a decentralized system of mandatory health insurance, complemented with financing from central and local budgets (see section 3.2). During the 1990s, the administration of most health care services and the ownership of most public health care facilities were transferred from the Ministry of Health initially to the voivodeships and *gminas* and later also to *powiats*, which were re-established as an intermediate level of public administration in 1999.

According to Article 68 of the 1997 Constitution of the Republic of Poland, all citizens, regardless of their financial circumstances, have the right to equal access to health services that are financed from public funds. Approximately 98% of the population is covered by the system of compulsory health insurance, including family members of persons paying insurance contributions and some vulnerable groups whose contributions are financed from the state budget (see section 3.3.1). Further, the system's legal framework is based on the 2004 Law on Health Care Services Financed from Public Sources, on the 2011 Law on Therapeutic Activity and on legislation harmonizing Polish law with that of the EU.

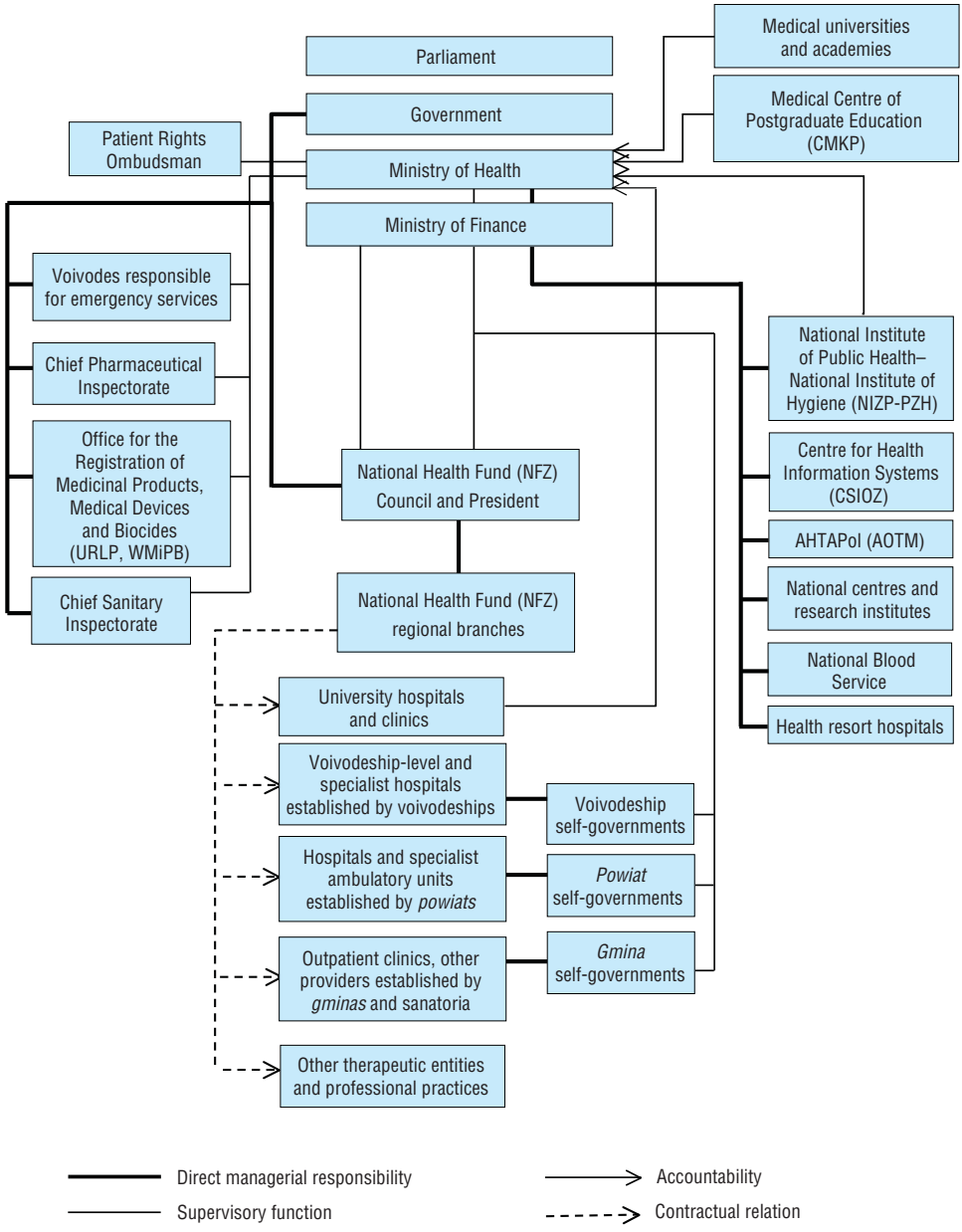
The stewardship, management and financing functions in the Polish health care system are divided between the Ministry of Health, the NFZ and territorial self-governments. The NFZ is charged with financing of health care services provided to the insured population. It manages the process of

contracting health services with public and non-public service providers. The operations of the NFZ are supervised by the Ministry of Health, while its finances are entrusted to the Ministry of Finance. The Ministry of Health is also responsible for national health policy, financing of long-term public health programmes and selected highly specialized medical services, major capital investments and medical science and education. It is tasked with implementing national public health programmes and has a number of supervisory and direct managerial functions (see section 2.3). At each administrative level, territorial health authorities are responsible for the identification of the health needs of their respective populations, for planning of health services delivery, health promotion and the management of public health care institutions.

The Polish system of social insurance provides income security (monetary benefits) for old age, disability, sickness and maternity, and for accidents at the workplace and occupational diseases. Key social insurance benefits are old-age and disability pensions. Health care in Poland is a separate part of the social insurance system with its own insurance fund (NFZ). The involvement of ZUS in the sphere of health is limited to collection of health insurance contributions from people earning their income outside the agricultural sector. The KRUS collects health insurance contributions from people getting their income from the agriculture sector. The NFZ pays ZUS and KRUS for collecting health insurance contributions.

A simplified overview of the structure of the Polish health system is given in Fig. 2.1. The particular issues of the system organization and of the respective roles and responsibilities of the key stewardship, management and financing institutions are described in detail in the following sections.

Fig. 2.1
Overview of the Polish health care system



Source: Adapted from Kuszewski & Gericke, 2005.
Note: Administrative units are *gmina* (municipality), *powiat* (district) and voivodeship (or region).

2.2 Historical background

The 1918–1989 period

The beginnings of the Polish health sector and its public activities can be traced back to the period of Polish independence between 1918 and 1939. The Law on Health Insurance, which came into force in 1920, covered only wage-earning employees: about 7% of the population. It was based on the German system of sickness funds (the so-called Bismarckian model) but it put more emphasis on the territorial structure of the sickness funds and their self-governance (Sadowska, 1993). The Ministry of Public Health, Social Assistance and Work Protection, established in 1918, was given responsibility over health issues. Its main activity focused on fighting infectious diseases and promoting hygiene among the population.

After the Second World War, public activities in the sphere of health focused on fighting infectious epidemics. The Commissariat for Combating Epidemics, established in 1944, became the nucleus of the Ministry of Health (created in 1945). Originally, the Ministry functioned on the basis of the pre-war experience but after a few years, in line with increasing centralization tendencies and the expansion of central planning into more sectors of the economy, health care organization was ultimately (1950) modelled on the Soviet system, developed by the Soviet Commissar of Public Health, Nikolai Semashko.

The administration of the health system, as of the economy in general, was strongly centralized (Golinowska, 1990). Health sector activity focused on capital and human resources investment (establishment of health units and education of doctors and nurses). The main health programme concerned mother and child health. Health care services were offered free of charge to all state employees in occupational health facilities set up at public workplaces. Private farm owners and their families had no access to free-of-charge public health care until 1972, when health service coverage was extended to include agricultural workers. Despite the system's extensive development over the next several decades, not all aspects of the Semashko model were adopted. For example, private practice was never formally abolished – in fact it was progressively developed.

During the Communist period some important changes occurred in the organization of health care provision. In 1972, integrated health care management units (*zespół opieki zdrowotnej*) were established to manage hospitals, outpatient clinics, specialist and primary health care, as well as some social care services. They embodied the so-called district health care model recommended by the WHO (Tarimo, 1991; Segall, 2003). Strengthening the

position of voivodeships and later the *gminas* was the main aim of the next wave of major reforms: the powers of the Ministry of Health and Social Care were reduced and the voivodeships and the integrated health care management units were given greater policy and administrative powers (until the 1980s).

Despite its shortcomings (e.g. scarcity of pharmaceuticals, low quality of care and out-dated medical equipment), provision of free health care under the Communist regime had a long-lasting impact on people's attitudes towards full government responsibility and participation in health care funding. The general unwillingness to undertake personal responsibility for health care observed today obstructs adoption of some reform measures, such as the additional VHI (see section 3.5 and Chapter 6). Another legacy of the Semashko system is corruption among health care professionals and the population's practice of expressing gratitude with what is often euphemistically described as "small gifts or proofs of gratitude" (see section 3.4.3).

Transformation of the health care system after 1989

Health system reforms since 1989 followed the very quick transition from centrally planned to market economy ("the big push") taking place in the country. However, economic changes (freedom of business activity and freeing of prices) had started earlier, during the (Communist) Government of Mieczysław Rakowski (1988–1989). Initial health sector reforms, introduced between 1991 and 1998, focused on health care decentralization, developing private medical practice and upgrading the infrastructure of public providers. Beginning in 1991, much of the authority over public health care was transferred from the Ministry of Health down to the voivodeships and, to a lesser extent, to the *gminas*, and publicly owned health facilities were given substantial autonomy and responsibility for managing their own budgets. Voivodeships and *gminas*, among others, were given the right to establish health care units (see section 2.3) and were awarded ownership of public health care facilities. *Powiats* took over responsibility for *powiat*-level hospitals (Fig. 2.1).

On 1 January 1999, the 1997 Law on the Universal Health Insurance came into force. It replaced the Semashko-style system of general tax financing based on budgetary rules for resource allocation with a system of financing from health contributions, based on social health insurance (SHI) rules. A system of health insurance institutions, the so-called sickness funds (*kasy chorych*), was established. There were 16 sickness funds – one for each voivodeship – and a separate sickness fund for the uniformed services (members of the police, the military and the state rail). The health care reform was introduced alongside a package of three other important and very costly reforms (pensions, education system and administrative decentralization) and during a period of economic

slowdown. The lack of both a unified strategy and contracting principles for the sickness funds as well as the application of different payment mechanisms for contracted services resulted in considerable regional differences in the access and quality of health services, potentially infringing the "equity" rule prescribed in the Constitution. These differences were further exacerbated by the constraints caused by the economic slowdown, and public satisfaction with the health care system was low. Consequently, after being in existence for only three years, sickness funds were replaced by a single central insurance institution – the NFZ.[4]

The 2003 Law on the Universal Health Insurance in the National Health Fund established the Head Office of the NFZ and 16 regional branches, one in each voivodeship. To eliminate regional differences in access to health care, the Law introduced uniform contracting procedures and point limits for contracted services. However, the 2003 Law was declared unconstitutional by the Polish Constitutional Tribunal, which challenged the following weaknesses: (1) imprecise formulation of the Law's provisions that could lead to discretionary decision-making in the system; (2) lack of sufficient guarantees that would ensure equal access to services for all (e.g. there was no precise definition of guaranteed services); (3) lack of mechanisms to control NFZ's finances by the treasury, parliament and the insured population; (4) lack of definition of the relationship between the NFZ and the state's budget, which could potentially imply the state's responsibility over NFZ's debts; and (5) various other imprecise and conflicting provisions, for example overlapping competencies of the NFZ and the Ministry of Health and lack of precisely delineated supervisory powers of the Ministry of Health. The contested Law was replaced by the 2004 Law on Health Care Services Financed from Public Sources.

The 2004 Law specified a negative list of services (excluded from public financing). The 2009 amendment of this Law obliged the Ministry of Health to issue positive lists of health services (defining the medical benefits baskets (*koszyki świadczeń*)) financed from public sources (NFZ, state budget and territorial budgets). By the end of September 2009, 13 executive regulations on guaranteed health care services were issued (see section 3.3.1). Additional rules for including health services in the benefits basket were delineated in the 2009 amendment and the 2001 Law on Prices. On 1 July, 2011 the Law on Therapeutic Activity came into force which aimed at transforming public hospitals (and other public health care providers) into Commercial Code

[4] An important political factor that contributed to dismantling the sickness funds was the rise to power of an SLD-led coalition government in 2001. Already during its election campaign, the SLD declared its plans to abolish sickness funds and replace them with a more concentrated system.

companies. It represents a continuation of earlier efforts to commercialize public hospitals with the intention of improving financial efficiency of hospital management and reduction of hospital debts (see Chapter 6). The 2011 Law on Therapeutic Activity replaces the term health care unit (*zakład opieki zdrowotnej* (ZOZ)) with therapeutic entity (*podmiot leczniczy*).

2.3 Organization

The Ministry of Health

Since 1989, the role of the Ministry of Health has progressively evolved from health care funder and organizer of health care provision to health policy-maker and regulator. The Ministry of Health has the overall responsibility for governance of the health sector and its organization. It is responsible for national health policy, major capital investments and for medical research and education. In the case of medical research, the Ministry has administrative responsibility only for the institutions that it finances directly from the part of the state budget allocated to health, including the Medical Centre of Postgraduate Education (*Centrum Medyczne Kształcenia Podyplomowego* (CMKP)), the Institute of Mother and Child and Institute of Cardiology.

Semi-autonomous medical academies, university hospitals and research institutes are accountable to the Ministry of Health. The Ministry is also responsible for supervising the training of health care personnel, for funding very expensive medical equipment (the responsibility in this area is shared with territorial self-governments) and for setting and monitoring health care standards. The Ministry finances certain emergency medical services and approves regional medical emergency care plans prepared by the voivodes (see section 5.5). It also supervises health resort treatment and regulates medical professions (in consultation with the respective professional chambers). It is also responsible for health policy, implementation and coordination of health policy programmes, development of guidelines for health promotion and disease prevention programmes, elaboration of solutions to health problems caused by environmental and social factors, and, jointly with the voivodeships, evaluation of access to health care.

The Ministry also has a number of supervisory functions. These include the supervision of the Chief Pharmaceutical Inspectorate (*Główny Inspektorat Farmaceutyczny*), the Office for Registration of Medicinal Products, Medical Devices and Biocides (*Urząd Rejestracji Produktów Leczniczych, Wyrobów Medycznych i Produktów Biobójczych* (URPL,WMiPB)) and the Chief

Sanitary Inspectorate (*Główny Inspektorat Sanitarny*), which is responsible for monitoring hygiene in various areas of life, food quality and safety and sanitary conditions in health care units. One of the latest additions to the supervisory functions of the Ministry is the supervision of the AOTM, which was created in 2005 (see section 2.7.2).

The NFZ

The major task of the NFZ is to finance health services provided to the entitled population (from the collected insurance fees). It negotiates and signs contracts for service provision with health care providers (setting their value, volume and structure), monitors the fulfilment of contractual terms and is in charge of contract accounting. The quality and accessibility of health care services are to a certain extent influenced by the negotiated terms. The NFZ is also responsible for covering the costs of health care services provided in other EU Member States to Polish citizens (see section 2.9.6).

The NFZ is prohibited from engaging in profit-making activities and cannot (directly or indirectly) operate, own or co-own health care institutions. Its activities are supervised by the NFZ Council, which consists of 10 members appointed by the prime minister for a five-year term. The NFZ is managed and represented by its president. On consulting the NFZ Council, the prime minister appoints the NFZ president from among the candidates selected through an open and competitive recruitment initiated by the Minister of Health. Two vice-presidents, one for medical affairs and one for the uniformed services, are appointed by the Ministry of Health on recommendation of the NFZ Council. The NFZ's annual financial plan is determined by its Council, the Parliamentary Commission for Health and the Parliamentary Commission for Public Finance of the *Sejm*. The plan needs to be approved by the Ministry of Health in consultation with the Ministry of Finance.

The NFZ has limited regulatory powers because these are generally held by the Ministry of Health (some experts claim that the NFZ is "the facade for the Ministry of Health"; see Jończyk, 2006). The level of NFZ's regulatory powers was diminished in 2009 when guaranteed benefits baskets were delineated by the 13 executive regulations of the Ministry of Health. Nevertheless, the NFZ still influences prices of contracted services. It also draws up, implements and finances health programmes (this includes implementation of health programmes assigned to it and funded by the Ministry). Furthermore, it is also tasked with health promotion (including publication of information in the area of health promotion and awareness), monitoring of medical prescribing and maintaining the Central Registry of Insured Persons. The NFZ has often been

criticized by health care providers on the grounds of its monopsonistic position as a payer in the system. For several years, reform proposals to split the NFZ into several competing funds have been voiced.

Territorial self-governments

Since the introduction of the three levels of territorial administration and self-government, territorial health authorities at each level (*gmina*, *powiat*, voivodeship) are responsible for health tasks defined in the legislation, for the assessment of the adequacy of service provision and health care infrastructure, and for health promotion and prevention. In addition, voivodeship self-governments are responsible for health care strategy and planning based on the health needs of their populations and the voivodes are responsible for medical emergency services in their region (see section 5.5).

Territorial self-governments at each level also have a so-called quasi-owner position (they are the establishing bodies) for the majority of public outpatient clinics and *powiat*- and voivodeship-level hospitals (Fig. 2.1). As quasi-owners of public hospitals, territorial self-governments are responsible for maintaining capital investments and perform a range of supervisory and control functions but have virtually no influence on their contracts with the NFZ (size and structure) and hence their revenues and the overall financial situation. However, in the event that a hospital is unable to cover its debts, the owner (most often a *powiat*) is obliged to take over its financial obligations and may initiate its transformation into a Commercial Code company or liquidate it – unless its liquidation would pose a threat to the continuity of health care provision for the population (Golinowska et al., 2002).

Health care providers

According to the 2011 Law on Therapeutic Activity, health care services are provided by public and non-public health care units as well as by individual and group medical practices. Non-public providers (former non-public ZOZs (*niepubliczny zakład opieki zdrowotnej*) and private practices) dominate in primary and ambulatory care. Public therapeutic entities can be established by the authorities at the *gmina*, *powiat*, voivodeship or central level (Ministries), by a state university active in the field of medicine or by the Medical Centre of Postgraduate Education. They can take the form of autonomous public health care units (*samodzielny publiczny zakład opieki zdrowotnej* (SPZOZ)), budgetary units (*jednostka budżetowa*) or research institutes (previously functioning in the form of scientific research units (*jednostka badawczo-rozwojowa*)). Until the end of 2010, public ZOZs could also take the form of budgetary establishments (*zakład budżetowy*). Budgetary units and

establishments have no legal personality, no influence over their finances and are entirely dependent on the budgetary means with which they are endowed. The SPZOZs constitute the vast majority of public health care units.

The SPZOZ model has had several shortcomings. The operational independence of the SPZOZs was not matched by an adequate financial responsibility, and their supervision by the territorial self-governments was limited. This resulted in the SPZOZs accumulating debts with impunity, even in cases where there was no need for borrowing. A number of experts saw privatization as a potential remedy for the unsound financial management of the SPZOZs. Since the early 2000s, there have been many attempts to transform SPZOZs into Commercial Code companies (see Chapter 6) (Mokrzycka & Kowalska, 2008). These efforts culminated in the 2011 Law on Therapeutic Activity, which came into force on 1 July 2011. The new legislation still needs to be accompanied by executive regulations, but it has definitely changed the systemic approach towards the formal status and establishment of hospitals (Mokrzycka, 2011).

Therapeutic activity comprises inpatient services (in hospitals and other institutions, such as rehabilitative, long-term and palliative care units) and outpatient services. According to this Act, health care services may be provided by two types of provider: therapeutic entities and professional practices (Table 2.1). The majority of therapeutic entities are in the form of SPZOZs, followed by private entrepreneurs.

Table 2.1

Classification of entities engaged in provision of therapeutic services, according to legal form

Entities engaged in provision of therapeutic services	
Therapeutic entities:	**Individual and group practices:**
Private entrepreneurs	Physicians
SPZOZs	Dentists
Budgetary units	Nurses
Research institutes	Midwives
Foundations and associations	Pharmacists
Churches and religious associations	

The 1996 Law on the Professions of Physician and Dentist defines the forms of private medical practice and health service delivery other than those based on salaried employment[5] in health care institutions. Individual and group medical

[5] Employment based on the Labour Code (and not Civil Code).

practices are the key categories specified in the 1996 Law, but medical practice may also be rendered at the place of call (at a patient's home or any other place). Medical practices may be established only by persons who have a licence to practise a medical profession and a permission to run a medical practice and they must be registered with a regional chamber of physicians and dentists. To avoid conflict of interest the establishment of private medical practices within public health care institutions is not allowed. For more information on the regulation of other types of practice, see sections 2.8.2 and 2.8.4.

Professional chambers

Physicians, dentists, pharmacists, nurses and midwives, and laboratory diagnosticians are associated in professional chambers (see section 2.8.3), which represent their interests by, among other things, providing expert opinion or arbitrating on matters of professional responsibility, and protect public health by supervising that provision of health care services is consistent with medical ethics, deontology and medical knowledge. Chambers participate in the establishment of education standards, maintain registers of licensed and active professionals and monitor their participation in continuous education (see also section 4.2.3). They also develop ethical codes of practice and may impose disciplinary measures on their members. Membership in the chambers is compulsory for all practising professionals.

The National Institute of Public Health

The National Institute of Public Health–National Institute of Hygiene (*Narodowy Instytut Zdrowia Publicznego–Państwowy Zakład Higieny* (NIZP-PZH)) received its current mandate in 2008.[6] It provides decision-makers, mainly the Ministry of Health, with recommendations on performance improvement from a broad public health perspective (beyond narrow epidemiological or legal perspectives). The Institute was conceived to address the shortage of expertise that became obvious during the long-lasting reform process.

Patient Rights Ombudsman

In 2009, the Office of Patient Rights Ombudsman was established to protect patients' interests, replacing the Office of Patient Rights that had been part of the Ministry of Health since 2005. The competencies of the Patient Rights Ombudsman include investigating infringements of collective or individual patient rights, initiating new legislation or changes in the existing legislation concerning protection of patient rights and promoting awareness of the protection of patient rights (see section 2.9.3).

[6] It was established in 1918, originally having a different name and other responsibilities.

2.4 Decentralization of the health care system

The Constitution of 1997 decentralized public power by allowing territorial self-governments to perform public tasks not exclusively reserved for public authorities at higher levels. In the area of health care, territorial self-governments are mainly responsible for health promotion and prevention (particularly in the area of occupational medicine, mental health care, and alcohol and tobacco consumption) and for tasks related to their function as the establishing bodies of public health care providers (which operate mainly in the form of SPZOZs) (Fig. 2.1). As such, territorial self-governments have the right (and under some conditions the obligation) to transform them into non-public therapeutic entities. Voivodes are responsible for coordination of activities of units of government and self-government administration in their respective territories in the area of prevention of threat to health and lives of their populations. Aided by the voivodeship sanitary inspectorates, the voivodes are responsible for the sanitary inspection in their territories (see section 5.1). Moreover, they maintain registers of therapeutic entities.

The shift towards three levels of territorial self-government (decentralization) proceeded in parallel with the disintegration of the health care system. Each level of territorial self-government is independent – it has its own organizational units and responsibilities. This makes coordination of activities in the health sector difficult. Current improvement proposals postulate a greater coordination of health care (Kozierkiewicz, 2011) and the increased role of the voivodeships in coordinating health care activities of the lower levels of territorial self-government (Kowalska, 2009).

2.5 Planning

Planning in the health sector is exercised by different entities and for different time periods. While voivodeship self-governments are responsible for the identification of health care needs and the planning of health care provision in their respective territories, the responsibility for planning the financing of health care services falls to the Ministry of Health and the NFZ (in relation to state budget planning). The Ministry of Regional Development (*Ministerstwo Rozwoju Regionalnego*) is responsible for strategic development plans, which also encompass the area of health care. Long-term strategies and health policy programmes are prepared by the NIZP-PZH and are approved by the Ministry of Health. Although the coordination of these various functions by the Ministry

of Health is generally limited, it does coordinate planning activities for selected health problems (e.g. cancer) or in relation to intersectoral issues, such as training of medical staff (see also section 2.6).

The Ministry of Health is responsible for health policy strategy and planning. Current national health policy has been formulated in the National Health Programme (*Narodowy Program Zdrowia* (NPZ)) for 2007–2015. The first NPZ was developed in 1990 as a response to the WHO *Health for All 2000* strategy. It was the first attempt to coordinate efforts of different units of government administration, nongovernmental organizations (NGOs) and local communities in order to protect, maintain and improve the health of Polish society. The current, fourth edition of the NPZ has eight strategic goals and 15 operational targets (Table 2.2), which are based on identified health needs of the population. The key objective of the NPZ is to improve health and health-related quality of life of the Polish population and reduce health inequalities. This is to be achieved by promoting healthy lifestyles; creating living, working and learning conditions conducive to good health; and by means of health-related interventions by local self-governments and NGOs.

The first three of the NPZ's strategic objectives have their specific sources of funding.[7] Other objectives do not have specifically earmarked sources of funding but are or were covered by budgetary allocations to various other health programmes, such as the Mental Health Programme 2006–2008. Financing of these objectives depends to a large extent on the needs, awareness and capabilities of those in charge of their implementation. Operational targets identified in the NPZ have been monitored since 1998. The NIZP-PZH is currently monitoring the NPZ on behalf of the Ministry of Health's Department of Public Health.

Plans of major political priority or those requiring interregional coordination or substantial means are made at the central or regional level. For example, the planning of assistance for victims of natural disasters or major traffic accidents, which requires a substantial logistical effort and use of central government resources, is initially worked out at the regional level and then coordinated centrally. More comprehensive planning (with more coordination between the Ministry of Health, NFZ and voivodeships) exists in some areas of care, particularly in the area of medical emergency care (see section 5.5).

[7] These are defined in the National Programme for Prevention and Treatment of Cardiovascular Diseases, the National Programme for Cancer Control and the 2006 Law on the National Emergency Medical Services.

Table 2.2

Strategic and operational objectives of the NPZ 2007–2015

Strategic objectives	Operational objectives
1. Reduction of morbidity and premature mortality due to cardiovascular disease, including stroke 2. Reduction of morbidity and premature mortality due to cancer 3. Reduction of the incidence of injuries resulting from accidents and limitation of their consequences 4. Addressing mental disorders through prevention and health promotion 5. Reduction of premature morbidity due to chronic diseases of the musculoskeletal system and limitation of their consequences 6. Reduction of morbidity and mortality due to chronic respiratory diseases 7. Increasing effectiveness of infectious disease prevention 8. Reducing social and regional health inequalities	**I. Operational objectives related to risk factors and health promotion** 1. Reduction of the prevalence of smoking 2. Change in alcohol consumption patterns and reduction of its health-related consequences 3. Improvement of population diet, food quality and reduction of the incidence of obesity 4. Increase in population physical activity 5. Reduction of drug use and related harm to health 6. Reduction of exposure to harmful factors in the living and working environment and their negative health effects and improvement of the overall sanitary condition of the country **II. Operational objectives related to specific populations** 7. Improvement of health care services for mothers, infants and young children 8. Support of physical and psychosocial health development of children and adolescents and the prevention of the most common health and social problems among them 9. Provision of conditions to support active and healthy life for seniors 10. Provision of conditions to support active life for people with disabilities 11. Intensification of preventive measures against dental caries among children and adolescents **III. Necessary action needed to be taken by the health and local self-government** 12. Active participation of the local self-government units and NGOs in public health 13. Improving the quality of health services in terms of efficiency, safety and social acceptability, including patient rights 14. Improving early diagnosis and care – particularly within primary care – for those at risk for cardiovascular disease, stroke, cancer, diabetes-related complications, and respiratory and rheumatic conditions 15. Increased and optimised utilization of local self-government infrastructure and resources for health promotion and education
Based on the last strategic objective, the following goals are also assumed: 1. Achieving full access to primary health care – achieving same-day admission for everyone 2. Developing primary health care measures aimed at groups at risk of poverty and social exclusion 3. Reducing differences in health status among children and youth from different regions and social strata	

Source: Council of Ministers, 2007.

Information on staffing needs in the health care sector is collected and analysed by health care consultants (national and voivodeship) and the Ministry of Health's Department of Science and Higher Education. Health care consultants may be appointed by the Ministry of Health, the Ministry of National Defence and the voivodes (voivodeship consultants). Their role is mainly to provide opinions in their respective area of specialization, including opinions on education and professional training. Admission limits for medical

studies are then set (annually) by the Ministry of Health in consultation with the Ministry of Science and Higher Education on the basis of teaching capacities and assessment of demand for medical graduates reported by medical universities.

The first attempt to develop a model for strategic planning of human resources in health care was initiated in the early 1990s by the Ministry of Health and led by Jagiellonian University, but this initiative, though promising, was suspended in 1995. Since then, no substantial developments in strategic human resource planning have taken place and no specific measures are currently being undertaken to improve the situation. Today, demand for human resources is indirectly determined by the NFZ's Plans for Purchase of Benefits, which determines the number of contracted units of account. Plans for Purchase of Benefits indirectly determine not only the staffing needs but also requirements concerning the facilities and equipment of health care providers. For information on infrastructure planning in Poland see section 4.1.1.

2.6 Intersectorality

Health is taken into account in policy decisions in a wide range of sectors. In the area of agriculture, it is considered in relation to the quality and safety of agricultural produce and the use of chemicals that may affect consumer health. The level of harmful chemical substances in agricultural produce is monitored by related institutes under the Ministry of Agriculture and Rural Development (*Ministerstwo Rolnictwa i Rozwoju Wsi*). Food production and processing are monitored by the Chief Veterinary Inspectorate (*Główny Inspektorat Weterynarii*); once food is available for retail sale, inspection is taken over by the Chief Sanitary Inspectorate, which is supervised by the Ministry of Health (see section 5.1). The Sanitary Inspectorate supervises workplace safety and working conditions together with the National Labour Inspectorate (*Państwowa Inspekcja Pracy*) and also assesses compliance with environmental norms and their effects on human health together with the Central Inspection for Environmental Protection (*Państwowa Inspekcja Ochrony Środowiska*). Occupational health and safety of agricultural workers are monitored by the Institute of Agricultural Medicine in Lublin (*Instytut Medycyny Wsi*). In 2010, Poland tightened its anti-tobacco law (1995), imposing more restrictions and higher penalties for smoking in public places. Sale, consumption and advertising of alcohol is regulated in the 1982 Law on Education in Sobriety and Prevention of Alcoholism (amended in 2009). According to this Law, the tasks of preventing and combating alcohol problems were entrusted to a special

agency, which is subordinated to the Ministry of Health. Moreover, a high excise tax is levied on alcoholic beverages and tobacco products, with the goal of curbing their consumption.

Health is also taken into account in crisis-response planning and implementation, with the Ministry of Health being represented in the Crisis Management Group. Specific targets related to the reduction of injuries, particularly those sustained during traffic accidents, are included in a special addendum to the NPZ and are the responsibility of the Ministry of Transport (*Ministerstwo Transportu, Budownictwa i Gospodarki Morskiej*). In its work, the Ministry of Transport consults the Road Safety Council, which includes a high representative of the Ministry of Health.

Since 2002, all normative acts of law are subjected to intersectoral public consultations before they are approved as draft legislation. Each new piece of legislation or change in existing legislation must be preceded by a regulatory impact assessment (*ocena skutków regulacji*), which determines which entities (public or private) are affected by the proposed regulation and the potential impact on population health. The assessment is carried out in cross-ministerial discussions of the anticipated effects of the legislation, and opinions from the relevant research institutions are often requested to aid decision-making.

While the NPZ has not been equipped with administrative tools that could influence health or other sectors, it provides general guidance in health-related matters across various sectors (see section 2.5). Since the majority of NPZ goals require intersectoral cooperation, an interdepartmental team was appointed in 1997 to manage the Programme's implementation. All Ministries and organizations involved in NPZ implementation are represented in the team, which is chaired by the prime minister, with the minister of health as deputy. NGOs, civil society and the private sector have been included in devising all operational objectives of the NPZ, reflecting the growing importance of these actors in Poland. For certain NPZ objectives, their participation is in fact explicitly mentioned (e.g. private owners of sports facilities may make these facilities available for mass sporting events, thereby contributing to increasing physical activity of the population).

The elimination of geographical and social inequalities in health is one of the strategic objectives of the NPZ. In addition, the prevention of poverty and the social exclusion of children was one of the key goals of the national programme *Social Security and Social Inclusion 2008–2010* of the Ministry of Labour and Social Policy, which included measures aimed at improving household income, developing childcare services and improving educational opportunities for

poor children. The Ministry of Labour also runs a programme for overcoming homelessness and implements initiatives for preventing unemployment. Other initiatives to tackle health inequalities can also be organized at the national or local level (e.g. prevention of alcohol or drug addiction or domestic violence).

2.7 Health information management

2.7.1 Information systems

Data on the functioning of health care system and on population health status are collected by various entities and by means of various information systems. The statistical survey programme of public statistics, prepared annually by the Statistical Council and published as a regulation of the Council of Ministers, sets the scope, form and frequency of public data collection and designates entities responsible for data collection (see Table 2.3 for entities and data types specified in the programme for 2011). Data are analysed by the entities that collect them and by the Central Statistical Office (*Główny Urząd Statystyczny* (GUS)), which also submits relevant data to international institutions such as the WHO, the European Commission for Eurostat or the OECD. Public statistics data can only be collected, published and utilized in an aggregated form since the 1995 Law on Public Statistics prohibits access to and publication of personal data (except in aggregate form). The timely submission of required data is ensured by fines for non-compliance. Accuracy of collected data may not always be assured and there is a need to train physicians in filling out statistical reporting forms. The compatibility of Polish statistical classification of health providers (as coded in the *International Classification of Health Accounts*) with the new OECD methodology and requirements of EU statistical reporting has been improved through training and cooperation between the Polish and international bodies involved in the collection and analysis of statistical data (OECD, Eurostat, WHO).

The information system operated by the NFZ is mainly used for the purpose of contract settlement. Data on the provision of health services is electronically transmitted by health care providers to the payer (the NFZ), which uses it to draw up reports for the Ministry of Health on the provision of services financed from public means. The range of data submitted by service providers is defined by the 2004 Law on Health Care Services Financed from Public Sources and includes the amount (or number) of health services provided, the number of patients on the waiting lists, drug prescriptions and consumption of refunded pharmaceuticals, and payment of insurance contributions by the insured.

Table 2.3
Examples of data collected under the programme of statistical surveys of public statistics

Institute/entity collecting data	Scope of data collected
Centre for Health Information Systems (CSIOZ)[a]	Health care professionals employed in health care institutions Health care professionals licensed to practice Activities of general hospitals and long-term care facilities (e.g. number of patients and beds, average length of stay)
Central Statistical Office (GUS)	Demographic and epidemiological data and prognoses National Health Accounts of ambulatory health care, emergency care, pharmacies and health resorts Health status of population based on statistical surveys
National Institute of Public Health – National Institute of Hygiene (NIZP-PZH)	Health status, detailed data on patients in hospitals
Institute of Psychiatry and Neurology	Activities and infrastructure of psychiatric clinics and hospitals
Nofer Institute of Occupational Medicine	Preventive examinations among the working population
Institute of Tuberculosis and Lung Diseases	Cases of tuberculosis and other lung diseases
Institute of Mother and Child	Preventive health care services for children and mothers
Chief Sanitary Inspectorate	Poisoning and infectious diseases including sexually transmitted diseases Functioning of the country border sanitary epidemiological stations, as well as the sanitary and epidemiological inspection
National Blood and Donor Centre	Blood donors, amount of donated blood and production of blood products

Sources: Council of Ministers, 2010; plus the statutes of the listed institutions.

Note: [a]CSIOZ collects data on behalf of the Ministry of Health. For example, it prepares statistical bulletins that cover demographic data and information on health care personnel and health care provision.

Various registers kept by the voivodes, medical professional chambers, scientific and research institutes and medical universities collect data (mainly) on health care professionals and incidence of various diseases. Health information systems are currently not fully integrated, but the Health Care Units Register (*Rejestr Zakładów Opieki Zdrowotnej* (RZOZ)) runs an online information-sharing platform, the "eRZOZ Project", and will in the future integrate all health care system information (according to the 2011 Law on the Information System in Health Care). The register will become the "Register of entities engaged in provision of therapeutic services" (*Rejestr podmiotów wykonujących działalność leczniczą*) based on the 2011 Law on Therapeutic Activity and will contain data not only on the former health care units but also on medical professionals.

Health at the individual level is monitored by primary health care physicians (including family doctors), nurses, midwives, school hygienists and other health care professionals. At the voivodeship and central level, health care consultants in all fields of health care monitor changes in population health. Health care data collected within the system of public statistics are reported to

public health centres at the voivodeship level. Aggregated data are sent to the Centre for Health Information Systems (*Centrum Systemów Informacyjnych Ochrony Zdrowia* (CSIOZ)) or to NIZP-PZH for national reporting. Every few years, the Centre for Monitoring and Analysing of Population Health Status within the NIZP-PZH publishes a report on the health status of the population (the latest is from 2008).

Collected information reflects various levels of care (Table 2.3). Differentiation among various population groups, such as children or seniors, will be progressively implemented in the future, for example in the P1 Platform built by the CSIOZ (see section 4.1.4). In spite of the unquestionable progress in the area of health information, there are still gaps that need to be filled. These include complete disease registers (including cancer registers), structural data on mortality and, in the area of health care management, data on the costs of health care provision.

2.7.2 HTA

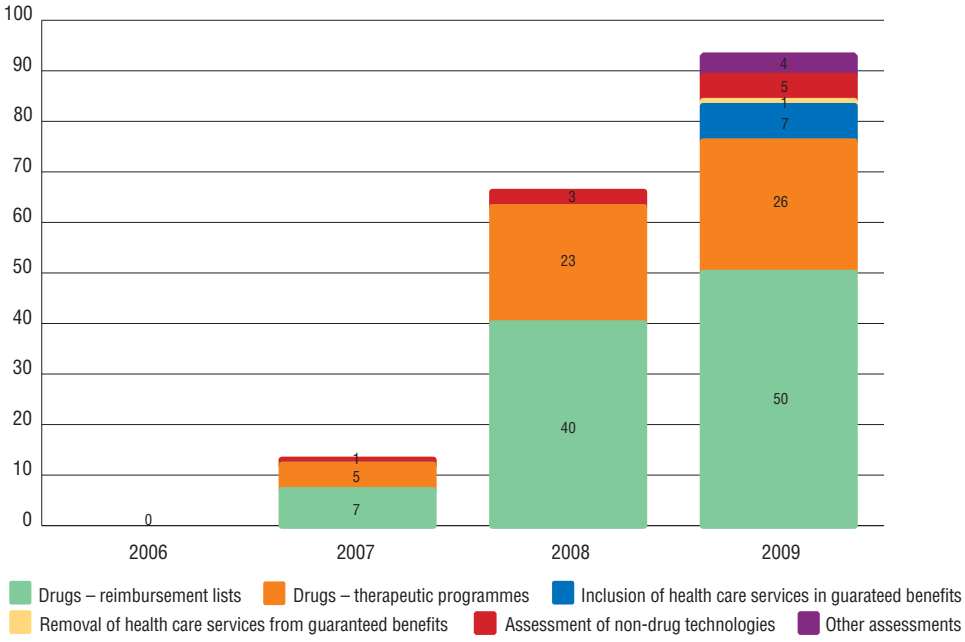
The AOTM is a state-financed agency that serves as an advisory body to the Minister of Health to inform decisions on public funding of health technologies, particularly those that are included in the basic benefits package. Before the Agency was created in 2005, there was no public entity in the Polish health care system whose main activity was the assessment of technologies financed by public means. However, some activities related to HTA are undertaken by the NFZ and by the CMJ, which was established in 1994.

The most important tasks of the AOTM are:

- issuing recommendation on health care services, determining:
  - their inclusion in the lists of guaranteed services,
  - the level or method of financing, or the conditions for provision of services (or changes in these), and
  - the removal of a service from the list of guaranteed services;
- issuing recommendation on the inclusion of medicines or medical devices in the lists of guaranteed benefits; and
- issuing appraisals of health programmes.

The Agency's main activity is drug appraisal (Fig. 2.2). To have a drug included in the reimbursement list, a pharmaceutical company must submit an application to the Ministry of Health and (in parallel) to the AOTM. This application must contain a full HTA report analysing clinical

Fig. 2.2
Number of assessments by the AOTM, 2006–2009



Source: Based on AOTM data.

effectiveness, cost-effectiveness and budget impact. The report is then critically assessed by an analytical team at the AOTM, according to a set of HTA guidelines elaborated by a team of experts under the auspices of the AOTM (Nowakowska, 2010). The review procedure includes a review of submitted evidence, a search for new available evidence, a review of the economic analysis, a recalculation of costs and economic modelling as well as a budget impact analysis. Key clinical experts and the NFZ are also consulted by the Agency. The outcome of the Agency's assessment can be commented on by the applicant during a special procedure implemented on 1 January 2010. Both the assessment and the comments are then presented to the Consultative Council of the AOTM, which formulates the final opinion. This opinion then provides the basis for the recommendation submitted to the Ministry of Health by the President of the Agency. The number of HTAs has increased rapidly since the Consultative Council was established in 2007. Recommendations of the AOTM are not legally binding and the final decision always belongs to the Minister of Health. Deadlines in the application process are in line with Council

Directive 89/105 EEC of 21 December 1988 (also called the Transparency Directive), which stipulates that a decision on the application is made within 90 days of submission.

International collaboration has always been extremely important for the AOTM. It was initially developed in order to build a team of trained analysts and to develop the Agency's assessment processes and is currently focused on experience exchange and advising countries without institutionalized HTA. For example, the AOTM is currently involved in the European Network for Health Technology Assessment (EUnetHTA) Joint Action 2010–2012, the aim of which is to develop an overall strategy and business model for coordination in the field of HTA in Europe, as well as develop and implement HTA tools and methods. The AOTM is responsible for a special line of activities within the business model development module called "Facilitation of national strategies for continuous development and sustainability of HTA".

2.8 Regulation

The health sector is extensively regulated. Regulations regarding standard setting and implementation mainly concern health professions, the training of medical personnel, the conditions in which health services are delivered to patients, the operation of service providers, health care financing, assuring availability of health care services and medicines (including the level of cost-sharing) and assuring observance of patient rights (Table 2.4). Proposals for new regulations and changes to existing regulations (in the form of draft laws) are submitted by the Ministry of Health. Draft laws are the subject of public and professional (by medical chambers, specialists and medical schools) consultations and are further examined in parliament. Some regulations, particularly on sensitive issues such as financing of contraception, can also be the result of bottom-up initiatives (e.g. by civil society groups). On adoption of a draft law by parliament, the Ministry of Health prepares executive regulations to implement the law. These executive regulations indicate institutions responsible for the implementation of the law and delineate their respective competencies. In the process of decentralization, some of the regulatory functions have been transferred to the territorial self-governments (see section 2.4)

Table 2.4
Regulatory functions and institutions in Poland

Function	Type of decentralization	Regulatory institution	Role
Standard setting	Centralization	Parliament	Enacts health care legislation
	Centralization	Ministry of Health	Prepares projects of legal acts (legislative initiative), enacts executive regulations, makes decisions (e.g. on the inclusion of medicine in the positive list) and creates health policy
	Centralization	NFZ central office	Prepares draft contracts with providers
	Devolution	*Voivodes*	Develop regional medical emergency care plans
Implementation	Delegation	NFZ regional branches	Contracts with health care providers in the regions
	Centralization	URPL,WMiPB	Evaluates quality, efficacy and safety of medicinal products and decides on marketing authorizations
	Centralization	AOTM	Recommends (to the Ministry of Health) health therapies and technologies to be included in the basic benefits package
Monitoring	Delegation	*Voivodes*	Supervises sanitary activities carried out by regional offices of the Chief Sanitary Inspectorate
	Devolution	*Voivodes*	Maintain registers of health care providers and monitor functioning of the national emergency care system
	Delegation	National and regional health care consultants	Perform advisory and supervisory tasks for central administration
	Delegation	Patient Rights Ombudsman	Monitors whether patient rights are respected and intervenes in case of their violation
	Delegation	NFZ regional branches	Monitors fulfilment of contracts for health care provision
	Devolution	Sanitary Inspectorate	Monitors and controls fulfilment of sanitary standards
	Deconcentration	CMJ	Monitors fulfilment of quality standards approved by the Ministry of Health

Monitoring and evaluation functions are institutionally not sufficiently developed or coordinated. They are carried out by various supervisory bodies, among which the Chief Sanitary Inspectorate has the strongest position. Deficiencies in the area of monitoring are particularly evident in the private health care sector.

2.8.1 Regulation and governance of third party payers

Lists of health services financed from public sources (NFZ or other), including levels of patient cost-sharing, price limits and conditions in which these services should be rendered (such as requirements on medical personnel and medical equipment), were specified in 2009 by way of 13 Ministry of Health executive regulations (see sections 3.3.1 and 3.4.1). Drug reimbursement (list of reimbursed drugs and level of reimbursement) is regulated by the 2011 Law

on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices. Contracts for provision of services between the NFZ and health care providers are awarded on the basis of Plans for Purchase of Benefits (see section 2.5), usually by means of competitive tenders (see section 3.3.4).

Being the sole public payer, the NFZ operates on a non-profit-making basis. Its annual financial plan must be approved by the Ministry of Health and the Ministry of Finance. The NFZ must assure transparency of public financing by granting free public access to selected (key) information on its annual financial plan and its implementation as well as on the contracts concluded with health care providers. The NFZ cannot be involved in the provision of health care services since there is a strict separation between public financing and health care provision (see also section 2.3).

A VHI market is not strongly developed in Poland (see section 3.5) and the term "private health insurance" has not been legally defined. Private health insurance (mainly sickness or accident insurance) is usually offered as a supplement to life insurance[8] or as quasi-insurance products (i.e. medical subscriptions offered by private and public health care institutions).

2.8.2 Regulation and governance of providers

Supervision of health care providers is exercised by the Minister of Health (overall activity), the voivodes and professional chambers (registration process), within the system of the State Sanitary Inspectorate (the so-called Sanepid, covering sanitary requirements for health care facilities; see section 5.1), and by the NFZ (contracts for provision of health care services).

Basic issues related to quality of care, such as key technical and sanitary requirements for health care facilities and equipment are regulated in the 2011 Law on Therapeutic Activity. More detailed requirements are set out in separate regulations of the Ministry of Health (e.g. in the areas of anaesthesiology and intensive care as well as in perinatal care) and in separate laws. For example, requirements regarding medical devices that may be used by therapeutic entities are regulated in the 2010 Law on Medical Devices (see section 2.8.4), and requirements to be met by health care professionals are set out in separate laws concerning these professions (see section 4.2.3).

[8] The VHI market is not regulated separately from the wider insurance market and companies offering VHI products are supervised by the Financial Supervision Commission (*Komisja Nadzoru Finansowego*).

Provision of care must be organized in a way that ensures adequate accessibility and quality of care – these are monitored by the provider founding bodies. The NFZ also has some responsibilities in relation to quality of health care provision: quality of care (as evidenced by internal and/or external quality assessment, such as accreditation certificates) is taken into account in the process of contracting (competitive tender). Moreover, contracts between the NFZ and health care providers contain provisions on the principles of quality control, adequacy and accessibility of services and the NFZ is responsible for monitoring of accessibility and quality of health care provision. No clinical pathways have been established in Poland to date and the entire course of care depends on the attending primary care physician or specialist.

In 1998, a national accreditation programme for hospitals was implemented by the CMJ and after a decade of experience with this programme, in 2008, a Law on Accreditation in Health Care was passed, defining accreditation rules and procedures. The purpose of accreditation is to confirm that a provider meets accreditation standards developed by the CMJ with regard to its functioning and provision of health care. Such standards have already been approved for hospitals and primary care and will in the future apply to all entities engaged in the provision of therapeutic services. The Minister of Health grants accreditation to health care institutions on recommendation of the Accreditation Board, in the form of accreditation certificates, which are valid for three years. Currently the CMJ is working on developing standards for outpatient care, addiction treatment, long-term care and mental health care. The accreditation process is voluntary.

Moreover, Poland actively participates in European Community projects related to ensuring quality of care, such as PATH, Handover (Improving the Continuity of Patient Care Through Identification and Implementation of Novel Patient Handover Processes in Europe), and MARQuIS (Methods of Assessing Response to Quality Improvement Strategies), focused on cross-border care (see also section 7.4.2).

Issues related to medical negligence are regulated in the Civil Code (with regard to monetary compensation), in the Criminal Code and in the 2011 amendment of the 1996 Law on the Professions of Physician and Dentist (with regards to disciplinary measures) (see section 2.9.4).

On 9 June 2009, EU Health Ministers adopted a European Council Recommendation that called on Member States to develop and implement plans and/or strategies for the treatment of rare diseases. Such works have not yet started in Poland. However, since 2011 Poland has been a formal partner

country of the Orphanet – a reference portal for information on rare diseases and orphan drugs, the aim of which is to improve diagnosis, treatment and care for patients affected by rare diseases. As such it is responsible for the collection of information on specialized clinics, medical laboratories, ongoing research and patient organizations in Poland.

2.8.3 Regulation of human resources

Several medical professions[9] are regulated by separate legal acts in Poland, which set out, among others, certification requirements and specifications concerning specialist training and continuing education. Other medical professions are not regulated separately and may currently be practised by people without formal qualifications, who have learnt their tasks on the job or completed relevant education or vocational training programmes. Some attempts to formalize the prerequisites for these positions have been made. For example, the PO-led government proposed a bill to regulate and establish a register for selected medical professions; however, the bill has not advanced since the last draft was circulated in May 2010.

There are four statutory organizations responsible for registering and licensing qualified medical personnel in Poland: the Chamber of Physicians and Dentists, the Chamber of Nurses and Midwives, the Pharmaceutical Chamber and the Chamber of Laboratory Diagnosticians (see section 2.3). Membership is compulsory for all practising medical professionals, and both regional and national chambers maintain registries of all professionals who have the right to practise or to a specialist title. Registers of physicians and dentists undergoing specialization training are maintained by the centres for medical personnel training at the voivodeship public health centres (*wojewódzkie centrum zdrowia publicznego*). Since there are no registries for other medical professions, it is difficult to assess the number of professionals working in medical fields other than those mentioned above.

All physicians, dentists and pharmacists must participate in continuing education, collecting points for the completion of continuing education courses (see section 4.2.3); this activity is monitored by the relevant chambers. Physicians, dentists, nurses, midwives, pharmacists and laboratory diagnosticians who have been inactive for more than five years must notify the relevant chamber and be retrained at their own expense. Failure to do so may result in a suspension of their right to practise.

[9] Physicians, dentists, nurses, midwives, pharmacists, laboratory diagnosticians, medical rescuers and rescuers, and *feldshers* (an auxiliary medical profession).

Some professional groups are represented in non-statutory organizations. For example, physiotherapists are represented in three: the Polish Society of Physiotherapy, the Poland-wide Trade Union "Fizjoterapia" and the Polish Physiotherapy Association. Likewise, the Polish Council of Medical Rescuers, created at the end of 2010, represents associations of medical rescuers and is working towards the establishment of a professional chamber for this group.

Health care professions regulated in Poland can be divided into those covered by the EU sectoral system of recognition of professional qualifications and those covered by the EU general system of recognition of professional qualifications. The first category covers physicians, dentists, nurses, midwives and pharmacists. For these professions, recognition of professional qualifications is automatic provided that the applicants have the necessary documents to prove their qualifications. These requirements were harmonized and regulated by EU sectoral directives, now replaced by Directive 2005/36/EC on the recognition of professional qualifications. The 2008 Law on the Conditions for Recognition of Professional Qualifications Obtained in EU Member States implements this Directive in Poland. The second category covers regulated professions for which Member States retain the right to set the minimum level of required qualification (laboratory diagnosticians, physiotherapists, dental assistants, etc.). These professions are not covered by EU sectoral directives, and their programmes of study are not harmonized. However, it is assumed that education and training programmes for regulated professions are essentially equivalent across Member States and qualifications obtained in one Member State should provide access to the same regulated profession in Poland. For professions that are not regulated in Poland, that is all medical professions mentioned in the 2010 proposed bill on selected medical professions, a person who was trained abroad does not need to apply for the recognition of their qualifications and employers may freely decide whether they want to employ them.

Professional chambers issue licences to practise for EU-trained physicians, dentists, *feldshers*, nurses, midwives, laboratory diagnosticians and pharmacists if they hold valid qualifications for these professions in another Member State (although there may be restrictions regarding some EU countries). In addition, applicants must supply the following:

- a certificate issued by the relevant EU Member State authorities showing that the applicant has permission to practise medicine on the territory of that Member State; and
- a written declaration by the applicant stating that he/she has a good command of the Polish language.

2.8.4 Regulation and governance of pharmaceuticals

The Ministry of Health has legislative and supervisory powers over the pharmaceutical market. The URPL,WMiPB is a governmental agency responsible for the evaluation of quality, efficacy and safety of medicinal products, medical devices and biocidal products. It is subordinated directly to the Minister of Health.

Safety of medicinal products is supervised by the President of the URPL,WMiPB, who issues market authorizations and can withdraw a previously granted market authorization in case of unexpected and severe or life-threatening adverse effects. Authorization may also be withdrawn in case of lack of declared therapeutic efficacy or when the risk of applying the product is incommensurate with its therapeutic effect. Entities that have obtained market authorization for medicinal products are obliged to continuously monitor their safety by keeping records of all adverse effects reported by physicians, pharmacists or patients undergoing treatment and to present yearly reports to the Pharmacovigilance Department at the URPL,WMiPB.

Good practices that ensure appropriate quality of products authorized for sale in Poland (Good Distribution Practice, Good Laboratory Practice, Good Clinical Practice and Good Manufacturing Practice) are defined in the 2001 Law on Pharmaceutical Law (as amended in 2009). This Law was developed in compliance with the relevant EU regulation. Basic quality requirements and testing methods for medicinal products and their packaging and for pharmaceutical raw materials are specified in the *Polish Pharmacopoeia*, which is fully compatible with the *European Pharmacopoeia*.

The manufacture and import of medicinal products and medical devices as well as the quality and advertising of medicinal products and medical devices sold by pharmaceutical wholesalers, pharmacies, pharmaceutical outlets[10] and other sales points are supervised within the system of State Pharmaceutical Inspection (*Państwowa Inspekcja Farmaceutyczna*). The central executive organ of the system is the Chief Pharmaceutical Inspector supported by the Chief Pharmaceutical Inspectorate.

Pharmaceuticals are classified into one of the following categories:

- Rp: prescription drugs;
- Rpz: prescription drugs for restricted use;

[10] Pharmaceutical outlets can only be located in rural areas where a normal pharmacy is not available. Those outlets are allowed to sell selected basic drugs to patients.

- Rpw: prescription drugs containing narcotic or psychotropic substances (a special prescription form is used for these drugs);
- Lz: used exclusively in hospital treatment under direct medical supervision; and
- OTC non-prescription drugs (i.e. sold to patients without prescription):
  - OTC drugs sold in pharmacies only (not approved for the general market), and
  - OTC drugs approved for general sale (in pharmacies, herbal stores, supermarkets, etc.), such as mild painkillers, vitamins, cough syrups.

There are three procedures for registration of medicinal products in Poland: centralized, decentralized and mutual recognition, all three compliant with EU standards. Medicinal products authorized in Poland are registered by the President of the URPL,WMiPB. Market authorizations are valid for five years but can be extended (even indefinitely) on request of the responsible entity (i.e. a pharmaceutical company). The following may be sold in Poland without market authorization: magistral formula (medicinal product prepared in a pharmacy in accordance with a physician's prescription for an individual patient), officinal formula (medicinal product prepared in a pharmacy in accordance with the prescriptions of a pharmacopoeia and intended to be supplied directly to the patients served by the pharmacy in question), radiopharmaceutical products, blood and plasma, pharmaceutical raw materials not intended for production of medicines, veterinary immunological products and tested medicinal products exclusively used for clinical or scientific trials.

Regulations on the patent protection of active substances have been in force in Poland since January 1993. From its EU accession in 2004, Poland grants the same period of market exclusivity as the one applied in the EU (ten years plus one year with respect to technologies of remarkable significance). Poland also agreed to introduce a supplementary patent protection (Supplementary Protection Certificate), which grants up to five years of additional patent protection over the normal 20-year protection period.

Advertising of medicinal products is also regulated by the Law on Pharmaceutical Law. The Law bans public advertising of prescription medications and of medicinal products containing narcotic and psychotropic substances or drugs used exclusively in hospital treatment. An advertisement may not be misleading and it should objectively inform about the properties of the product. It cannot target children. Publicly known persons, scientists, pharmacists or doctors cannot be used to advertise drugs. Companies are not

allowed to offer any benefits in return for purchase. Moreover, the advertisement must not suggest that by taking the advertised medication a person can avoid seeing a physician and that one's health will deteriorate by not taking it.

Any natural or legal person can own a pharmacy or a pharmaceutical wholesaler in Poland. Nevertheless, there are some limitations with respect to pharmacy networks – one entity cannot own more than 1% of pharmacies in one voivodeship. In order to open a pharmacy or a pharmaceutical wholesaler, authorization from a voivodeship pharmaceutical inspector is required. The pharmacy has to be managed by a pharmacist with at least five years of experience in managing a pharmacy (or at least three years of experience for a pharmacist specialized in the field of retail pharmacy) and a pharmaceutical wholesaler must be managed by a pharmacist with two years of work experience in a pharmacy or a pharmaceutical wholesaler. Premises must meet certain sanitary requirements.

Pharmacies are obliged to inform customers about the possibility of purchasing a reimbursed medication other than that prescribed by the physician, with the same international name, dosage and therapeutic indication and in a similar pharmaceutical form that does not cause any differences in the effectiveness of the treatment. From 2012, they will also be obliged to provide those products. Mail or Internet trading of pharmaceuticals is not permitted, with the exception of non-prescription pharmaceuticals. Only pharmacies and pharmaceutical outlets are allowed to operate a mail-order retail sale under Polish law. Certain medicinal products may be sold without prescription in pharmacies, herbal stores, specialized medical supply shops and other shops open to the general public. A list of such products was last defined in 2010 by the Ministry of Health.

Reimbursed drugs are available to all insured persons:

- free of charge (drugs proven to be effective in cancer treatment, some psychiatric conditions or severe infectious diseases);
- at a flat fee (for drugs on the basic drugs list defined in the 2011 Law on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices and for drugs normally requiring a 30% or 50% co-payment when therapy lasts longer than 30 days and the monthly cost of treatment exceeds 5% or 30% of the minimum wage, respectively);
- for 50% of the price (for therapies shorter than 30 days); and
- for 30% of the price in other cases.

The Ministry of Health decides on drug and medical devices reimbursement, including whether cost-sharing is applied and its extent, on the official sales price and risk-sharing instruments (if applicable). The decision is issued for five, three or two years, depending on the drug's effectiveness. In making reimbursement decisions, the Ministry of Health is supported by the AOTM and the Economic Commission (an advisory board established by the Ministry). The final decision is based on the opinion of the Economic Commission; the recommendation of AOTM; the clinical, cost-effectiveness and safety of the drug, as well as its health benefits and budget impact; the availability of clinical alternatives; and existing health priorities. The lists of reimbursed drugs and medical devices are published by the Ministry and updated every two months.

Wholesale pharmaceutical prices are set by adding a 8.91% margin to the agreed producer's price. This margin will be reduced to 7% in 2012, 6% in 2013 and 5% in 2014. Retail prices are set by combining a fixed margin and a decreasing margin starting at 40% for the cheapest drugs (no fixed margin is applied to drugs for which a 40% decreasing margin is used) to 1.25% for the most expensive drugs. Statutory margins do not apply to drugs without reimbursement coverage, and prices for this group of drugs are not controlled. Hospitals purchase drugs at prices negotiated with wholesalers or drug producers or at statutory prices if applicable.

Given the rising consumption of pharmaceuticals in Poland (see section 5.6), already visible in 2003, the National Pharmaceutical Policy for 2004–2008 identified a need for the development of ambulatory health care formularies, which would contain guidelines on the use of medicines in specific cases and set standards of medical treatment, taking into account their costs. Work on these formularies has not been completed. Meanwhile, there are therapeutic committees in most hospitals that develop hospital formularies containing a list of drugs used in a particular hospital and information on the restrictions in their use. Moreover, prescribing of reimbursed drugs is monitored by the NFZ. It is used for controlling potential abuses rather than as a criterion for selecting health care providers for NFZ's contracts.

Recognizing the importance of the problem of counterfeit drugs in Poland (particularly prevalent in mail or Internet trading), in 2009 the Minister of Health undertook an information campaign under the motto "Falsified medications kill you". In addition, a special interdepartmental team for falsified products was established in 2007 at the Ministry of Health to undertake measures (mainly informative and legislative) aimed at minimizing the trade in falsified medicinal

products, sale of medications in unauthorized places and sale of falsified dietary supplements that are, in fact, medicinal products owing to the use of undeclared active ingredients.

2.9 Patient empowerment

Evidence on the level of health literacy among Polish patients is scarce. A survey in 2009 among big city inhabitants found that the level of health literacy varied with sociodemographic factors such as age, gender, type of residence (apartment, house, etc.), duration of residence in a big city, education, level of income and type of occupation (Cylkowska-Nowak & Pajko, 2009). Unsurprisingly, the motivation and ability to gain access, understand and use information in ways that promote and maintain good health was greater among younger, wealthier and better educated individuals.

2.9.1 Patient information

Educating patients on how to stay healthy, how to live with a disease and what privileges and rights patients have in the Polish health system is mainly performed by medical personnel, but also by public institutions (Patient Rights Ombudsman) and patient organizations or NGOs (e.g. Institute of Patient Rights and Health Education). When making decisions about accessing health services, patients have the right to obtain information on their health status, planned and alternative method(s) of treatment, list of entities providing health services under the public health care system, waiting times for elective care, and quality certificates held by the health care facilities. The main sources of such information are the NFZ and health care providers, but not all patients are aware of their rights and patients may not take full advantage of the available choices.

The NFZ provides comprehensive information on its website: on health insurance; on the rights and obligations of patients; on health care benefits and responsibilities of health care providers (by means of the *Patient's Vademecum*, a downloadable booklet); on contracted providers and the scope of services contracted with each provider; on waiting lists (information is obtained from all contracted health care providers and is available for various types of service, such as hip replacement or hospitalization in a neurological ward; lists are updated on a monthly basis); on the rights and responsibilities of recipients of services (information provided on regional branch websites); on the coordination of social security systems within the EU, and how to access health care services

financed from public funds outside Poland; and information for foreigners on the functioning of the public health care system in Poland (available on the NFZ's website in English, German, French and Spanish).

Dissemination of information by health care providers is regulated by the 2004 Law on Health Care Services Financed from Public Sources and by the NFZ. The NFZ obliges each contracted health care provider to display the following information in their facilities: on patient rights, contacting the Patient Rights Ombudsman, working hours of providers and their subcontractors (e.g. laboratories), principles of making appointments and requesting home visits, enrolling on waiting lists, complaint and request procedures, and accessing services at night and on public holidays. NFZ-contracted providers are obligated to display a NFZ sign at an accessible and clearly visible spot on the outside of the building to inform patients that the institution provides health care services within the public system of health care insurance. Additionally, based on the 2008 Law on Patient Rights and the Patient Rights Ombudsman, patients have the right to obtain information on their health status; diagnosis; available diagnostic and treatment methods, and the potential consequences of their application or non-application; likely results of treatment; and prognosis. Such information must be conveyed in a clear and straightforward manner. Patients may also decide who, beside themselves, may receive such information.

Information on quality certificates (in particular, accreditation certificates) held by health care providers is available through the RZOZ Register, which before the enactment of the 2011 Law on Therapeutic Activity only contained information on health care units (now "therapeutic entities") but will in the future also contain information on health care practices (see section 2.7.1). Information on accreditation certificates is also published on the CMJ's website. Apart from the accreditation system, there is no comprehensive information system on the quality of inpatient care in Poland. Voluntary hospital rankings have been compiled and published in the last couple of years by some newspapers (e.g. *Wprost*, *Rzeczpospolita*), and NGOs (e.g. by the Society for the Promotion of Quality (*Towarzystwo Promocji Jakości*)), but not necessarily on a regular basis. Assessment criteria used in these rankings were usually prepared in cooperation with the CMJ or the Society for the Promotion of Quality and mainly included management and quality assurance aspects.

Finally, the website of the Ministry of Health is another source of information on the organization and functioning of the health care system in Poland (information may also be obtained over the phone, by e-mail or in person).

2.9.2 Patient choice

Universal health insurance is compulsory for the majority of citizens without the possibility of opting out (see section 3.3.1). Individuals who are not covered by the compulsory scheme, such as foreign students, can subscribe to the universal health insurance system on a voluntary basis. Contributions collected within the compulsory scheme are managed by the NFZ, which is the sole payer in the system, and hence patients do not have a choice of purchasing organization. They must register with one of the NFZ's regional branches, which is usually based on their place of work. Introduction of VHI, currently debated, may in the future provide enhanced choice of benefits and cost-sharing for the patients (see section 3.5). The scope of the benefits package and the level of insurance contributions are defined in the 2004 Law on Health Care Services Financed from Public Sources, regulations on the benefits baskets (2009) and the 2011 Law on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices, leaving patients no choice in benefit options or the level of cost-sharing (see sections 3.3.1 and 3.4.1).

One of the basic patient rights under the SHI system is the free choice of health care provider. At each level of care, every patient has the right to choose among contracted providers a physician, nurse or midwife (primary care), a specialist ambulatory clinic and specialist therein (specialist ambulatory care), a dental clinic and dentist therein (dental care) and a hospital (with the exception of emergencies, where patients may receive care also at non-contracted facilities, see section 5.5 for more information).

Patients can freely choose to register with any primary care physician contracted by the NFZ. Switching to a different physician is possible free of charge twice a year.[11] A referral from a primary care physician is usually needed to access specialist care but exceptions are made for certain specialist types and certain population groups (see section 5.4.1), where direct access is possible. A referral is also needed to access hospital care in a facility chosen by the patient. The NFZ covers costs of treatment obtained abroad if such treatment had been approved by a regional consultant in a relevant medical specialty (see also section 2.9.6). Patients can refuse a medical treatment, but this choice may be limited in the case of some infectious diseases or psychiatric care. Patients have the right to consent to or refuse a proposed treatment after being fully and appropriately informed. For minors and persons incapable of making decisions on their own, consent can be given by their legal representative. Patients are

[11] With a few exceptions (change of residence or factors beyond the individual's control), a fee is due for more frequent changes.

entitled to choose their treatment among available therapies presented by a medical professional and to co-determine the time of treatment. Patients can leave the hospital or a clinical trial at any time on request. No in-depth analyses are available on how patient rights to choose health care providers or the type of medical treatment are exercised. Patients usually choose the nearest primary care physician or hospital and, although since 1999 they may choose any provider outside their region of residence, elderly people accustomed to one provider usually do not seek to change. Decisions to choose a particular provider are mainly based on waiting times, information about which can be obtained by phone directly or from the NFZ's website.

2.9.3 Patient rights

Article 68 (1) of the Polish Constitution of 1997 grants a general right to health care to every citizen. All citizens, regardless of their financial status, must have equal access to publicly financed health care services. Special care should be granted to children, pregnant women, people with disabilities and seniors. Moreover, public authorities are mandated to combat epidemics and prevent the negative health consequences of environmental degradation. They should also support physical education among children and adolescents.

Until 2009, patient rights were spread among many different legal acts, such as legislation concerning medical professions, mental health, activities of health providers and the functioning of the NFZ. The 1991 Law on Health Care Units was the first piece of legislation to specify fundamental rights of patients in a separate legal act. However, this first set of patient rights was in the form of obligations put on providers (e.g. providers were obliged to inform patients) rather than being directly attributed to the patient. This approach was also repeated in the 1991 Physician Code of Ethics, which forms a base for the ethical and professional responsibilities of physicians. Patients' complaints were almost exclusively examined by the special medical courts under the control of professional medical chambers, and state courts were involved only in a handful of cases. In both situations, patients were disadvantaged – they could not personally take part in the proceedings of medical courts (representation by a plenipotentiary was required) and, they had to pay the full court's fee upfront (at the moment of lodging complaint) in a civil court suit, and courts rarely relied on patient rights in cases against physicians.

The 1998 *Charter of Patient Rights* was the first comprehensive attempt by the Ministry of Health to collect all legal norms in one document. The Charter provided a catalogue of patient rights with references to the corresponding regulations, but was itself not a source of law and has not been updated since its

publication. At the end of 2008, the Law on Patient Rights and the Patient Rights Ombudsman, which entered into force in June 2009, gathered all dispersed patient rights in one well-defined legal act and established the post of Patient Rights Ombudsman. The Law defines a catalogue of patient rights, the rules for access to medical records, the obligations of entities providing health services with regard to patient rights, the competencies of the Patient Rights Ombudsman, as well as the rules for appointment and dismissal of the Patient Rights Ombudsman and procedures in the case of infringement of collective patient rights. Further patient rights can be found in the 2004 Law on Health Care Services Financed from Public Sources and the 2011 Law on Therapeutic Activity (Table 2.5).

Other sources of patient rights are the informal European Charter of Patient Rights compiled in 2002 by the Active Citizenship Network and the 1998 Charter of Patient Rights based on the 1994 Declaration on the Promotion of Patient Rights in Europe (WHO, 1994).

On 1 January 2002, the Minister of Health established the Office for Patient Rights, a state-owned unit supervised by the Ministry of Health set up to assist patients in defending their rights (e.g. by helping them contact lawyers and medical consultants). The Office for Patient Rights was transformed into the Office of the Patient Rights Ombudsman in 2008. The role of the Patient Rights Ombudsman is similar to that of the President of the Office for Competition and Consumer Protection (*Urząd Ochrony Konkurencji i Konsumentów*). Both are central government authorities, appointed and dismissed by the prime minister (they are publicly recruited and recruitment is based on merit). The Ombudsman acts independently of the Minister of Health and the President of the NFZ, aiming to ensure that patient rights are protected and providing support in exercising those rights. The key competencies of Patient Rights Ombudsman include:

- taking action in cases of infringement of collective patient rights through the actions or inactions of health care providers that restrict the rights of patients or deprive them thereof, as well as through the activities of health care providers undertaken for private financial gain;
- taking action in cases of infringement of individual patient rights and participating in civil lawsuits related to infringement of individual patient rights;
- organizing and managing educational programmes aimed at raising awareness of patient rights; and
- analysing patient complaints in order to identify threats to patient rights and areas requiring improvement.

Table 2.5
Overview of patient rights in Poland

Guaranteed patient rights	Scope	Compliance with the 1994 WHO framework
Right to health care services	Right to state-of-art health care services Right to a second opinion Transparent and objective waiting time system Immediate access to emergency care	Full compliance
Right to information	Right to easily accessible, understandable information on the diagnosis, available and proposed therapies, and expected outcomes (in case of compliance and refusal of treatment) Right to be informed about patient rights by health care providers (information on patient rights must be displayed in a visible way in all health care facilities contracted by the NFZ)	Partial compliance (one condition not always met in public hospitals is the availability of an interpreter if patients do not speak Polish).
Right to confidentiality of patient's information	Health care professionals are obliged to not reveal information to any person not authorized by the patient (this right is limited in emergency cases and in case of legal decisions to the contrary)	Full compliance
Right to give consent	Patients can freely decide to accept or refuse proposed treatment In case of surgery or high-risk treatments consent must be in written form	Full compliance
Right to intimacy and dignity	Includes right to die in dignity Relatives are allowed to be present during consultation	Full compliance
Right to medical documentation	Providers must maintain and store medical documentation and make it accessible to patients on demand Medical documentation can only be accessed and processed by authorized physicians, nurses and midwives Medical documentation must contain complete information about the patient, health care provider and services provided	n/a
Right to challenge medical opinions or diagnoses	Medical opinions or diagnoses can be challenged by the patient	n/a
Right to private and family life	Right to maintain or refuse contact with relatives Right to additional nursing care during stay at a stationary health care facility (obtainable through a civil law contract with the patient, family member or legal representative)	Full compliance
Right to pastoral care	Right to pastoral care according to one's beliefs	Full compliance
Right to have one's personal belongings safely deposited	Patient valuables must be safely deposited by the hospital during treatment	n/a

Note: n/a: not included in the framework (WHO, 1994).

The Ombudsman is entitled to impose financial penalties of up to PLN 500 000 on entities infringing collective patient rights and failing either to stop the infringement or to eliminate the consequences thereof. If a given entity is suspected of resorting to practices that might infringe collective patient rights and fails to submit, upon request, relevant documentation or information on these practices, the Ombudsman may impose a fine of up to PLN 50 000.

Departments for patient affairs exist within the structure of the regional branches of the NFZ since 2004. They are also in charge of representing the interests of the insured by:

- monitoring if health care services are provided with respect to patient rights and submitting requests to the President of the NFZ in cases of violation;
- proposing possible courses of action in cases of infringement of individual patient rights upon the patient's request;
- intervening in cases of infringement of patient rights;
- issuing decisions on submitted complaints and requests and preparing periodic reports and analyses;
- ordering audits of contracts concluded by the NFZ with health care providers in case of flagrant patient rights infringement;
- undertaking initiatives aimed at preventing patient rights infringement;
- cooperating with the Ombudsman for Civil Rights and government organizations protecting patient rights; and
- operating a hotline for the insured to answer their questions regarding the health insurance system.

The United Nations Convention on the Rights of Persons with Disabilities of 13 December 2006 has not yet been transposed into Polish law. Buildings in which health care services are provided are classified as buildings of public use in Poland (as are schools and public administration offices) and as such must provide unobstructed access for people with disabilities. This can include personal lifts, special support rails and safety ramps for wheelchairs; the technical parameters are regulated in detail by the Ministry of Infrastructure (*Ministerstwo Infrastruktury*). However, not all facilities (particularly older hospitals) comply with these requirements (see section 4.1.1).

In 2008, the Institute of Patient Rights and Health Education conducted a survey among the population aged between 15 and 75 on their knowledge of patient rights (Wagner, 2008). The survey showed that only 50% of respondents were aware of the existence of patient rights: 38% of them were familiar with at least one right and 19% were aware of all rights mentioned in the survey. Right to health care services, right to information and freedom of choice were the most widely recognized rights among the respondents.

2.9.4 Complaints procedures

Every NFZ branch as well as the NFZ's head office has a department of complaints and requests that deals with patients' complaints in case of rights violations by a health care unit contracted by the NFZ, provided that the violation in question concerns a contractual obligation of the provider vis-à-vis the NFZ, in which case the NFZ can impose financial penalties on the provider. If patient rights are breached by a provider without an NFZ contract, patients can turn to the Patient Rights Ombudsman or go directly to a civil court. Victims of medical malpractice may also seek compensation from the health care unit at fault in a civil court.

Complaint procedures are governed by the Civil or the Penal Code provided that a state prosecutor decides that a crime has taken place. The burden of proof lies on the side of the patient and a no-fault compensation system does not exist in Poland. A link between the physician's action or inaction and the damages sustained has to be proved. The plaintiff has to pay an upfront court fee of 5% of the disputed amount (capped at PLN 100 000) but can ask for a waiver in case of financial difficulties. To avoid the often costly and lengthy legal procedures, patients may also seek an extrajudicial settlement with the provider's insurance company. Entities providing health care services and entities subcontracted to provide health care services are obliged to take out third party liability insurance, which is regulated by the 2011 Law on Therapeutic Activity, and – for providers contracted by the NFZ – by the 2004 Law on Health Care Services Financed from Public Sources (Article 136b). Despite these two different sources of law, the principles governing third party liability are almost identical, with the exception of minimum sums of compensation. Compulsory third party liability insurance may be additionally supplemented with voluntary third party liability insurance policies. These policies indemnify physicians against claims resulting from damages inflicted during provision of health care services other than those contracted or subcontracted (and hence covered by the compulsory insurance). Such policies cover activities conducted in a private surgery (treating private patients), services rendered under subcontract, or emergency assistance provided outside the place of work (e.g. on the street). Voluntary insurance can, therefore, cover almost the entirety of a physician's professional activity. It is not known how many physicians purchase voluntary insurance policies.

Complaints with regard to insufficient due diligence, medical errors, negligence in treatment and breach of the rules of ethical conduct by a physician may also be submitted to the ombudsman of professional responsibility of the

regional chambers of doctors and dentists or the regional chambers of nurses and midwives. This type of complaint may result in vocational consequences for the professional at fault (the highest penalty is the loss of right to practise) but not in financial compensation.

The 2008 Law on Patient Rights and the Patient Rights Ombudsman does not directly refer to the issue of medical malpractice. It solely indicates that patients have the right to receive state-of-art health services and entitles patients to pursue damages in case of a culpable breach of patient rights, on the basis of Article 448 of the Civil Code (Article 4 of the 2008 Law). Financial compensation may be awarded to offset or compensate the claimant for harmful experiences associated with the violation of personal rights and its effects by providing compensation at a level that will allow him/her to function normally in the future (e.g. pay for medical rehabilitation). Medical malpractice may also result in criminal liability. While the Criminal Code does not provide for medical malpractice in particular, it includes provisions that may result in criminal responsibility in such cases (e.g. manslaughter, inflicting severe bodily harm, inflicting bodily harm to a child *in utero*, putting somebody in imminent danger of loss of life or serious bodily injury, and providing medical treatment without patient consent). No statistics are currently collected on the incidence of medical malpractice in Poland. However, according to a *Eurobarometer* survey on medical errors published in January 2006, 91% of Polish respondents perceived the problem of medical errors as important (compared with an EU average of 78%), 51% were worried about experiencing a medical error (compared with an EU average of 40%) and 51% had often read or heard about medical errors (compared with an EU average of 34%) (European Commission, 2006a). Adverse effects of medicinal products have been registered for at least 20 years by the URPL,WMiPB (see section 2.8.4).

2.9.5 Population participation/involvement

Under existing regulation, patients have a right to indirectly participate in the decision-making process to define the basic benefits package. Under Article 31e of the Law on Health Care Services Financed from Public Sources (as amended in 2009), foundations and associations the statutory objective of which is to protect patient rights may submit, through a national consultant, a request to the Ministry of Health to remove a particular benefit from the list of guaranteed health care benefits or change the level or method of financing or the conditions in which it is provided.

Patients are actively involved in public life and there are many NGOs supporting their participation. These NGOs undertake various activities to influence policy-makers, often seeking support from the media, politicians, and formal research. According to an online NGO database (ngo-pl), there are 11 500 registered NGOs involved in health protection and promotion and in activities aimed at ensuring equal access to health care for all.

Research on the satisfaction of citizens with health care is regularly carried out by the Public Opinion Research Centre (*Centrum Badania Opinii Społecznej*). No data on their impact is available.

2.9.6 Patients and cross-border health care

As of its EU accession on 1 May, 2004, Poland has been subject to EU regulations on the coordination of social security systems. The latest rules on a "modernized EU social security coordination" cover not only migrant workers but also people who are currently out of work, not yet working or no longer working (EC No. 883/2004 and EC No. 987/2009).

By virtue of these regulations, insured Polish citizens residing in another Member State are fully entitled to benefits in-kind provided by health care institutions in their place of residence at the expense of the Polish NFZ. Similarly, a person insured in another Member State who resides in Poland is fully entitled to services at the expense of their insurer. The same regulation (Articles 19–20 (EC) No. 883/2004) also provides for statutory coverage of treatment received outside the state of residence or affiliation. This access to cross-border care is subject to certain conditions, which depend on the type of care (occasional or planned) (Bertinato et al., 2005). When urgent treatment is needed during a temporary stay abroad, an insured person and the members of his/her family are entitled to necessary benefits in-kind without prior authorization (cash benefits are paid by the Member State of affiliation). Prior authorization is required in the case of travelling abroad with the purpose of receiving treatment there because of unreasonable waiting times or lack of availability of the necessary medical treatment in Poland.

Between Poland's accession on 1 May 2004 and the end of October 2006, according to the invoices received by the NFZ from other Member States, almost 38 000 people insured by the NFZ received health care abroad and 18 000 EU citizens received care in Poland.[12] According to information provided

[12] Polish position on the Communication from the Commission of 26 September 2006/SEC (2006)1195/4/: Consultation regarding Community action on health services (http://ec.europa.eu/health/archive/ph_overview/co_operation/mobility/docs/health_services_co253_en.pdf, accessed 2 February 2012).

by the NFZ to the Ministry of Health, about 200 authorizations for planned care abroad were issued in 2009. In the same year, more than 1.25 million documents confirming the right of Polish insured citizens to receive health care in other EU/EFTA countries (such as the European Health Insurance Cards and other E series certificates) were issued and over 75 000 Poles were treated in EU/EFTA States, mainly in Germany (72% or almost 54 000 of all patients treated abroad in that year). At the same time, more than 107 000 foreigners were treated by Polish health care providers, 29% of whom were from Germany. German patients dominated in each category of health care services except for dental services, where they were the third largest group after Czechs and Norwegians. The number of Polish patients going abroad to receive treatment outside the coordination of social security systems is marginal. Most foreign patients coming to Poland for treatment benefit from the lower price of health services. The most popular services are dental care, prosthetics, health resort treatment and plastic surgery. As of the beginning of 2011, there was no private health insurance product in Poland offering planned care abroad.

Poland has bilateral agreements with Albania, Bosnia and Herzegovina, Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Russia, Serbia and Tunisia; these guarantee emergency health care during temporary (tourist) stays. The cost of this care is to be covered by the host states, and in 2008 and 2009 the Polish Ministry of Health received only about 100 invoices from Polish health care providers claiming reimbursement. Neither the Ministry of Health nor the NFZ collects data on usage of emergency care services in the territories of the bilateral partners by Polish citizens. One can only suppose that the vast majority of cases take place in Croatia, which is one of the most popular holiday destinations for Polish tourists.

The Directive on Application of Patient Rights in Cross-border Health Care (2011/24/EU) was adopted by the EU Council on 28 February 2011. Besides Poland, Austria, Portugal and Romania voted against it and Slovakia abstained. Since the deadline for transposition of this Directive is 25 October 2013, it is still too early to assess its impact on the Polish health care system.

3. Financing

Since 1989, the system of health care financing has undergone three major changes. Until 1999, health care was funded from the state budget and thus through general tax revenues. In the wake of the administrative reform, 17 sickness funds were created within a system of mandatory universal SHI. SHI contributions subsequently became the major public source of health care funding, relegating the state and territorial budgets to a complementary role. After only four years of activity, sickness funds were replaced by a single institution – the NFZ – in 2003. Although SHI covers approximately 98% of the population, private spending on health care as a share of total health expenditure is higher in Poland than in most other EU Member States. This trend was apparent by the early 1990s, when the share of public resources clearly began to decrease, and OOP spending reached 30% of total health expenditures within a short period of time, by the year 2000.

3.1 Health expenditure

Although the level and the structure of health care financing have undergone substantial changes, the share of GDP devoted to health has remained fairly constant. Based on OECD data, the 1995–2009 period was characterized by an approximately five-fold increase in health care expenditure (from PLN 18.5 billion to PLN 99.0 billion). As GDP also grew considerably, but not as steeply, during the same period (see Table 1.2), the percentage of GDP devoted to health increased by only 1.9 percentage points, from 5.5% to 7.4% of GDP, in the same period (Table 3.1). Adjusted for purchasing power, health care expenditure per capita increased three and a half-fold from PPP US$ 409.6 in 1995 to PPP US$ 1394.3 in 2009. Both at the beginning and towards the end of this period, around 72% of the expenditure came from public sources, while this share was slightly lower in the 2000–2005 period. Taken together with

the increased expenditure on health, this relatively stable percentage of public sources compared with total health expenditure translated into an increasing percentage of both GDP (from 4.0% to 5.3%) as well as total government expenditure (from 8.4% to 10.9%). Private expenditure on health was mainly OOP spending and only to a very small, albeit growing, degree for VHI.

Table 3.1

Trends in health expenditure in Poland, 1995–2009 (selected years)

	1995	2000	2005	2008	2009
THE (PLN million)	18 466	41 098	61 200	89 307	98 975
THE per capita, US$ purchasing power parity	409.6	583.4	856.6	1 264.7	1 394.3
THE as % of GDP	5.5	5.5	6.2	7.0	7.4
Public (general government) expenditure on health as % of THE	72.9	70.0	69.3	72.2	72.2
Private expenditure on health as % of THE	27.1	30.0	30.6	27.7	27.6
Public (general government) expenditure on health as % of total government spending[a]	8.4	9.4	9.2	10.9	10.9
Public expenditure on health as % of GDP	4.0	3.9	4.3	5.0	5.3
Private expenditure on health as % of GDP	1.5	1.7	1.9	1.9	2.0
OOPs as % of THE	27.1	30.0	26.1	22.4	22.2
OOPs as % of private expenditure on health[a]	100.0	100.0	88.6	86.2	88.4
OOPs as % of GDP	1.5	1.7	1.6	1.6	1.6
VHI spending as % of THE	0.0	0.2	0.6	0.6	0.6
VHI spending as % of private expenditure on health[a]	0.0	0.8	1.9	2.2	2.2

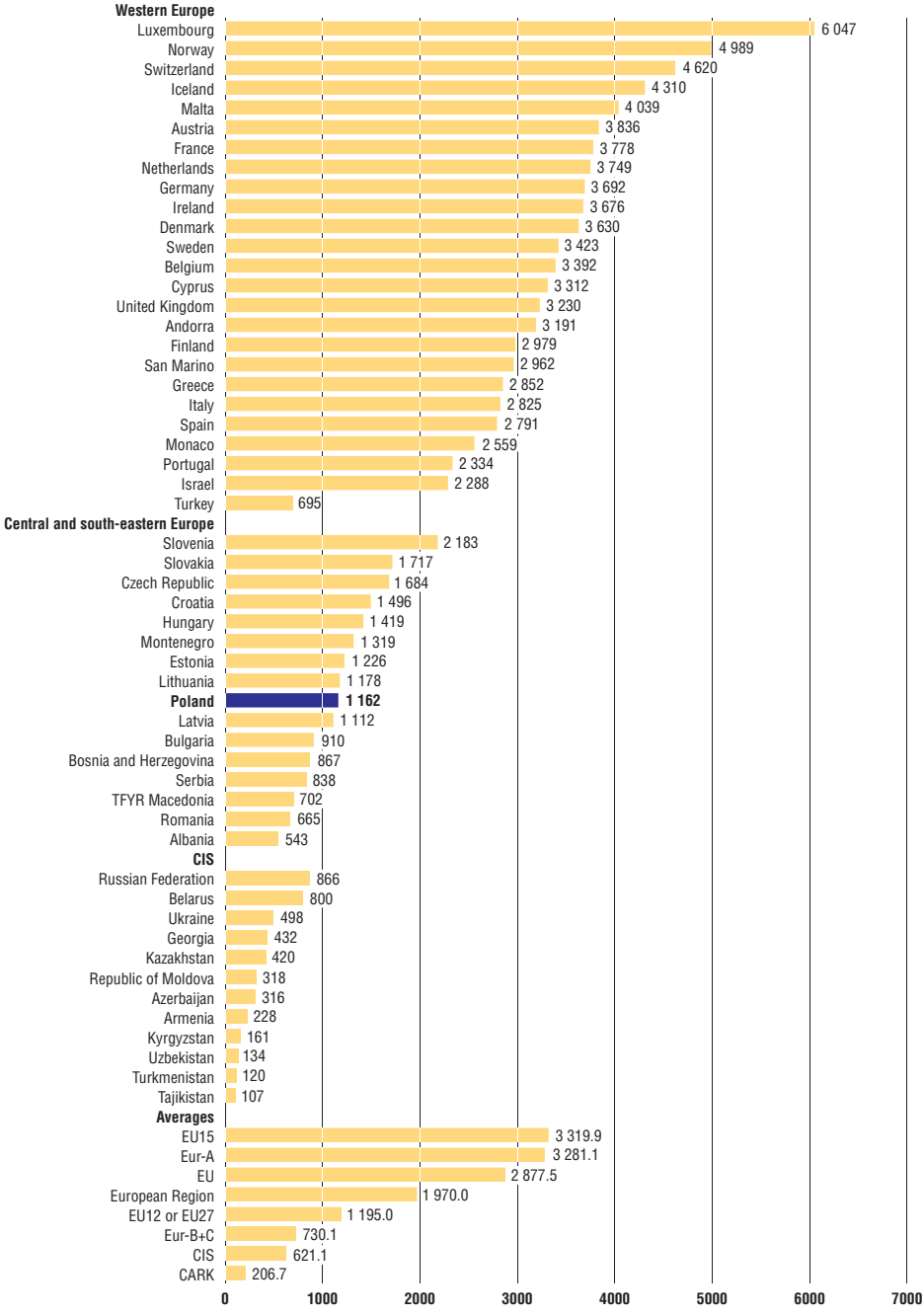
Sources: OECD, 2010a; [a] WHO, 2011.
Notes: Expenditures outside general government and private sectors (i.e. international aid) are not included; THE: Total expenditure on health.

Despite these increases, Poland was among the EU countries with the lowest health expenditure per capita measured in US dollars PPP in 2008, with only Bulgaria, Latvia and Romania ranking lower among EU Member States (Fig. 3.1). Low initial levels of per capita health spending have hindered Poland in closing the gap with other European countries, with the exception of Hungary (the gap was narrower in 2009 than 1995, see Fig. 3.2).

The comparatively low level of per capita health spending in Poland is not only a consequence of lower GDP but also of the relatively low share of GDP devoted to health, a situation which Poland shares with a number of eastern European countries (Fig. 3.3). In 2008, Poland's share of GDP devoted to health care was roughly at the same level as the EU12 average but substantially lower than the EU15 and EU27 averages (Fig. 3.4).

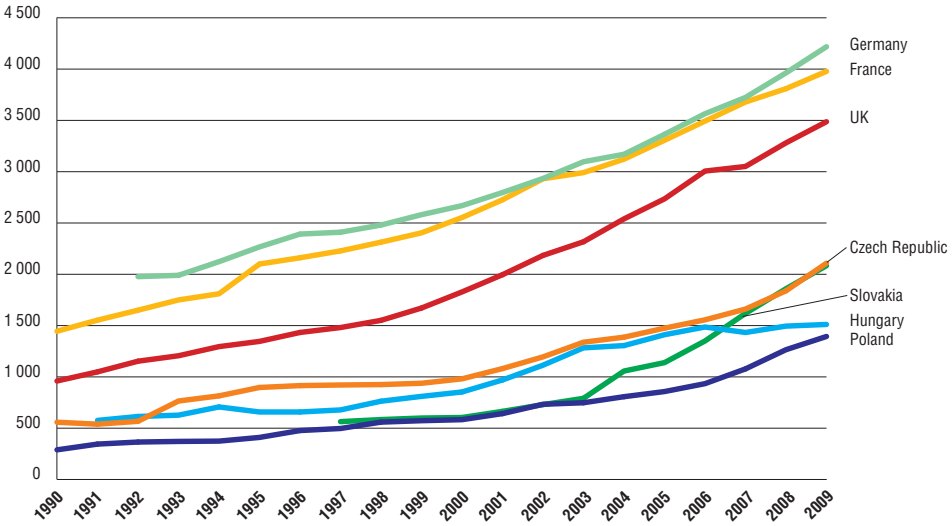
Fig. 3.1

Health expenditure in US$ PPP per capita in the WHO European Region, 2008



Source: WHO Regional Office for Europe, 2011b.
Notes: **European Region:** the 53 countries in the WHO European Region; **Eur-A:** 27 countries in the WHO European Region with very low child and adult mortality (see WHO definition); **Eur-B+C:** 26 countries in the WHO European Region with higher levels of mortality (see WHO definition).

Fig. 3.2
Per capita health expenditure in US$ PPP in Poland and selected countries, 1990–2009



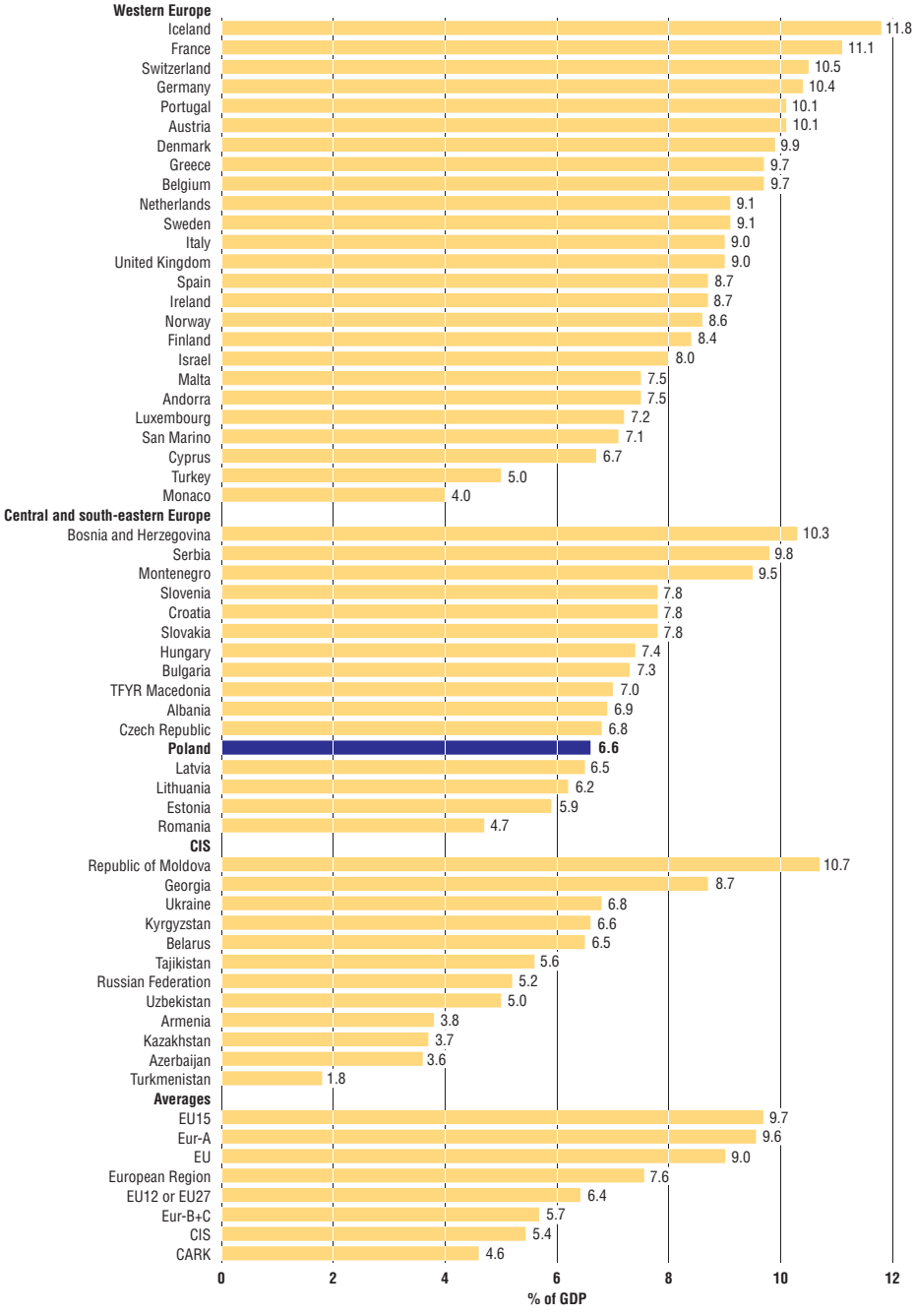
Source: OECD, 2011.

Conclusions on the actual availability of health care services drawn from the main health care financing indicators, such as per capita expenditure and the share of expenditure in the GDP, should be interpreted with caution, since such country rankings do not always reflect important differences in the production costs of health services. The Euro Health Consumer Index 2009 report suggested using an alternative index that would describe the relation between health outcomes/outputs and health expenditures. In the classification developed in line with this index, Poland is ranked 17 out of 33 European countries assessed in the report, higher than Switzerland, the United Kingdom and Norway (Björnberg, Cebolla Garrofé & Lindblad, 2009).

As discussed above (see Table 3.1), approximately 70% of health care expenditure in Poland is covered from public sources. Over 83.5% of this expenditure can be attributed to the universal health insurance, and NFZ expenditure accounted for over 91% of public expenditure on individual health care in 2008 (GUS, 2010b). It is important to note that private health care financing plays a larger role in Poland than in most other EU Member States (Fig. 3.5). Even in the early 1990s, the share of public resources in health care financing clearly started to decrease, and private sources reached 30% of total health expenditure in a short period of time. This share, however, has shown a slowly decreasing trend since 2000.

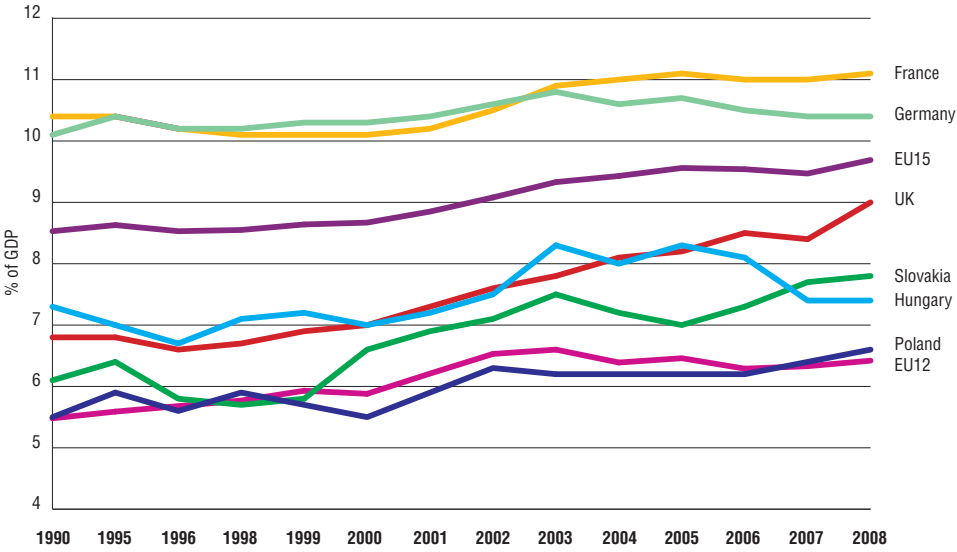
Fig. 3.3

Health expenditure as a share of GDP in the WHO European Region, 2008



Source: WHO Regional Office for Europe, 2011b.
Notes: **European Region:** the 53 countries in the WHO European Region; **Eur-A:** 27 countries in the WHO European Region with very low child and adult mortality (see WHO definition); **Eur-B+C:** 26 countries in the WHO European Region with higher levels of mortality (see WHO definition).

Fig. 3.4
Trends in health expenditure as a share of GDP in Poland and selected countries, 1990–2008

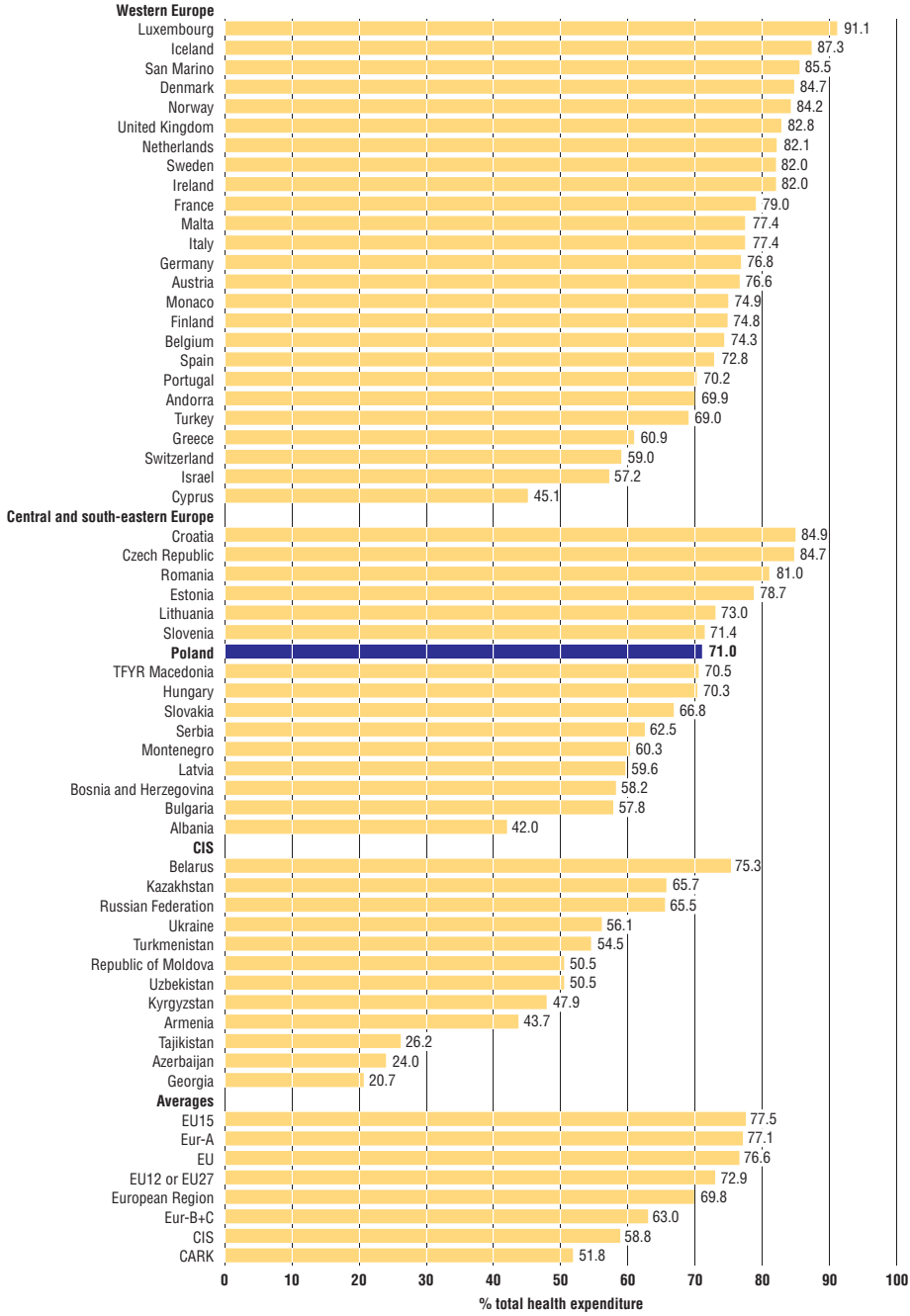


Source: WHO Regional Office for Europe, 2011b.

Table 3.2 shows available data on the main types of health expenditure considering all sources for selected years between 1999 and 2008, while Table 3.3 shows NFZ expenditure by service type for selected years between 2004 and 2009. In 2008, public expenditure on individual health care (International Classification for Health Accounts HC categories 1–5) constituted 71.9% of total health expenditure and 65.7% of NFZ expenditure. It should be emphasized that the NFZ allocates almost 95% of all its income to financing health care services. Remaining expenditure is mainly for financing individual health programmes as well as for emergency services, for which funding is also available through the state budget. Inpatient curative care is the biggest and fastest growing NFZ expense, constituting 43.4% of total NFZ expenditure on health care services in 2004 and 48.7% in 2009 (NFZ 2006, 2010) – the latter value almost matching the level observed in the first year of operation of the sickness funds (1999), when inpatient care accounted for over half of all health care expenses (50.4%). This can be seen as an indication that neither the 1999 reform (which reinforced the role of the family doctor in the system) nor the one in 2003 achieved a stable reduction in the share of expenses on inpatient care by transferring less serious cases to more cost-efficient outpatient services. Expenditure on medical goods for outpatients (particularly on medicines) rose

Fig. 3.5

Public sector health expenditure as a share of total health expenditure in the WHO Region, 2008



Source: WHO Regional Office for Europe, 2011b.
Notes: **European Region:** the 53 countries in the WHO European Region; **Eur-A:** 27 countries in the WHO European Region with very low child and adult mortality (see WHO definition); **Eur-B+C:** 26 countries in the WHO European Region with higher levels of mortality (see WHO definition).

Table 3.2

Total expenditure on health by service type in Poland, 1999-2008 (selected years)

Type of service	ICHA-HC category	1999		2004		2006		2008	
		PLN million	% of THE	PLN million	% of THE	PLN million	% of THE	PLN million	% of THE
Curative care	HC.1	21 198	51.2	28 625	49.91	31 435	47.82	45 442	50.90
Rehabilitation care	HC.2					1 877	2.86	2 664	2.98
Long-term nursing care	HC.3	2 465	5.96	3 567	6.22	4 291	6.53	4 651	5.21
Ancillary services	HC.4	1 251	3.02	1 923	3.35	2 433	3.70	4 880	5.47
Medical goods for outpatients	HC.5	10 797	26.10	18 285	31.88	19 589	29.80	22 421	25.12
Pharmaceuticals and other medical non-durables	HC.5.1	10 086	24.38	16 975	29.59	17 884	27.21	20 168	22.59
Therapeutic appliances and other durables	HC.5.2	710	1.72	1 310	2.28	1 705	2.59	2 253	2.52
Expenditure on individual health care	**HC.1–HC.5**	**36 624**[a]	**88.54**	**52 400**	**91.36**	**59 624**	**90.71**	**80 058**	**89.68**
Prevention and public health	HC.6	1 497	3.62	965	1.68	1 517	2.31	1 957	2.19
Administration of health care and health insurance	HC.7	1 712	4.14	1 393	2.43	915	1.39	1 379	1.54
Total current health care expenditure	**HC.1–HC.7**	**39 832**	**96.29**	**54 758**	**95.47**	**62 057**	**94.41**	**83 393**	**93.42**
Investment expenditure	HC.R.1	1 534	3.71	2 599	4.53	3 674	5.59	5 877	6.58
Total health care expenditure	**HC.1–HC.7. HC.R.1**	**41 366**	**100.00**	**57 358**	**100.00**	**65 731**	**100.00**	**89 270**	**100.00**
Education and training of health care personnel	HC.R.2	1	n/a	1 156	n/a	1 351	n/a	1 508	n/a
Research and development in health care	HC.R.3	489	n/a	571	n/a	652	n/a	723	n/a
Food. hygiene and drinking water control	HC.R.4	n/a	n/a	10	n/a	627	n/a	790	n/a
Administration and provision of health-related cash benefits	HC.R.7	33 015	n/a	35 387	n/a	27 900	n/a	31 165	n/a

Sources: GUS, 2005, 2006b,c, 2007b, 2008, 2009, 2010b.

Notes: [a]Including PLN 912.6 million in unclassified goods and services; ICHA-HC: International Classification for Health Accounts; n/a: not available.

from 26.1% of total health expenditure in 1999 to almost 32% in 2004, before the trend was reversed through more restrictive NFZ policies on reimbursement. By 2008, the share of expenditure on medical products for outpatients had fallen back to 25.1%. Reimbursement of medicines fell from 20.1% of total NFZ health care expenditure in 2004 to 15% in 2009 (compared with 16.4% in 1999).

Table 3.3

NFZ expenditure on health services in 2004–2009 (selected years)

Type of service		2004	2006	2008	2009 (planned)
Primary health care	mln PLN	3 507.6	3 988.0	5 833.9	7 359.4
	%	**11.5**	**11.1**	**11.8**	**13.8**
Outpatient specialist care	mln PLN	2 032.9	2 672.4	3 940.4	4 304.9
	%	**6.7**	**7.4**	**8.0**	**8.0**
Inpatient curative care	mln PLN	13 241.2	15 688.1	23 802.1	26 053.6
	%	**43.4**	**43.6**	**48.2**	**48.7**
Psychiatric care and addiction treatment	mln PLN	1 026.3	1 169.9	1 677.9	1 962.1
	%	**3.4**	**3.3**	**3.4**	**3.7**
Medical rehabilitation	mln PLN	814.6	1 035.8	1 561.3	1 783.3
	%	**2.7**	**2.9**	**3.2**	**3.3**
Long-term and hospice care	mln PLN	466.8	578.1	912.0	1 055.9
	%	**1.6**	**1.8**	**2.0**	**1.6**
Dental care	mln PLN	909.1	1 058.1	1 738.8	1 901.8
	%	**3.0**	**2.9**	**3.5**	**3.6**
Health resort services	mln PLN	324.2	346.4	475.4	669.6
	%	**1.1**	**1.0**	**1.0**	**1.3**
First aid and medical transport	mln PLN	881.7	1 017.5	30.5[a]	35.4[a]
	%	**2.9**	**2.8**	**0.1**	**0.1**
Prevention	mln PLN	0	103.3	94.9	132.3
	%	**0.0**	**0.3**	**0.2**	**0.2**
Separately contracted services	mln PLN	771.7	957.8	1 156.0	1 305.5
	%	**2.5**	**2.7**	**2.3**	**2.4**
Orthopaedic equipment, medical aids and protheses	mln PLN	386.4	495.3	577.0	595.6
	%	**1.3**	**1.4**	**1.2**	**1.1**
Pharmaceutical reimbursement	mln PLN	6 118.4	6 695.8	7 367.0	8 047.4
	%	**20.1**	**18.6**	**14.9**	**15.0**
Cost of services provided abroad	mln PLN	6.2	161.3	154.6	240.6
	%	**0.0**	**0.4**	**0.2**	**0.4**
Total	**mln PLN**	**30 487.1**	**35 967.8**	**49 321.8**	**55 447.4**
	%	**100**	**100**	**100**	**100**

Source: Based on NFZ data.

Note: [a]The financing of emergency services (with the exception of hospital emergency departments) was taken over by the state budget in 2007.

The share of expenditure dedicated to other health services has also changed, with an increase of 2.3 percentage points in spending on primary health care services and of 1.3 percentage points in spending on outpatient specialist care between 2004 and 2009. By comparison, the share of NFZ expenditure on emergency services fell from 2.9% in 2004 to 0.1% in 2009 as financing of most emergency medical services was taken over by the state budget in 2007. Other service programmes, such as public health and health system management as well as functions related to health care (education and training of medical personnel; research and development; and food, hygiene and drinking water control), are financed by the state budget and territorial budgets, which are also quite strongly engaged in the financing of ancillary health care services (in 2008 this share amounted to 31.3%).[13] Capital investment also saw substantial increases: its share of total health expenditure rose from 3.7% in 1999 to 6.6% in 2008. Investment costs are mostly (approximately 75%) borne by the territorial self-governments (mainly voivodeships), which are the establishing bodies for most public Polish hospitals (see section 4.1.1).

The state and territorial self-governments also directly finance health services, but their shares are not as sizeable (see section 3.2). Since 2007, the largest item in the state budget related to the financing of health care services has been emergency services, for which PLN 1.2 billion was allocated in 2007, PLN 1.6 billion in 2008, and slightly over PLN 1.9 billion in 2009. Financing from the state budget also covers certain highly specialized services (e.g. organ transplants, certain expensive cardiological and radiological interventions). The list of highly specialized procedures is defined by executive regulation from the Ministry of Health and has shown a restrictive trend since the beginning of the universal health insurance system. The number of such services dropped from 52 in 1999 to 18 by 2007 (the financing of the excluded items was taken over by the NFZ), in line with the decrease in the respective allocation from the state budget (see Table 3.4). Funds from the state budget are also provided for prevention, public health and system administration and account for a substantial share of investment expenditure, which exceeded PLN 1 billion in 2007 (almost 19% of the state budget expenditure for health care) but has also shown a decreasing trend.

[13] As indicated in Table 3.2, these expenditure categories are not included in total health expenditure but are part of overall public expenditure related to health.

Table 3.4
State budget expenditure for highly specialized procedures, 1999–2009

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Expenditure (PLN million)	579.7	641.4	603.9	661.8	436.9	485.9	390.0	384.5	392.6	400.6	448.9
Yearly growth rate %; (preceding year = 100)	–	110.6	94.2	109.6	66.0	111.2	80.3	98.6	102.1	102.0	112.5
Share in the state budget health care expenditure (%)	10.9	16.2	13.0	18.4	11.6	12.7	10.1	10.0	7.1	6.0	6.4

Sources: GUS, 2000, 2001, 2003, 2004, 2005, 2006c, 2007b, 2008, 2009, 2010b.

According to the green paper of 2009, the second largest item after investment funding in the expenditure of territorial self-governments was benefits for persons not subject to obligatory health insurance and certain contributions to health insurance (20.9% in 2009), followed by prevention and public health programmes to tackle alcoholism (14.3% in 2009) (see Table 3.5).

Table 3.5
Expenditure of territorial self-governments on health care (PLN million), 2001–2009

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Health care expenditure	3 474.4	1 974.9	1 910.4	2 107.7	2 581.9	3 066.7	3 062.0	3 680.7	4 104.6
Of which:									
General hospitals	1 051.3	724.8	683.7	724.9	1 029.6	1 350.4	1 403.4	1 758.1	1 894.0
Outpatient health services	130.0	136.5	83.0	124.8	113.8	155.1	162.1	157.0	136.5
Occupational medicine	73.3	64.2	66.2	62.7	66.61	72.1	79.1	84.7	86.7
Alcoholism counteraction	327.3	393.5	435.7	481.6	515.1	513.3	521.4	553.4	587.6
Contributions to health insurance and benefits for persons not subject to compulsory health insurance	1 128.3	342.2	334.4	394.9	398.8	439.1	408.2	575.1	859.2

Sources: GUS, 2000, 2001, 2003, 2004, 2005, 2006c, 2007b, 2008, 2009, 2010b; Golinowska, 2008.

Private expenditure on health, including OOP, is high, mainly because of costs incurred by households on payments or co-payments for medicines and other medicinal products. Spending on medicines and medical non-durables amounted to 61.7% of private health expenditure in 2008. Therapeutic appliances and other medical durables are also mainly financed from private sources (56.9% in 2008). Private sources are also involved in funding preventive

programmes and public health services (in 2008, 37.6% of costs for these services were paid from private sources), which mostly involve occupational health care services (including periodic check-ups) financed by employers.

3.2 Sources of revenue and financial flows

The system of universal mandatory SHI, which covers approximately 98% of the population, accounts for over 80% of public expenditure and almost 60% of total expenditure on health care in Poland. In 2008, the NFZ covered 65.7% of current health expenditure. The second most important source of public funds is the state budget, followed by the budgets of the territorial self-governments. Approximately 30% of health expenditure comes from private sources (Table 3.6). In 2008, a lower public share of total health expenditure in the EU was found only in Bulgaria, Cyprus, Greece, Hungary, Latvia, Portugal and Slovakia (Fig. 3.5).

Table 3.6

Structure of total health expenditure by source (%), 1999–2008 (selected years)

	1999	2002	2005	2007	2008
General government expenditure (excl. social security)	13.6	9.8	11.4	12.3	11.9
Social security funds: sickness funds (until 2003) and NFZ	57.6	61.3	57.9	58.6	60.3
OOPs	26.6	25.4	26.1	24.3	22.4
VHI	0.4	0.5	0.6	0.5	0.6
Other:					
Corporations	1.0	2.1	2.9	3.4	3.6
Non-profit institutions	0.8	0.7	1.0	0.9	1.6

Sources: GUS, 2006b,c, 2008, 2010b.

After the introduction of the universal SHI, the importance of the state budget as a direct source of financing for health care decreased while the importance of territorial self-governments increased. In 2008, financing from the state and the territorial self-government budgets covered approximately 6.3% of expenditure for individual health care, 7.6% of current expenditure for health care and nearly 11.9% of total health care expenditure (Table 3.7). The share is higher in total expenditure on health as the state share in capital investment is much higher than for current health expenditure. After a long period in which budgetary expenditure (spending from the state and territorial budgets) in total health expenditure was limited, it has increased slightly in

recent years, from 11.3% in 2006 to 11.9% in 2008. However, this was mainly the result of the state budget's takeover of certain emergency medical services (see section 5.5).

Table 3.7

State and territorial budget shares in total health expenditure (%), 1999–2008 (selected years)

	1999	2004	2006	2008
Share in the expenditure for individual health care	6.1	5.4	5.3	6.3
Share in current health expenditure	10.3	8.5	7.2	7.6
Share in the total expenditure for health care	13.6	12.0	11.3	11.9

Sources: GUS, 2000, 2005, 2006b, 2007b, 2010b.

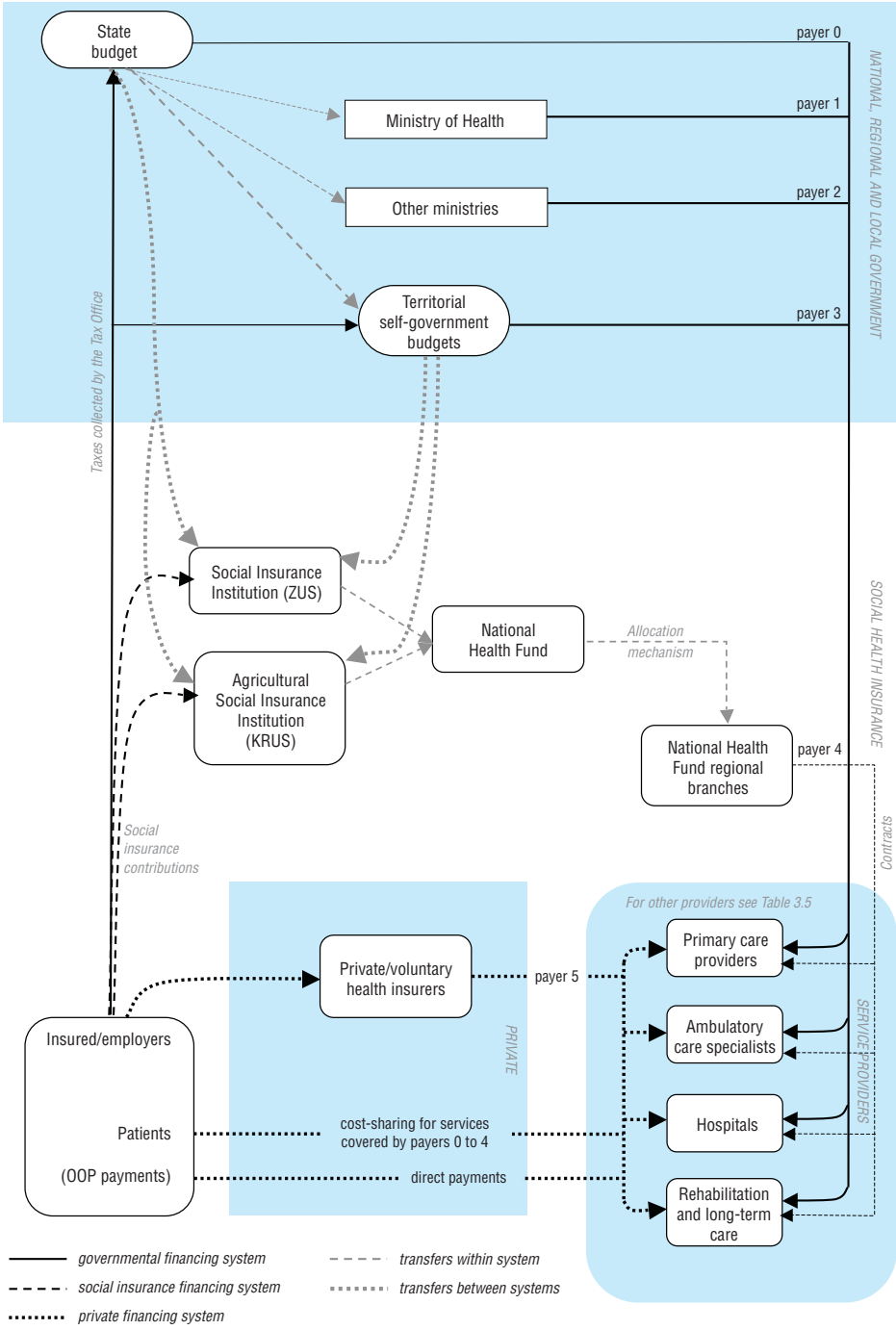
Compulsory health insurance formally guarantees access to a very broad range of health services, with no need for the patients to pay OOP (with the notable exception of cost-sharing for pharmaceuticals and certain health resort services). From 1 January 2007, the health insurance contribution has been set at 9% of the calculation base.[14] The ZUS and the KRUS are responsible for collecting health insurance contributions and transferring them to the NFZ (for more details see sections 3.3.1 to 3.3.3).

OOPs from private households accounted for approximately 22% of total health care expenditure in 2009. More than 60% of this OOP expense is for medicinal products for outpatients, including medicines and other non-durables (see also section 3.4). VHI in Poland is not a substantial source of health care financing (see section 3.5).

An outline of the resource flow for funds allocated to health care in the Polish health care system is presented in Fig. 3.6. Flows in the governmental, SHI and private systems of financing and transfers within and between systems are distinguished, as well as private payments.

[14] The calculation base includes certain elements of individually taxed income (wages, pensions, contracts, etc.). Contributions for farmers and self-employed individuals are calculated differently (see section 7.2.2).

Fig. 3.6
Financial flows



3.3 Overview of the statutory financing system

The main piece of legislation regulating the financing of health care services in Poland is the 2004 Law on Health Care Services Financed from Public Sources. Very few inhabitants are exempt from the obligation to pay health insurance contributions. Of public funds allocated for health care in Poland, 83.5% is redistributed by the NFZ, which is the sole payer in the system.

3.3.1 Coverage

Who is covered

Article 68 of the Polish Constitution stipulates that all citizens, regardless of their financial circumstances, have the right to equal access to publicly financed health services. Ensuring special health care for children, pregnant women, individuals with disabilities and seniors is mentioned specifically as being the responsibility of public authorities. Moreover, the state is also responsible for combating epidemics, prevention of negative health consequences of environmental degradation, and encouraging physical activity, particularly among children and youths. Article 2 of the 2004 Law on Health Care Services Financed from Public Sources specifies who is entitled to benefit from publicly financed health benefits in Poland.

As of 31 December 2009, approximately 97.6% of the Polish population had health insurance cover through the NFZ. Of these 37.2 million individuals, almost 28.7 million (about 77%) were insured on a mandatory basis and 8.5 million (about 23%) were covered as dependents. Only 26 771 (0.07%; including dependents) were insured on a voluntary basis.

For the vast majority of Polish citizens and legal residents, membership in the SHI scheme is mandatory. Article 66 of the Law on Health Care Services Financed from Public Sources includes a detailed list of people subject to the mandatory health insurance requirement. This list includes employees, self-employed individuals and business owners, farmers, pensioners and some students. For people with mandatory health insurance, there is no way to opt out of the SHI scheme. Family members (spouses, children, grandchildren, parents, grandparents and other dependent relatives) of individuals subject to the mandatory insurance requirement are generally eligible for cover as long as they are not themselves insured through the NFZ. Children must be under 18, or 26 if they are studying, in order to be covered as dependents. Parents, grandparents and other dependent relatives must live in the same household as the person through whom they obtain their coverage. Individuals who do not

meet these criteria may apply for and are granted voluntary insurance through the NFZ. This group includes employees on unpaid leave, persons engaged in certain types of contract work, volunteers and foreigners who do not have health insurance. Family members of these individuals are also eligible for coverage. As noted above, this entire group accounts for only 0.07% of the insured population.[15]

The remaining 2.4% of the population without health insurance coverage through the NFZ is nevertheless entitled to receive free health care services at the point of delivery. This group comprises resident citizens who meet the income criteria to receive benefits from social assistance (*pomoc społeczna*); all uninsured children under the age of 18; all uninsured women during pregnancy, childbirth and the postpartum period; alcoholics undergoing addiction treatment; persons with drug addictions; persons with mental illnesses who are receiving psychiatric treatment; persons affected by certain infectious diseases; and prisoners. Also covered are some groups whose sources of income do not qualify them for payment of compulsory NFZ health insurance contributions, for example rentiers (with incomes from owning financial assets) or the homeless. Uninsured non-residents or non-citizens who experience a life-threatening medical emergency must reimburse service providers at a later date for any care received.

What is covered

People insured under the NFZ, along with the various other groups described above, are entitled to a very broad range of health care services pursuant to Article 15 of the 2004 Law on Health Care Services Financed from Public Sources. Apart from a few exceptions concerning reimbursement of medicines and auxiliary medical appliances, where privileges are provided for certain groups (veterans with disabilities and service members, distinguished volunteer blood and organ transplant donors) in the form of exemption from and/or reduction of co-payment, legislation does not distinguish between insured groups in relation to the guaranteed scope of services. These include:

- primary health care (internal medicine, emergency medicine, family medicine)
- ambulatory specialist care
- hospital treatment
- psychiatric care and addiction treatment

[15] A detailed list of eligible individuals can be found in Article 68 of the 2004 Law on Health Care Services Financed from Public Sources.

- therapeutic rehabilitation
- nursing and long-term care services
- dental treatment
- health resort treatment
- provision of orthopaedic and auxiliary medical devices
- medical rescue services
- palliative and hospice care
- highly specialized services (e.g. transplant surgery)
- health programmes
- pharmaceuticals.

Positive reimbursement lists have been in place since the end of 2009 and are issued periodically by the Ministry of Health through regulations on the basis of HTA (see section 2.7.2). Unfortunately, limited financial resources of the NFZ mean that broad entitlements guaranteed on paper are not always available. As a result, the health care system has long been plagued by certain imbalances, both in terms of income versus expenditure (which is reflected by permanent debt and loss, particularly among public health care institutions – mainly public hospitals), and in terms of the level of income versus health needs (as indicated by very long waiting lists for planned services in comparison with standards accepted in most European countries) (see Golinowska, 2004, 2008).

How much of the benefit cost is covered

Cost-sharing is very limited under statutory insurance in Poland. With the exception of medicines, medicinal products and auxiliary medical devices, as well as health resort treatments and certain dental procedures and materials (see section 5.12), services are fully covered (see section 3.4.1).

3.3.2 Collection

Contributions are collected by two intermediary organizations – the ZUS and the KRUS – and subsequently forwarded to the NFZ. For their services, the ZUS and KRUS charge a small fee of 0.2% on all contributions transferred.

Since 2007, the SHI contribution has been calculated as 9% of the contribution base (e.g. gross income from gainful employment, old-age pensions or unemployment benefits). For employees, the SHI contribution is based on gross wages minus social insurance contributions made for old-age

pension, disability pension and sickness insurance.[16] The SHI contribution takes the form of a withholding tax borne entirely by the employee; it is not split with, or matched by, the employer. For people receiving an old-age or disability pension, the SHI contribution is based on their gross benefits. For self-employed individuals engaged in non-agricultural business activities, the contribution is based on either (a) their gross profit/income or (b) 75% of the average Polish salary in the previous year, whichever is greater. For individuals receiving unemployment benefits, SHI contributions are calculated based on the total amount of these benefits. However, the majority of people without work (i.e. 86% of the unemployed in 2007) are not eligible for unemployment benefits. For this group, contributions are covered by the state budget. Before 2005, these costs were calculated based on the standard rate of welfare benefits and were 40% thereof. In order to protect the state budget from excessive costs, payment for these groups was calculated on the basis of social assistance benefits[17] between 2005 and 2011 (and amounted to 50%, 60% and 70% of these benefits in 2005, 2006 and 2007, respectively). As of January 2011, state budget transfers for non-contributing groups have been calculated on the basis of unemployment benefits. About 80% of all ZUS contributions are accounted for by contributions from employees (about 55%) and old-age and disability pension (25%). Table 3.8 gives a breakdown of ZUS transfers in 2007.

Table 3.8

Total health insurance contributions transferred by ZUS (PLN million), 2007

Contributions	Amount (PLN million)	%
Employees	21 772.1	55.2
Persons engaged in non-agricultural business activities and persons who work with them	3 943.9	10.0
Persons working under commission contract or agency contract	817.5	2.1
Unemployed persons and persons who receive pre-retirement benefits or pre-retirement allowance, including:	854.1	2.2
Unemployed persons who do not receive unemployment benefits	408.2	1.0
Persons who receive pre-retirement benefits or pre-retirement allowance	335.7	0.9
Persons who receive retirement or disability pension	10 438.0	26.5
People working in uniformed services	920.1	2.3
Others	669.2	1.7
Total	**39 414.8**	**100.0**

Source: Golinowska, 2008.

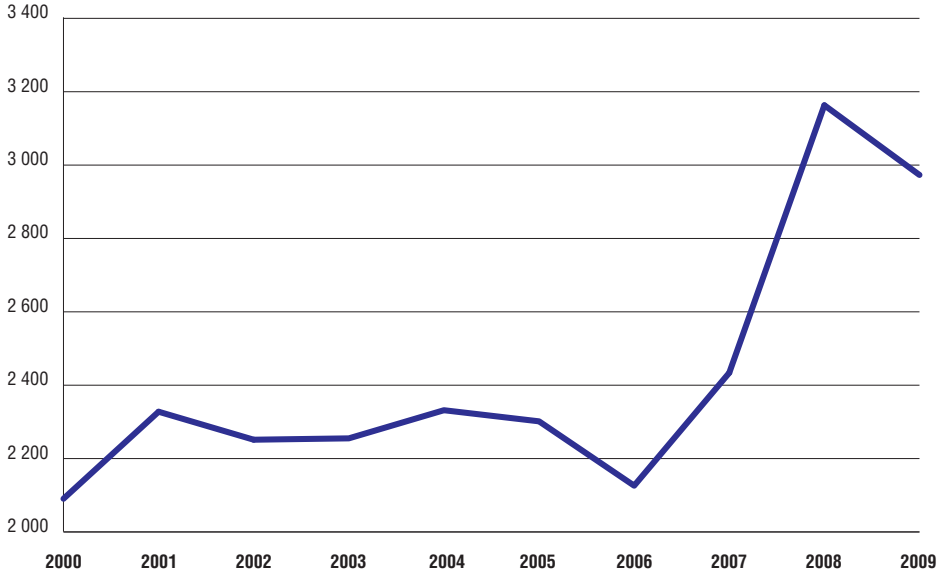
[16] One characteristic of the system after the 1999 reform is the separation of health and sickness insurance. Sickness insurance contributions go towards cash benefits (maternity, illness).

[17] This change was financially advantageous to the state budget since the standard welfare rate is much higher than social care benefits.

Health insurance contributions paid by farmers covered by social insurance and transferred by the KRUS to the NFZ are calculated by multiplying the number of standard hectares of croplands (maximum 50) farmed by the price of 0.5 quintal of rye (see also section 7.2.2). This has clearly resulted in large variations in the level of contributions collected by the KRUS (Fig. 3.7), particularly in recent years. Subsidies from the state budget dominate KRUS revenues. The rest of KRUS income is made up of other social insurance contributions, mainly contributions towards old-age and disability pensions and contributions from farmers who run business activity in special zones.

Fig. 3.7

Contributions transferred by KRUS (constant prices 2000, PLN), 2000–2009



Source: Based on NFZ and GUS data.

Identifying and collecting contributions proved to be considerably challenging during the existence of the sickness funds, particularly for ZUS. Recent years have brought about major improvements in the collection of contributions, and the collection rate of health insurance contributions exceeded 99% in 2008. This figure has diminished slightly since then because of the worsening economic conditions, but at 97%, the rate can still be considered very high. The costs of collecting and recording contributions by ZUS and KRUS amounted to PLN 106.2 million in 2009 – less than 0.2% of contribution income.

Importantly, no more than 86% of SHI contributions paid in a given year can be deducted directly from tax contributions. The SHI contribution rate in Poland is specified by an act of parliament and has risen continually over the past decade. It was set at 7.5% from 1999 to 2000, and then rose to 7.75% from 2001 to 2002, the last year when it could be directly deducted in full. Since then, the deductible has remained fixed at 7.75% of the contribution base while the rate itself increased by 0.25% annually until it reached 9% in 2007. In other words, a sum equal to 1.25% of the income basis for calculating SHI contributions cannot currently be deducted. At the same time, it should be emphasized that the deduction applies to taxes owed and not to taxable income.

3.3.3 Pooling of funds and allocation

Centrally pooled SHI contributions are divided by the NFZ head office between the voivodeships according to an allocation formula. There is one NFZ branch in each voivodeship and allocations among branches are based on algorithms defined annually by the government. In recent years, allocation algorithms have been constantly changing, although the fundamental determinants do not vary: number, gender and age structure of the insured persons and the amount of formerly granted allowances. One-year groups of insured persons between the ages of 0 and 99 and a group of insured persons aged 100 or more are established. Age and gender structure are meant to reflect, although imperfectly, the diversity of health risk. No further mechanism of risk adjustment is in place.

Certain more controversial changes to the algorithms have been introduced over the years to account for differences in the costs of production of medical services (e.g. remuneration of medical personnel) and regional differences in the consumption of health care services. For example, in 2008, average monthly household income by voivodeship was used as determinant of regional labour costs (proxy for differences in the cost of production of health care services). In 2006 and 2010, a special approach was used to account for the amount of highly specialized services provided. However, solutions of this type were found imperfect because they reinforced either the differences in the remuneration of medical personnel or the regional inequalities related to the availability of the best and the most expensive services (past high expenditures on specialized services translated into higher allocation of funds in the future, resulting in increased regional inequalities), or both. As such, these variables are no longer used in the allocation algorithms.

Since 1999, the main source of health services financing has been insurance contributions collected by the ZUS and KRUS and transferred to the NFZ. Therefore, the NFZ largely determines the current structure of public health care expenditure in Poland.[18] NFZ's regional voivodeship branches are responsible for contracting health care services in respective voivodeships. Regional differences in expenditure structure reflect, among other things, differing health care needs and health resource distribution between the voivodeships. Average expenditure per insuree also varies based on the population's social, demographic and economic characteristics (Table 3.9).

Table 3.9

Average expenditure on health services per insuree by NFZ branch, 2005–2009

NFZ branch	Average expenditure per insured individual (in PLN)				
	2005	2006	2007	2008	2009
Dolnośląskie	885	939	1 057	1 323	1 514
Kujawsko-Pomorskie	870	938	1 071	1 321	1 464
Lubelskie	821	911	1 053	1 295	1 418
Lubuskie	807	851	961	1 255	1 393
Łódzkie	844	920	1 030	1 335	1 506
Małopolskie	890	963	1 095	1 303	1 420
Mazowieckie	1 039	1 088	1 204	1 411	1 638
Opolskie	820	896	1 028	1 338	1 459
Podkarpackie	813	853	955	1 189	1 327
Podlaskie	841	942	1 054	1 308	1 428
Pomorskie	828	875	986	1 289	1 482
Śląskie	969	991	1 124	1 389	1 527
Świętokrzyskie	833	878	997	1 279	1 403
Warmińsko-Mazurskie	843	882	1 004	1 237	1 367
Wielkopolskie	851	929	1 069	1 294	1 422
Zachodniopomorskie	861	914	1 031	1 282	1 452

Source: Based on NFZ data.

As a result of the allocations, individual NFZ branches have various amounts of money to spend on health services per insured person. In 2008, the Mazowieckie NFZ branch spent almost 14.1% more per insured person than the poorest branch (Podkarpackie). In 2005, the difference in spending between the richest and the poorest branch was as high as 28.7%. NFZ branches independently contract health services for the insured and divide their budgets between various types of service. The results of this practice – differences in spending structures among NFZ branches – are presented in Table 3.10.

[18] The structure of expenditures is defined by the NFZ and approved by the Ministry of Health and the Ministry of Finance. A parliamentary commission is also involved in the process.

Table 3.10

Selected health services as a percentage of total expenditure on health services, by *voivodeship*, 2005 and 2008

	Primary health care		Ambulatory specialist care		Inpatient care		Psychiatric care and addiction treatment		Long-term care		Rehabilitative care		Other services contracted separately		Dental treatment	
	2005	2008	2005	2008	2005	2008	2005	2008	2005	2008	2005	2008	2005	2008	2005	2008
Dolnośląskie	11.11	11.67	6.68	8.29	42.98	37.57	2.95	3.38	1.56	2.07	2.88	3.37	2.90	2.59	2.58	3.33
Kujawsko-Pomorskie	11.27	12.05	7.54	8.02	41.37	38.73	2.77	3.15	1.54	1.98	2.47	2.70	2.86	2.60	3.14	3.53
Lubelskie	12.05	12.46	5.65	7.12	44.98	38.37	3.42	3.50	1.24	1.65	1.65	2.85	2.87	2.41	2.96	3.92
Lubuskie	11.96	12.44	6.33	7.19	41.77	37.89	6.21	4.88	1.38	1.45	3.11	3.20	2.67	2.31	2.58	3.18
Łódzkie	11.22	11.56	5.12	6.89	44.31	39.25	3.53	3.46	1.43	1.67	2.59	3.00	2.45	2.27	2.90	3.52
Małopolskie	10.92	11.78	7.22	8.00	4.21	37.94	2.75	305	1.92	2.30	2.77	3.22	2.99	2.55	2.95	3.89
Mazowieckie	9.44	11.27	7.09	7.61	46.68	41.89	0.29	3.58	1.64	1.80	3.52	3.92	2.81	2.30	2.35	2.67
Opolskie	12.01	11.53	6.47	7.78	42.46	37.99	3.80	3.66	1.62	2.45	4.28	3.78	2.60	2.30	2.81	3.49
Podkarpackie	11.92	12.76	6.51	7.08	42.90	36.91	2.96	3.11	1.96	2.39	2.90	3.62	2.13	2.39	3.43	3.43
Podlaskie	11.57	11.84	7.23	8.55	45.13	38.86	4.05	3.99	1.30	1.68	1.99	2.64	2.41	1.99	2.76	3.93
Pomorskie	11.50	11.75	8.24	8.87	4067	35.83	3.29	3.62	1.20	1.36	2.33	2.91	2.80	2.55	3.57	3.93
Śląskie	9.98	11.22	8.13	9.26	45.49	41.06	3.06	3.23	2.00	2.27	2.63	3.03	2.33	2.18	3.24	3.99
Świętokrzyskie	11.87	11.72	6.41	6.71	44.63	39.48	3.53	3.49	1.02	1.40	2.95	2.91	2.29	2.14	2.32	3.33
Warmińsko-Mazurskie	11.53	12.75	8.02	8.27	42.73	36.07	3.70	3.72	1.67	1.71	2.90	2.87	2.67	2.32	3.93	4.50
Wielkopolskie	11.75	12.63	7.86	8.61	45.42	39.71	3.13	3.14	1.42	1.54	2.36	2.89	2.78	2.28	2.52	3.22
Zachodniopomorskie	11.45	12.40	6.99	7.87	42.61	40.08	2.76	3.17	0.74	1.11	2.40	2.84	2.03	2.26	2.76	3.80

Source: Based on NFZ, 2006, 2009.

There are considerable differences between amounts allocated for various types of health service in the budgets of NFZ branches. In the area of primary health care, the difference between the biggest and the smallest shares of expenditures in 2005 amounted to as much as 2.61 percentage points (between 12.05% for the Lubelskie branch and 9.44% for the Mazowieckie branch). In 2008, the range between largest and smallest shares narrowed slightly, to 1.54 percentage points. The differences between maximum and minimum shares spent for specialist outpatient care, meanwhile, amounted to 3.12 percentage points in 2005, slightly decreasing to 2.55 percentage points in 2008. This diversity in spending allocation also extends to services that account for a smaller portion of overall costs. Although some degree of convergence between regional allocations (e.g. in the area of primary care) may be desirable, achieving identical expenditure structures between the voivodeships is not the ultimate goal of having a centralized NFZ.[19] Regional differences in allocation will persist because of differences in health care needs of the respective populations and variations in the geographical distribution of health care infrastructure.

3.3.4 Purchasing and purchaser–provider relations

Since 1999, the responsibility for purchasing health services has been separated from that for supplying services, and the process of purchasing health care services has been based on selective contracting between the payer (initially the sickness funds and now the NFZ) and health care providers (see section 2.2). Contracts are regulated by the Civil Code and the principles of contracting are defined in the 2004 Law on Health Care Services Financed from Public Sources. Contracting procedures for various types of service are further specified in the decrees of the President of the NFZ. According to these regulations, the NFZ regional branches are responsible for the entire process of contracting – they organize quasi-market conditions for contracts, conduct negotiations, conclude contracts, monitor their implementation and eventually settle them. To ensure the transparency of the process, the NFZ publishes information on all contracts on its website (information on awarded contracts in excess of €130 000 is also published by the Office for Official Publications of the European Union).

Each regional branch of the NFZ is responsible for securing continuous provision of health care services for its population within the available financial resources. All health care providers that meet certain criteria (such as sanitary and epidemiological standards) may compete for contracts with the NFZ. Successful bidders are obliged to inform the NFZ about any changes that could

[19] The aim of having a central NFZ was rather to standardize contracting rules and mechanisms.

affect meeting the contractual obligation (e.g. changes in medical personnel) and must ensure that patient claims can be met – for that reason they must purchase obligatory civil liability insurance. Health care providers may only conclude contracts for provision of services that are mentioned in their statutes and are listed in the Ministry of Health regulations on guaranteed health care benefits.

With the exception of primary care services and purchasing of medical devices, contracts can be awarded by means of competitive tenders or (rarely) negotiations. The NFZ initiates a competitive tender by placing an advertisement including the criteria that determine which providers are eligible to compete (based on professional and technical qualifications, including Polish standards harmonized with EU standards). Competitive tendering consists of an open part and a confidential part. During the open part, the bidding commission informs bidders about the number of offers put out to tender, announces which bids meet the requirements, and enters explanations and declarations made by bidders into the tendering record. During the confidential part, the committee selects the best offer (in terms of price, continuity of service provision, accessibility, quality and complexity of services) or a number of offers if one provider alone cannot fill the contract. It may also reject all offers if none of them ensures the required quality of services. The committee can negotiate both the number of purchased services and their prices. Negotiations are carried out with the bidder who submits the best offer. If there are more bidders, the committee is obliged to negotiate with at least two of them.

In certain cases, for example when a competitive tender has been annulled, when there is an urgent need to conclude a contract for provision of services or when there are no more than five providers that can provide a particular service, a contract may be awarded by means of negotiations with a set of providers selected and invited by the NFZ. Negotiations also consist of an open and a confidential part.

If the NFZ violates contracting procedures, bidders may file an appeal or complaint to the director of the regional NFZ branch. During the contracting process and within seven working days from the date of the contested action, bidders may also submit a reasoned protest to the selection committee. Selection proceedings are thereupon suspended until the protest has been considered.

The directors of the regional NFZ branches have the power to monitor and settle contracts for provision of services and monitor prescribing of medicines. They also control health care providers regarding the organization and provision

of health care services and their accessibility, adherence to the contract, appropriate choice of medicines and medical devices, compliance with the principles of prescribing and maintenance of medical records.

3.4 OOP expenditure of private households

Private expenditure accounts for 30% of total health care expenditure in Poland, with the largest burden falling on private households. However, the proportion of total health expenditure paid by OOPs has been decreasing: it fell from 28.1% in 2004 to 22.4% in 2008 (Table 3.11).

Table 3.11
OOP expenditure for health care, 1999–2008

	1999	2004	2005	2006	2007	2008
OOP expenditure on health care (PLN mln)	11 021	16 123	15 959	16 821	18 337	20 025
As % of total health care expenditure	26.6	28.1	26.1	25.6	24.3	22.4

Sources: GUS, 2005, 2006b,c, 2007b, 2008, 2009, 2010b.

Medicinal products account for the largest portion of OOP expenses (see section 3.1). Medical and rehabilitation services also constitute an important item in OOP expenses, amounting to 31.1% of all private household expenditure on health in 2008.

3.4.1 Cost-sharing

Patient cost-sharing has been a matter of policy debates for years. However, just as for private health insurance (see section 3.5), nothing has changed. Co-payments are used minimally, mainly in the area of medicines and other medicinal products and to a lesser extent for room and board in long-term care institutions, rehabilitation centres and sanatoria. Co-payment levels for prescription medicines vary depending on the type of medicine. For basic medicines or magistral formulae included in the positive reimbursement lists, the patient disburses a lump sum of no more than PLN 4.25 or PLN 12.74, respectively. The patient pays 30% or 50% of the price for supplementary medicines on the positive reimbursement list.

Separate reimbursement lists for chronic, infectious and psychiatric diseases and disabilities (for which separate reimbursement rules are applied) are also issued by the Minister of Health; such medicines and medicinal products can be

prescribed free of charge, against a lump sum payment or against a co-payment. Co-payment exemptions are also extended to veterans with disabilities and their spouses if they are dependent, as well as to their widows or widowers if they are entitled to a survivor's pension, to servicemen and their families and to distinguished blood and organ donors. The law does not provide a cap on co-payments for medicines or other health goods or services. However, the most disadvantaged can claim social assistance that covers the costs of co-payment.

Co-payments are also required for orthopaedic items and auxiliary devices, although public funds cover at least half of the price. The extent of the subsidy is decided by the Ministry of Health. Moreover, adult patients also bear a partial responsibility for room and board in health resorts. See section 7.2.1 for more information on the impact of co-payments on health care users.

3.4.2 Direct payments

Since co-payments for publicly provided health care services are not foreseen in the Polish law, it can be assumed that private household expenditure for outpatient care reflects direct payments for privately purchased services. In 2008, Polish households spent PLN 6.1 billion for this purpose, almost 54.6% of which was spent on dental services and 35.9% in outpatient clinics and care centres (mainly for specialist services). In comparison, private households spent approximately PLN 4.3 billion for outpatient care services in 2004, with 51% on dental services and 40% in outpatient clinics and care centres. In 1999, this expenditure amounted to PLN 3.4 billion, with 47.5% for dental services and 52% in outpatient clinics and care centres.

It should be noted that the share of private household expenditure in dental services financing has remained high – nearly 85% – for years. This is the result of limited NFZ benefits in this area, which include only the most essential dental services and materials. In the early years of operation of the sickness funds, patients had the option of extra billing to obtain services of higher quality than those guaranteed by the funds with their basic benefit basket. These regulations changed after the introduction of the NFZ, leaving patients with the choice to either accept the NFZ-financed service or pay the entire cost OOP. In 2006, the idea of supplemental payments was revived; however, it was abandoned again in 2009 in order to safeguard access to dental services for insured persons with lower incomes.

Residents in nursing homes (*zakład pielegnacyjno-opiekuńczy* (ZPO), long-term care institutions – chronic medical care homes (*zakład opiekuńczo-leczniczy* (ZOL)) – and stationary[20] rehabilitation centres bear their own boarding costs, which for adults are set at 250% of the minimum old-age pension, or 70% of the resident's monthly income (whichever is lower). In the case of children aged 18 or younger, or full-time students under 26, the fee amounts to 200% of the lowest pension or 70% of the average monthly income of one person in the family. Moreover, patients pay travel costs to health resorts and the costs of medical transport in non-emergency situations or when patient's mobility is not impaired and permits the use of public transport (see also section 5.8).

3.4.3 Informal payments

Informal payments in Poland take the form of gratitude payments for received care, donations to financially support underfunded or indebted hospitals (usually as payment for services in-kind), direct bribes to physicians in order to reduce waiting times[21] or "envelope payments" given under the table to medical staff. Informal payments mainly concern services provided in public hospitals, with the greatest beneficiaries being the highest-qualified professionals such as heads of wards (Golinowska & Kozierkiewicz, 2007). Evidence from 1998 suggested that informal payments in Poland amounted to almost 100% of official salaries of physicians, particularly in the hospital sector, where they reached 46% of all patient expenditure in hospitals (Chawla, Berman & Kawiorska, 1998). More recent GUS research, however, finds the extent of informal payments to be less substantial. According to Household Budget Survey data provided by GUS, it is estimated that informal payments amounted to nearly 2% of total OOP expenditure in 2006 and 1.5% in 2009 (Golinowska, 2010a).

This decrease is the result of several anticorruption initiatives that were initiated after the initial political commitment in 2005, both in general and in the health care sector in particular. In 2006, a working group for counteracting fraud and corruption in the health sector was established at the Ministry of Health and a special handbook on fair, legal and moral behaviour was made available for the education of physicians. Further, the Patient Rights Bureau established an online platform and prepared a relevant guidebook for patients. Physicians responded by forming their own working group to partake in the

[20] Stationary comprises residential/inpatient settings.

[21] Physicians increasingly maintain private offices while still working at hospitals, and the private consultation fee has been replacing direct bribes (a visit to the private office first secures an admission to the hospital).

debate, openly requested an increase in salaries and supported a privatization reform scenario that would include a formal payment option (Golinowska & Kozierkiewicz, 2007; Golinowska, 2010a).

3.5 VHI

3.5.1 Market role and size

A strong VHI market has not yet developed in Poland. There is no VHI with complementary or substitutive functions, and existing VHI forms play a supplementary role (additional to the public system). Since VHI is not defined, many products offered in the market as prepayment for certain benefits in case of health problems may be treated as VHI. Consequently, VHI in Poland has only supplementary character and is offered in two forms and by two different types of economic entity (Sobczak, 2004):

- medical subscriptions offered by various commercial companies or public providers (the most common form, held by about 1 million people); and
- health insurance policies offered by insurance companies operating according to the 2003 Law on Universal Health Insurance in the National Health Fund.

Health insurance policies may include benefits in cash (e.g. a lump sum for hospital treatment or per hospitalization day) or benefits in-kind (e.g. ambulatory care, certain hospital procedures) and are currently offered by an increasing number of companies. Extended medical options offered as supplements to life or personal insurance are a separate type of insurance product. In June 2004, 30 companies offered private accident insurance; 23 companies offered full health insurance plans, and 32 companies offered supplemental accident and health insurance packages (Stachura, 2004).

Based on National Health Accounts data, VHI expenditure in Poland exceeded PLN 499 million in 2008 and PLN 340 million in 2004 in absolute terms. The share of VHI did not exceed 0.6% of total health expenditure and 2.2% of private health expenditure in 2009. Interestingly, a report on the private health care market in Poland in 2011 showed that VHI demonstrated the fastest growth in recent years within the private health care market (PMR, 2011).

Although development of VHI has so far been limited in Poland, there is potential for VHI to address deficiencies in the public insurance system. Because of the limited financial resources available to the NFZ, the availability of formally guaranteed services is also limited and there are long waiting lists for some services (especially for elective surgeries). Moreover, the quality of guaranteed services is relatively low, particularly with regard to inpatient amenities (e.g. food and accommodation in hospitals). Industry representatives cite two major factors that hinder the development of the VHI market in Poland. First, the wide range of public sector services that is guaranteed to all citizens and legal residents by law crowds out voluntary schemes. Second, the public health care system does not operate transparently – relevant issues include the management of waiting lists, the lack of a guaranteed ceiling for waiting times and the lack of a legal definition of the term "voluntary health insurance". Against these, the fact that companies offering medical subscriptions function under the Commercial Code rather than the stricter provisions of insurance law giving them a competitive advantage regarding prices.

3.5.2 Market structure and conduct

Medical subscriptions are mainly offered by employers as additional benefits to their employees and usually include the occupational medicine services that the employers are legally obliged to provide (periodic check-ups and preventive care). Expanded subscription packages, which are the most common, facilitate access to services and guarantee a higher standard of care, thus providing an effective incentive for employees, while employer tax incentives also make them attractive to employers. It is worth mentioning that subscriptions mostly cover outpatient health services (consultations provided by primary health care physicians and specialists, diagnostic procedures, prevention and, albeit to a smaller extent, dental care). Individuals may also purchase subscription packages with varied coverage and prices; however, these clients constitute a very small percentage of beneficiaries (individual subscriptions are very expensive), and they are mostly employees of private companies and institutions. Monthly contributions are not high, ranging from PLN 12 to several hundred zloty, depending on the range of services in the package. The most expensive packages (VIP category) are aimed at top executives and rich individual clients. They also include other services such as coordination of hospital care, home visits or sanitary transport.

Different insurance products protecting against the risk of health care costs are offered by insurance companies. These include, for example, sickness or accident insurance, or insurance with "medical" options such as a supplement

to life insurance. Short-term accident and sickness insurance for travellers to cover against expenditure on health and other services during international trips are most frequent. Among personal accident or sickness policies valid within the country, those with extended medical options are quite common.

3.5.3 Public policy

Provisions on VHI are made in the 2003 Law on Insurance Activity and the Civil Code and there are no separate regulations for VHI only. The VHI market, similar to other insurance segments, has been regulated by the Polish Financial Supervision Authority (*Komisja Nadzoru Finansowego*) since 2006, but a comprehensive definition of VHI itself is not officially in place and there are no financial incentives (such as tax relief) for individuals to purchase it. However, given the great potential described above, several proposals and pilots for the expansion of the VHI market have been considered in recent years and the topic remains on the policy agenda.

Following the first important proposal by the Ministry of Health and the World Bank in 2001, a couple of government initiatives were introduced aimed at exploring the options for VHI, particularly in order to relieve the NFZ. A comprehensive approach to endorse private payers was prepared by the Polish Chamber of Insurance in 2008 and supported by the PO political party, but without success. In March 2011, a bill on supplementary health insurance was presented by the Ministry of Health aiming at market regulation but it was met with criticism from almost all sides and is still under consideration.

3.6 Other financing

3.6.1 Parallel health systems

The Ministry of National Defence (*Ministerstwo Obrony Narodowej*), the Ministry of Interior and Administration (*Ministerstwo Spraw Wewnętrznych*), the Ministry of Justice (*Ministerstwo Sprawiedliwości*), and the Internal Security Agency (*Agencja Bezpieczeństwa Wewnętrznego*) used to have their own health care establishments providing health care services to their active and retired employees as well as their families. These establishments are nowadays accessible to all insured persons. All citizens are covered by the NFZ so the case for a parallel health system cannot be made. Section 5.14 contains more detail on health for specific populations.

3.6.2 External sources of funds

EU structural funds have played an important role in health care investment in Poland since its accession in 2004. For the period 2007–2013, direct health sector investment financed from structural funds targets infrastructure, healthy working lives, occupational health, health education and training as well as the development of better quality management systems. Telemedicine, information technology (IT) and communication technology infrastructure are also the focus of EU structural funding. Other areas with a potential impact on health are also supported by structural funds (e.g. community engagement, inclusive employment, or urban development) (Watson, 2009). Under the Regional Operational Programmes, €597 million was assigned to support health care infrastructure in different regions in Poland, while an additional €350 million was made available through the Operational Programme Infrastructure and Environment to improve the quality of services (Kałużyńska, Smyk & Wiśniewski, 2009) (see section 4.1.1). Within the Operational Programme Human Capital, the European Social Fund assigned €105 million to create health programmes, to support training and continuous education for health care professionals and to increase the quality of management in the health sector.

The health sector in Poland is also supported by European Economic Area grants–Norway grants.[22] In the years 2005–2009, almost €60 million was assigned for health promotion and prevention programmes, for improving the quality of services in health care institutions, for increasing accessibility and to support primary and specialist health care. For the period 2009–2014, another €70 million is earmarked for two programmes aimed at improving access to and quality of health services and reducing social inequalities in health. Special focus is put on reproductive and preventive child health care, health care related to the ageing population, and preventing lifestyle-related diseases.

3.6.3 Other sources of financing

NGOs (foundations, associations and churches) are particularly active in the health sector in Poland, providing both support to patients and their families (such as legal advice, psychological and financial assistance) and also certain types of service (such as hospice care, see sections 5.8 and 5.10). The amount of funding provided from these sources is not substantial. Corporations finance services for their employees in the realm of occupational health, with most

[22] Details can be found at http://www.eeagrants.org/ (accessed 22 January 2012).

of the funding going towards curative services (around 35%), 13.5% going to prevention and around 46% being used for investment purposes (see also section 3.5.2).

3.7 Payment mechanisms

3.7.1 Paying for health services

Different types of payment mechanism are in place according to both the level of care and sometimes the type of service provided (Table 3.12). Public health, for example, is financed by the state budget (e.g. for sanitary inspection) and on a fee-for-service principle within public health programmes, which can be set up at the central and territorial levels. Primary care services are financed according to an annual capitation payment per patient registered with a primary care physician.[23] This payment covers the cost of consultation and the cost of diagnostic tests prescribed by the primary care physician (except for the most expensive tests such as computer tomography or magnetic resonance imaging, which are contracted separately).

Table 3.12
Payment mechanisms

	Ministry of Health (state budget)	Regional budgets	Territorial authorities	NFZ branches	Cost sharing	Direct payments
Primary care physicians				C, FFS		
Ambulatory specialists				FFS, C, DRG		FFS
Nurses and midwives				C, FFS		FFS
Acute hospitals	FFS			DRG		FFS[a]
Other hospitals	FFS[b]			DRG	FFS	FFS[a]
Outpatient hospital services				FFS		FFS
Dentists				FFS		FFS
Public health services	Budget, FFS		FFS	FFS		
Social care	Budget		Budget			
Emergency care	PD[c]	PD[d]		DRG[e]		

Notes: [a] for persons or services not covered by the NFZ; [b] for specific procedures such as transplantations; [c] for on-call air rescue; [d] for on-call medical emergency teams; [e] for emergency wards; FFS: Fee for service; PD: Per diem; S: Salary; C: Capitation.

[23] For certain patient groups, such as children, seniors and persons with chronic conditions, capitation payments are weighed by higher indexes.

A fee-for-service principle is applied for specialist ambulatory services (with capitation-like payments for patients with chronic conditions). Inpatient care is paid for on the basis of case payments by the Polish JGP, a DRG-like system, introduced in 2008. All NFZ-contracted hospitals are financed by the JPG system irrespective of ownership status, hospital type and regional differences. With the exception of psychiatric and rehabilitation care, the system also applies to all hospital patients and is supposed to cover the full costs of treatment (with the exception of major investment costs of the provider) (Busse et al., 2011). However, particularly complicated and/or expensive procedures, such as transplant surgery, are paid directly from the state budget. Inpatient care is also the sector where the majority of informal payments is absorbed (see section 3.4). As of July 2011, DRG-type payments were activated for specialist ambulatory services as well, aiming to shift lighter cases from inpatient care and thus encourage the concept of day care and avoiding unnecessary hospitalizations and costs.

Pharmaceuticals in ambulatory care are financed by the NFZ but require co-payments (see section 3.4.1), whereas drugs dispersed in inpatient care are free of charge and are paid for through the DRG scheme, standard chemotherapy schemes and health programmes (particularly for expensive pharmaceuticals). The state budget took over financing of emergency services in 2007. These are paid on a per diem basis for on-call ambulatory and transport services and through the DRG system for emergency hospital wards. Dental care is financed from public sources based on a fee-for-service principle (capped in contractual agreements) and from direct payments (see also section 3.4).

3.7.2 Paying health care professionals

There are a few basic methods of paying medical personnel in Poland. They include contractual employment, civil law agreements (contract, mandate), self-employment and state financing of medical students and trainees. Even though the majority of health care facilities is non-public (ambulatory care has been largely privatized), most health care professionals work in public facilities (reflecting the large number of public hospitals). Most hospital personnel are employed under contracts of employment, or under civil law agreements. Exceptions are medical students undergoing the compulsory postgraduate training or medical physicians undergoing residency training (see section 4.2.3), who are financed by the Minister of Health.

No minimum remuneration for individual professional groups has been established in the health care system (other than the overall minimum income for contractual employment). Average remuneration in the Polish economy amounted to PLN 3500 per month in the first quarter of 2011. According to a poll conducted by the Ministry of Health in public hospitals in May 2009, the average total gross remuneration amounted to PLN 3500 per month for nurses and midwives with specialization, PLN 5300 for physicians without specialization and PLN 6400 and PLN 7200 for physicians with specialization (with first and second specialization degrees, respectively). Between 2000 and 2010, salaries in the health sector increased by 15 percentage points (they corresponded to 75% of the average salary in Poland in 2000 and to 90% in 2010). Physicians undergoing residency training were particularly prioritized to receive higher remuneration in order to discourage professional migration (see section 4.2.2).

4. Physical and human resources

4.1 Physical resources

4.1.1 Capital stock and investments

In 2009, there were 754 general hospitals in Poland. The vast majority (526, or 70%) were public, and the rest (228) were private, representing 90.2% and 9.8% of general hospital beds, respectively (Table 4.1). In addition, there were 19 general hospitals of the Ministry of Defence and 22 general hospitals of the Ministry of the Interior and Administration, which translates into 6117 and 4226 beds, respectively (GUS, 2010b). In the same year, there were 52 psychiatric hospitals (see also section 5.11). There are substantial differences in the geographical distribution of hospitals in Poland (Table 4.2);

Table 4.1

Hospital and hospital beds, 2005 and 2009

Type and ownership	2005			2009		
	Hospitals	Number of beds	% beds	Hospitals	Number of beds[b]	% beds
I. General hospitals	**781[a]**	**179 493**	**90% of total**	**754[a]**	**183 040[b]**	**90.8% of total**
(a) Public	611	171 278	95.4% of I	526	165 012	90.2% of I
Hospitals owned by local self-governments	552	146 650	85.6% of (a)	469	138 869	84.2% of (a)
Ministry of Health hospitals[c]	17[d]	4 859	2.8% of (a)	16[e]	5 428	3.3% of (a)
Other hospitals[f]	42	19 769	11.5% of (a)	41	20 715	12.6% of (a)
(b) Non-public	170	8 215	4.6% of I	228	18 028	9.8% of I
II. Psychiatric hospitals[g]	**54**	**20 276**	**10% of total**	**52**	**18 507**	**9.2% of total**
Total (I + II)	**835**	**199 769**	**100%**	**806**	**201 547**	**100%**

Sources: CSIOZ, 2006a, 2010.
Notes: [a]Excluding hospital branches; [b]The number of beds comprises beds in hospitals and hospital branches, including beds and incubators for newborns; [c]Hospitals owned by the Ministry of Health; excluding hospitals owned by the Ministry of Defence and the Ministry of the Interior and Administration; [d]Including the Silesian Centre for Heart Diseases in Zabrze and the Górnośląski Oncological Hospital in Gliwice; [e]Including the Silesian Centre for Heart Diseases in Zabrze and three hospitals of the Oncology Centre; [f]Hospitals owned by a public medical university or a public university conducting research and teaching in the area of medical sciences; [g]Including the Institute of Psychiatry and Neurology.

Table 4.2
Regional distribution of general hospital infrastructure and occupancy rates, 2009

	Number of hospitals			Number of hospital beds			Beds per 1000 pop.	Occupancy (%)
	Total	Public (%)	Non-public (%)	Total	Public (%)	Non-public (%)		
Poland	**754**	**70**	**30**	**183 040**	**90**	**10**	**4.8**	**69.7**
Dolnośląskie	60	60	40	13 907	79	21	4.8	66.4
Kujawsko-Pomorskie	39	49	51	9 038	76	24	4.3	64.9
Lubelskie	38	82	18	11 477	97	3	5.3	75.8
Lubuskie	20	70	30	4 357	85	15	4.3	67.2
Łódzkie	56	68	32	13 624	89	11	5.3	72.3
Małopolskie	68	61	39	14 387	93	7	4.3	73.2
Mazowieckie	93	81	19	24 110	96	4	4.6	72.9
Opolskie	22	68	22	4 451	84	16	4.3	69.7
Podkarpackie	34	76	24	9 717	95	5	4.6	69.8
Podlaskie	30	77	23	6 230	97	3	5.2	66.5
Pomorskie	36	56	44	8 875	81	19	3.9	68.2
Śląskie	107	73	27	26 624	92	8	5.7	66.5
Świętokrzyskie	22	82	18	6 312	92	8	4.9	70.7
Warmińsko-Mazurskie	37	70	30	6 056	86	14	4.2	67.2
Wielkopolskie	61	77	23	15 923	91	9	4.6	71.2
Zachodniopomorskie	31	71	29	7 952	94	6	4.7	66.7

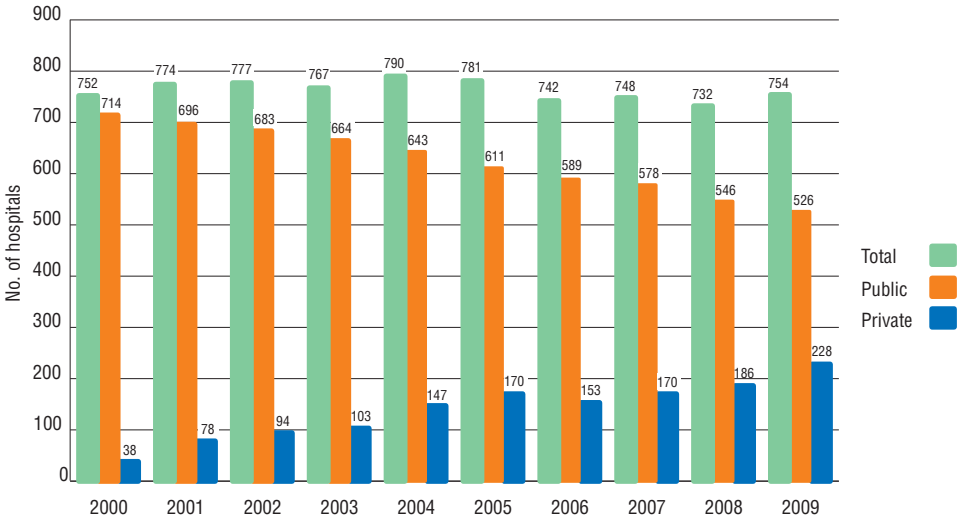
Source: CSIOZ, 2010.
Note: Highest values are shaded in light grey; lowest values are shaded in dark grey.

this distribution has historic origins and does not necessarily reflect population health needs. Data on the distribution of hospital beds per 1000 inhabitants and on occupancy rates also indicate substantial regional differences.

Most Polish hospitals are public. Between 2000 and 2009, the number of public hospitals decreased substantially while the number of private and non-public hospitals established by territorial self-governments increased (Fig. 4.1). This was largely the result of commercialization of hospitals: between 1999 and 2009, local self-governments privatized 77 public hospitals (see Chapter 6) (Świderek, 2010). Newly established private hospitals are small compared with public hospitals and account for a small share of total hospital beds.

Non-public hospitals can be divided into those with 100% private ownership and those where local self-governments (mainly *powiats*) are majority shareholders. According to recent estimations, the majority of non-public hospitals (65%) are exclusively in private hands, which indicates that private investors are reluctant to co-invest alongside the public sector (Szetela, 2009). Non-public hospitals, on the one hand, operate according to the Commercial

Fig. 4.1
Number of public and private hospitals in Poland, 2000–2009



Source: GUS, 2010b.

Code and are, unlike public hospitals, not immune from bankruptcy. On the other hand, public hospitals can accumulate debts since the state is ultimately responsible for their financial obligations. For that reason, private health care institutions are usually more financially stable (achieving higher revenues and lower costs) than their public counterparts (Świderek, 2010).

There are also substantial differences in the proportion of public and private hospitals between regions. Voivodeships with the highest proportions of private hospitals (such as Kujawsko-Pomorskie, Pomorskie and Dolnośląskie; see Table 4.2) are those that are economically well developed or are located close to national borders.

There is no precise definition of "hospital" in Poland, and health care units with as few as one or two beds are included in the CSIOZ's RZOZ, which collects this type of information. According to these records, about 50% of all hospitals in Poland have fewer than 150 beds, with the proportion of small hospitals being higher for private institutions. Most medium-sized hospitals (between 151 and 500 beds) are public, and hospitals with capacity above 500 beds are almost exclusively in public hands (Table 4.3). A reduction in the number of small hospitals and improvement in the geographical distribution of hospital infrastructure across the country were the goals of the draft law on "hospital networks", which was proposed by PiS in 2006 (Włodarczyk, 2007)

but never implemented. Since then, the new government coalition leader (PO) has not sought to develop a centralized hospital restructuring plan – instead, this task has been entrusted to the local self-governments.

Table 4.3

Number of hospitals by size, mid-2011

Number of beds	Public hospitals	% Public	Private hospitals	% Private	Total	% Total
<50	27	4.4	311	61.7	338	30.2
50–150	133	21.6	92	18.3	225	20.1
151–250	138	22.4	43	8.5	181	16.2
251–500	195	31.7	40	7.9	235	21.0
>500	120	19.5	9	1.8	129	11.5
Hospitals with only day-care beds	2	0.3	9	1.8	11	1.0
Total	**615**	**100.0**	**504**	**100.0**	**1119**	**100.0**

Source: CSIOZ, 2011.
Notes: Data as of July 18, 2011, including general, psychiatric and specialist hospitals. Hospital branches are not included in the hospital count (they are treated as parts of hospitals). The number of hospitals here is inconsistent with the number of hospitals provided in Tables 4.1 and 4.2 because the statutory definition of a hospital is imprecise (e.g. it does not define a minimum number of beds that a hospital should have and health care units with as few as one or two beds are included in the CSIOZ's RZOZ register). Data in the table also include a few (about 10) health care units that do not operate but are merely registered and hospitals with only day care beds; these are not included in Tables 4.1 and 4.2.

RZOZ data on the average age of hospitals in Poland (15.1 years in July 2011) is misleading, given the imprecise statutory definition of the term hospital and the inclusion of very small or non-functioning units in the registry. According to more accurate data from a 2006 survey conducted by the Ministry of Health, the average age of hospital buildings was 42 years (CIOZ, 2008). Most private hospitals were established after 1999 and are, therefore, in relatively good condition. Some public ones, by comparison, were built in the 1970s and 1980s, and many are still housed in buildings constructed before the Second World War. As a result, their general condition is poor, and maintenance is very costly. This is reflected in the reports of the Ministry of Health and the Supreme Audit Office (*Najwyższa Izba Kontroli* (NIK)).

According to the 2008 *Green Book II*, on health care financing in Poland (Ministry of Health, 2008), the average level of depreciation of fixed assets in the health care sector was approximately 62% at the end of 2006, whereas (according to construction industry standards) 40% is the level of depreciation that would qualify a building for an extensive overhaul (Ministry of Health, 2008). The situation is further aggravated by the widespread, long-standing practice of using amortization write-offs to cover financial losses. This practice stems from the financial limitations faced by the SPZOZs and results

in reduced spending on modernization and renovation of facilities. According to the *Green Book*, over 60% of hospitals' fixed assets require major repairs or replacement and 40% of the buildings must be modernized. Based on a 2009 NIK audit of a sample of 48 SPZOZs, the technical condition of facilities used by 69% of the sampled facilities was inadequate and often posed a threat to patients' lives or health. Fire protection was largely inadequate and almost half of the hospitals had not been adapted for the needs of persons with disabilities. Almost two-thirds of the hospitals failed to conduct periodic inspections of the technical condition of their buildings and over 40% of them did not perform the mandatory inspection every five years (NIK, 2009). Following the audit, the NIK sent out guidelines to the directors of SPZOZs, which have been either carried out or accepted for implementation. However, the poor financial situation of hospitals remains a major constraint to modernization of facilities.

Capital investment is funded separately from current costs of health care delivery. While reimbursement for services is carried by the NFZ, the responsibility for investment funding in public hospitals is borne by the state and hospital owners (mainly territorial self-governments). Non-public health care units fund investments from their own sources or from external sources, such as bank loans. There are currently no legal restrictions on financing capital investment, and there are generally no differences in this respect between various types of health care provider (such as hospitals or outpatient centres). Territorial self-governments are the principal source of investment funding – between 1999 and 2009 they invested twice as much as the state budget. Most of the funding came from voivodeships, followed by *powiats* and *powiat* cities, and it also included loans (with local self-governments acting as guarantors for bank loans).

Capital investments depend on the specific needs of the hospital and the resources available to its owner; they do not usually result from common investment strategies agreed between the government, the owners and the NFZ. Given the diversity and number of owners, the territorial coordination of investment in public hospitals is difficult and is, in fact, performed only for very large investments. The Management of Central Investments (*Zarząd Inwestycji Centralnych*) serves, on behalf of the Treasury, as project supervisor for medical investments that are too large-scale to be managed by the Department of Budget, Finances and Investment of the Ministry of Health.

The amount earmarked by the state for investment in health care is determined yearly in the budget. In the budget planned for 2011, over PLN 807 million was allocated to investment funding in health care, out of which PLN 265 million

was allocated to health care programmes (some of these programmes also cover investments in equipment and clinics). The majority of budgetary funding (80–90%) was allocated to implementation of projects co-financed by the EU (Pasowicz et al., 2009). In theory, contracts with the NFZ should also provide hospitals with money for renovations, expansion and replacement of equipment. However, after paying for human resources, medicines and other expenses, the amount left for capital investments is negligible. Other sources, such as NGOs are used to finance smaller investments (see section 4.1.3).

The latest additions to the portfolio of investment funding sources in health care are public–private partnerships. The 2008 Law on Public–Private Partnership regulates both institutionalized and contractual public–private partnerships. According to the first model, public and private partners establish a special purpose company, which then founds a non-public health care facility (co-owned by the private partner). In the second model, the cooperation is solely based on a public–private partnership contract, and health services are provided by a health care facility that is fully owned by the public partner. Furthermore, according to the 2009 Law on Concession for Construction Works or Services, a private partner can finance construction work or services, and its compensation comes from the proceeds generated by the constructed building. Such projects are not financed by the EU, while public–private partnerships may be subsidized from EU funds. The 2008 regulation was followed by many enquiries about potential public–private collaborations in the first year after its implementation. Out of 34 public–private partnership projects advertised in the *Public Procurement Bulletin* and/or the *Official Journal of the European Union* in 2009, six were related to large infrastructure investments in the health sector and their value was between PLN 1.5 million and PLN 145 million.

At the national level, EU investments in health care infrastructure for 2007–2013 are channelled through the Operational Programme Infrastructure and Environment, which provides European Community support under the Convergence Objective. The total budget of this Programme is €37.56 billion (this is the biggest Operational Programme both in Poland and in the EU), out of which nearly €412 million[24] was allocated to Priority 12 (Health security and improvement of efficiency of health care system), which provides support for developing an integrated emergency medical services system and health care

[24] Including both EU (European Regional Development Fund) and national contributions.

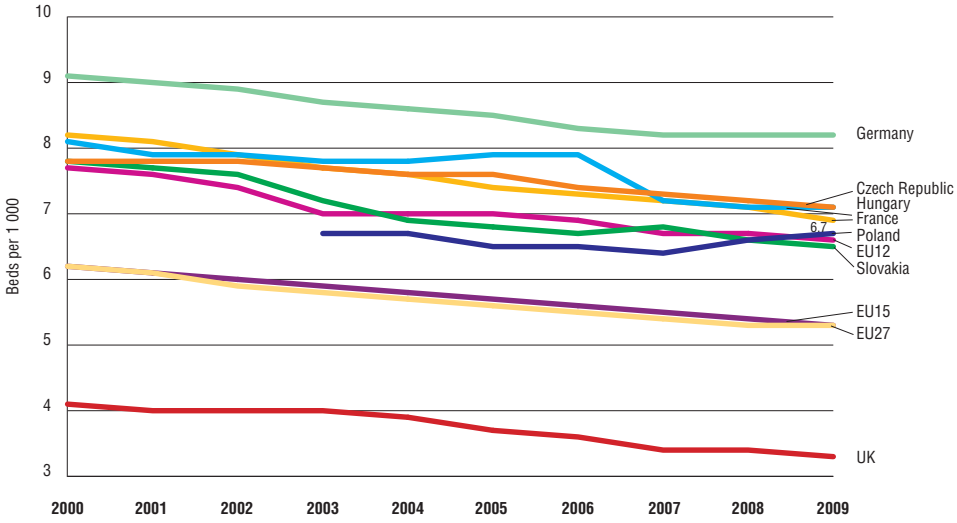
infrastructure. At the end of 2010, the value of contracted funds amounted to 86% of the total funds available for Priority 12. Most contracts (231 out of a total of 283) were in the area of the integrated emergency medical services system (see section 5.5).

4.1.2 Infrastructure

The number of hospital beds per 1000 inhabitants has been falling steadily in western European countries since the early 1980s (Fig. 4.2). In Poland, there was very little change in the number of beds until the late 1990s, but the restructuring that followed the 1999 reform resulted in a decrease of 11 547 beds between 1999 and 2002.[25] Since then, the number of beds has been slowly declining (Table 4.4). An increase in the number of general hospital beds between 2007 and 2008, visible in public statistics, was mainly caused by the change in the methodology of counting beds (beds and incubators for the newborns were included in the number of general beds).

Fig. 4.2

Hospital beds per 1000 inhabitants in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

[25] Including beds in hospitals of the Ministry of Health and in psychiatric hospitals but excluding beds in hospitals of the Ministry of National Defence and the Ministry of the Interior and Administration (CSIOZ, 2001).

Table 4.4

Number of beds in general, psychiatric and long-term hospitals and other long-term care institutions, 2000 and 2009

Hospital type	2000			2009		
	Hospitals	Beds	% beds	Hospitals	Beds[c]	% beds
General hospitals:	752[a]	191 290	89.0	754[b]	183 040	90.8
Acute beds		183 733	96.0		176 712	96.5
Psychiatric beds		4 331	2.3		4 635	2.5
Chronic beds		3 226	1.7		1 693	0.9
Psychiatric hospitals[d]	51	23 728	11.0	52	18 507	9.2
Total	**803**	**215 018**	**100**	**806**	**201 547**	**100**

Sources: CSIOZ, 2001, 2010.
Notes: [a]Including hospital branches (36); [b]Excluding hospital branches (39); [c]The number of beds comprises beds in hospitals and hospital branches, including beds and incubators for the newborns; [d]Including the Institute of Psychiatry and Neurology.

In 2009, there were 6.7 hospital beds per 1000 inhabitants in Poland, compared with an average of 5.3 in the EU15 and 6.6 in the EU12 (Fig. 4.2). In 2005, the estimated surplus of hospital beds (assuming an occupancy rate of 80%) was 11%, reaching 36% for certain ward types and showing regional variation (Wojtyniak, Goryński & Kuszewski, 2006). No such estimates are available for later years.

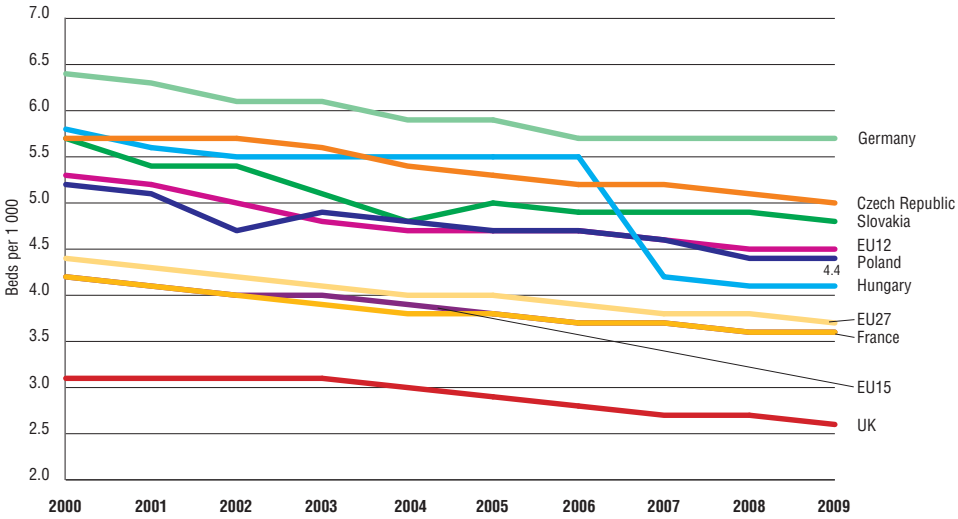
The structure of hospital beds has changed very little since the early 2000s. In 2009, approximately 91% of all beds were in general hospitals. Of those, 96.5% were acute beds, 2.5% psychiatric beds and 0.9% long-term beds for the chronically ill. Chronic care beds also existed in long-term care institutions (other than hospitals). Long-term hospital wards ceased to exist at the end of 2009 and were transformed either into geriatric care wards or into other types of long-term care institution (see section 5.8). In the same year, there were 18 507 beds in psychiatric hospitals and 4635 psychiatric care beds in general hospitals, representing 9.2% of total hospital beds and 2.5% of all general hospital beds, respectively.

The deficit of long-term care beds has long been on the health policy agenda. Plans to reduce the number of acute hospital beds in favour of long-term and psychiatric beds have been in place since the early 1990s (Murkowski & Koronkiewicz, 1997). For example, conversion of acute care beds into long-term care beds was one of the components of the 2006 draft law on "hospital networks" but, as mentioned above, this law was not implemented in the end (see also Chapter 6).

Since the definition of acute care hospital beds has been changing over the years, a longitudinal analysis of acute care hospital beds would be misleading. In 2009, the number of acute beds in Poland was estimated at 4.4 per 1000 inhabitants (Fig. 4.3), which, although slightly lower than the EU12 average of 4.5, is still considerably higher than the EU15 average of 3.6. At 2.3 beds per 1000 inhabitants, the number of long-term beds in Poland is clearly lagging behind other European countries such as Germany, France and the United Kingdom, which managed to increase their number of long-term beds (up to 10.3 per 1000 in Germany) (Fig. 4.4). In 2009, there were 18 507 beds in psychiatric hospitals in Poland. The number of psychiatric beds per 1000 inhabitants has been decreasing in the EU countries, owing to the shift away from institutionalized psychiatric care towards treatment in outpatient and community settings. Poland's ratio of 0.6 psychiatric beds per 1000 inhabitants in 2009 is relatively low compared with other countries (Fig. 4.5).

Fig. 4.3

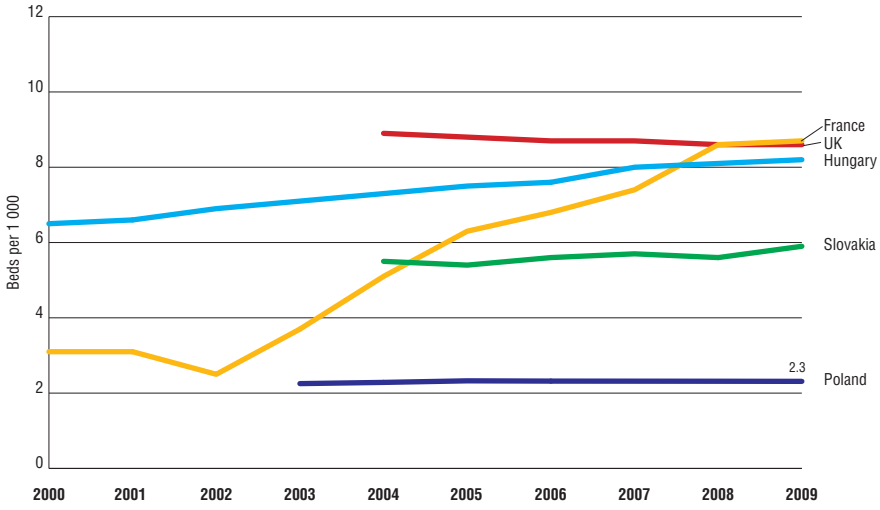
Acute hospital beds per 1000 inhabitants in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

Fig. 4.4

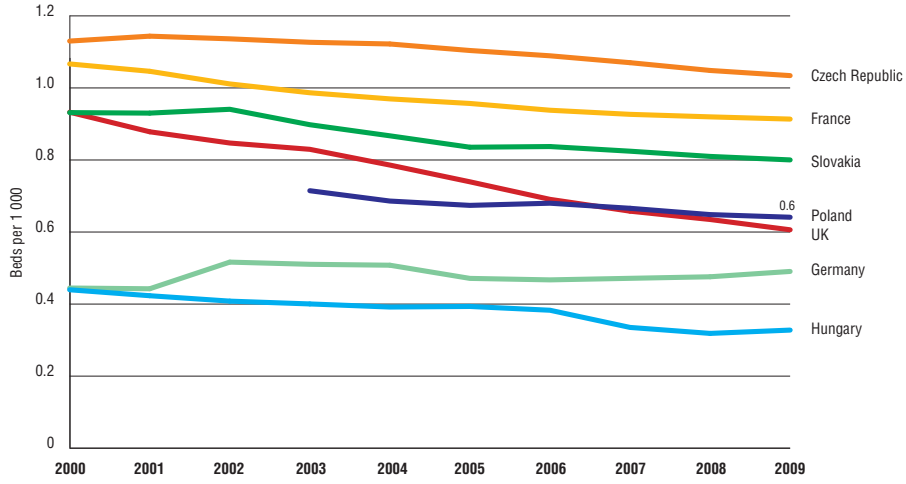
Long-term (nursing and elderly) hospital beds per 1000 inhabitants, in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.
Notes: There have been several changes in the methodology of counting hospitals beds in Poland during the 2000s; the latest change, in 2008, included beds and incubators for newborns (on the neonatology wards) in the number of curative beds of general hospitals. For more information, see WHO Regional Office for Europe (2011b). No data are available for EU12, EU15 and EU27.

Fig. 4.5

Psychiatric hospital beds per 1000 inhabitants in Poland and selected EU countries, 2000–2009

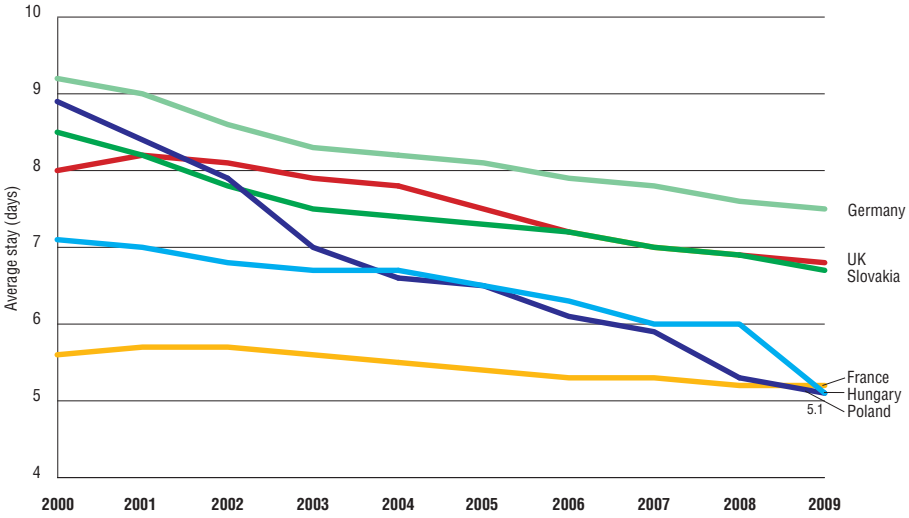


Source: WHO Regional Office for Europe, 2011b.
Notes: Data includes beds in mental health and substance abuse hospitals, beds in psychiatric departments of general and specialized hospitals. No data available for EU12, EU15 and EU27.

The average length of stay in hospital has been falling continuously in Europe over the past few decades. At 5.1 days in 2009, the average length of stay in Poland compares relatively well with other European countries (Fig. 4.6).

Fig. 4.6

Average length of acute hospital stay in Poland and selected EU countries, 2000–2009



Source: OECD, 2010a.

The hospital occupancy rate in Poland has increased since the 1990s. However, at 69.7 % in 2009 it was lower than that observed in most western European countries (Table 4.5). Occupancy rates and average lengths of stay vary considerable for different types of hospital wards. In 2009, the highest

Table 4.5

Hospital occupancy rates in selected EU countries, 1990–2009 (selected years)

Country	Hospital bed occupancy (%)					
	1990	1995	2000	2005	2008	2009
Czech Republic	69.6	72.6	73.8	78.4	69.7	75.3
France	77.3	76.0	75.0	73.5	74.2	74.4
Germany	n/a	81.8	81.5	74.5	76.2	76.2
Hungary	74.9	72.6	73.2	75.7	75.3	74.3
Poland	**66.0**	**67.3**	**74.0**	**71.0**[a]	**70.3**[a]	**69.7**[a]
Slovakia	n/a	n/a	70.6	66.7	67.5	67.3
United Kingdom	n/a	n/a	82.3	83.7	84.5	84.2

Sources: OECD, 2010a; [a]CSIOZ, 2006a, 2009a, 2010.
Note: n/a: not applicable.

occupancy rates were observed in haematology, psychiatric and addiction wards and the lowest in ophthalmological, neonatology and paediatric wards. The average length of stay was the shortest in ophthalmological, otolaryngology and gynaecology/obstetric wards and the longest in psychiatric, rehabilitation and chronic wards (GUS, 2010b).

4.1.3 Medical equipment

Highly specialized hospital equipment is funded by the Ministry of Health from the state budget. Funding may also be awarded under the Operational Programme Infrastructure and Environment. NFZ contracts for provision of services should, in theory, provide sufficient funding for replacement of medical equipment (see section 4.1.1), but the amounts are negligible. Hospitals also rely on individual and institutional donations to buy new equipment. For example, the Great Orchestra of Christmas Charity, a charitable foundation established in 1993, has purchased more than 20 000 pieces of medical equipment within five nationwide medical programmes from funds collected during its annual fund-raising concerts and from income tax transfers (the charity has the status of a public benefit organization, which means that individuals may elect to transfer 1% of their income tax to it instead of to the state budget). Unfortunately, anecdotal evidence suggests that some of the equipment purchased from EU funds is not used because decisions to purchase medical equipment are not coordinated between local self-governments and the NFZ, and hence the latter may not be aware of such investments in its decisions to award contracts for provision of services. Moreover, because of limited financing, the ability of the NFZ to contract services for which the purchased equipment is used may be restricted.

Funding of medical rescue equipment in Poland is regulated in the 2006 Law on the National Medical Emergency Services. Medical equipment used by emergency rescue teams and hospital emergency wards may be financed by the Ministry of Health, other ministries, voivodeships and local self-governments (funds from these sources may also be used for the modernization of existing equipment). Additional funding comes from the Operational Programme Infrastructure and Environment (see section 4.1.1).

Availability of medical equipment in Polish hospitals varies for different types of equipment. For example, in 2009, the availability of units for computer tomography, lithotripsy, mammography and digital subtraction angiography per 1 million inhabitants was relatively good in Poland, whereas the availability of units for magnetic resonance imaging, radiography, gamma scanning and positron emission tomography was relatively poor (Table 4.6).

Table 4.6

Number and population ratio of medical equipment (per 1 million inhabitants), 2009

Country	Magnetic resonance imaging units		Computed tomography scanners		X-ray units		Gamma cameras		Lithotripters		Positron emission tomography scanners		Mammographs		Digital subtraction angiography units	
	No	Ratio	No	Ratio	No	Ratio	No	Ratio	No	Ratio	No	Ratio	No	Ratio	No	Ratio
Czech Republic	60	5.7	148	14.1	89	8.5	124	11.8	31	3.0	6	0.6	133	12.7	79	7.5
France	415	6.5	715	11.1	702[a]	10.9[a]	324	5.0	139[a]	2.2[a]	60	0.9	n/a	n/a	498[a]	7.7[a]
Germany	776[a]	9.5[a]	1 412[a]	17.2[a]	390[a]	4.8[a]	595[a]	7.3[a]	324[a]	4.0[a]	97[a]	1.2[a]	n/a	n/a	691[a]	8.4[a]
Hungary	28	2.8	72	7.5	41	4.1	109	10.9	49	4.9	4	0.4	146	14.6	37	3.7
Poland	141	3.7	473	12.4	107	2.8	114	3.0	161	4.2	16	0.4	544	14.3	292	7.7
Slovak Republic	33	6.1	72	13.3	73	13.5	40	7.4	33	6.1	3	0.6	78	14.4	48	8.9
United Kingdom	365[b]	6.0[b]	510[b]	8.3[b]	320[b]	5.2[b]	n/a	n/a	n/a	n/a	n/a	n/a	548	8.9	n/a	n/a

Source: OECD, 2010a.
Notes: [a]Numbers restricted to hospital count as opposed to total count; [b]Estimate for 2010 as 2009 not available; n/a: not available.

A 2010 NIK report on the condition of specialized medical equipment in 53 public hospitals pointed out that hospital equipment is often obsolete or not maintained properly. The report showed that as many as 88% of X-ray scanners in the audited hospitals were largely worn out. Half of the inspected hospitals did not maintain their equipment in adequate technical condition and almost two-thirds of hospitals failed to check if it was safe for use. New medical equipment purchased from public funds was often not used for a long time because of a lack of hospital premises or trained staff.

4.1.4 IT

According to a 2009 population survey, 55.1% of Polish households had a computer and 50.9% had access to the Internet. The share of people using the Internet was higher for the younger age groups: 86.8% of the 16–24 year olds and 73.7% of the 25–34 year olds used the Internet. By comparison, this share was 62.1%, 39.5% and 20.6% in the 35–44, 45–59 and 60–64 age groups, respectively. However, according to this study, the Internet was used by more and more households and by an increasing number of older people (Czapiński & Panek, 2010). According to Eurostat data in 2010, approximately 25% of Poles aged 16–74 used the Internet to seek health-related information (Table 4.7). This share has risen dramatically over the last few years but is still substantially lower than the EU27 average of 34% in the same year.

Table 4.7

Percentage of individuals aged 16 to 74 using the Internet for seeking health-related information, 2003–2010

Country	2003	2004	2005	2006	2007	2008	2009	2010
EU27	**n/a**	**17**	**16**	**19**	**24**	**28**	**33**	**34**
Czech Republic	n/a	n/a	3	10	11	14	20	21
Germany	n/a	n/a	n/a	34	41	41	48	48
France	n/a	n/a	n/a	13	29	39	37	36
Hungary	n/a	8	10	17	23	29	36	41
Poland	**n/a**	**5**	**7**	**11**	**13**	**19**	**22**	**25**
Slovakia	n/a	18	9	14	16	25	30	35
United Kingdom	29	26	25	18	20	26	34	32

Source: European Commission, 2011b.
Note: n/a: not applicable.

In primary care, computers are mainly used for patient registration and administrative purposes but not during medical consultations – neither the physician nor the patient has access to electronic data (such as patient records).

Although computers are used in the majority of health care units in Poland, usage in single-physician medical practices and middle-sized ambulatories is low, and medical documentation is still maintained in paper form. Several voivodeships have well-developed IT systems in large clinics and specialist hospitals, in which the administration is connected to the flow of medical data from hospital wards, hospital pharmacies and surgery management systems.[26] However, the use of IT in secondary care still seems to be much less advanced than in western Europe. The use of e-health in Poland is very low, but some initiatives in this area have been piloted. For example, although virtually all prescriptions are dispensed in printed form, prototype e-prescriptions were implemented in 16 pharmacies, 2 medical practices and 2 outpatient clinics in 2011 in Leszno. A prototype of internet patient accounts (with information on medical history) was introduced in 2011 in several diabetic medical centres in Kraków. Countywide rollouts (by 2014) are the ultimate goal in both cases.

Some university clinics and specialist hospitals use telemedicine in areas such as cardiology and orthopaedics. Electronic appointment booking is not widespread but there are encouraging examples of such practices (e.g. for online booking of specialist appointments in hospitals). Electronic patient registration is one of the tools foreseen in Project P1 of the Healthcare Computerization Programme, which was launched in 2009 and is 85% co-financed by the EU under the Innovative Economy Programme 2007–2013. Large hospitals are more likely to use IT infrastructure, for both administrative purposes and for medical record keeping. According to a survey conducted by CSIOZ in 2009 (CSIOZ, 2010), there is a wide variation in terms of IT use, which seems to be correlated with hospital size. In general, 83% of the surveyed hospitals had access to the Internet – mostly in administrative departments (in this case there was no correlation with hospital size) (Potyra & Górecki, 2010).

Currently, there is redundancy of collected data (the same or similar data can be found in different registers), inconsistency of data between registers (e.g. a change of address in one register is not automatically updated in other registers) and no linkages between various databases (Oleński, 2006). Medical IT and communication technology systems are usually developed separately by individual health care units, and compatibility and coordination are low. There have been initiatives (co-funded by the EU) to unify these technology infrastructures and software, but these were small and only on a regional level. However, a more comprehensive approach was introduced by the Healthcare Computerization Programme. This included the creation of an electronic

[26] Two examples are the John Paul II Specialist Hospital in Kraków (Pasowicz et al., 2009) and the Orthopaedics and Traumatology Department of the Musculoskeletal System Clinic within the Infant Jesus Clinical Hospital in Warsaw.

platform for gathering, analysing and sharing of digital records, with mostly patient-oriented functionalities (for which patients and health care employees will be the principal users) and a second platform providing entrepreneurs (health care providers) with online access to the services and resources of digital medical registers (Project P2) (CSIOZ, 2007). This initiative is particularly useful since medical records are currently maintained by individual health service providers and a central register is lacking. Implementation of the Programme, which is managed by CSIOZ, is due to be finished in 2014.

There are also regional initiatives in the area of e-health. An Ernst & Young report prepared for CSIOZ at the end of 2009 identified several such initiatives at various stages of implementation. They included regional medical information systems, implementation of IT systems in health care units, and purchase of IT and communication technology infrastructure for health care units (Ernst & Young, 2009). Future strategy in the area of e-health is outlined in a recent CSIOZ study introducing the "e-Health Poland" strategy (Ministry of Health, 2011). Its key goals include digitalizing medical registers and strengthening their legal basis (some have out-dated or no legal basis); achieving interoperability of information systems; improving accessibility to information systems for the public administration, physicians and patients; reducing the cost of data collection and processing; and implementing the EU Directive on Patient Rights in Cross-border Health Care (Directive 2011/24/EU). The strategy was supported by legislation proposed by the Ministry of Health and adopted in April 2011 (Law on the Information System in Health Care). The Law sets out the organization and operation of an information system in health care, with the goal of reducing information gaps in the sector. An improved health care information system should facilitate optimal policy decisions in the future and lead to improved performance of the Polish health care sector.

4.2 Human resources

Information about health workers comes from various sources, which use differing definitions of medical professionals in their data collection. For example, the professional chambers collect data on all persons who have the right to practise a medical profession, regardless of where they work (medical practice, academia, etc.); the GUS provides information about the employment of medical professionals only in health sector institutions, while the financial data in the National Health Accounts also includes information on activities in health and health-related areas.

4.2.1 Health workforce trends

According to data collected by professional chambers, 132 800 physicians, 36 900 dentists, 278 200 nurses, 33 900 midwives, 27 600 pharmacists and 12 500 diagnosticians had the right to practise in Poland in 2009. Data collected from therapeutic entities, medical practices, pharmacies and social care institutions show how many of the licensed health care professionals were actually actively employed in health care institutions in which provision of services is financed from public sources: 82 900 physicians (62.5% of all with licences), 12 100 dentists (32.7%), 24 200 pharmacists (87.6%), 200 500 nurses (72.0%), 22 400 midwives (66.0%) and 9200 laboratory diagnosticians (73.5%). There were also 21 200 active physiotherapists and 9100 medical rescuers (GUS, 2010b).

Although there are no reliable estimates on the adequacy of staffing levels in the health care sector, available evidence suggests a shortage of health care professionals. According to data compiled by the voivodes, the biggest shortages for the medical profession were observed in the specialties of anaesthesiology and intensive care, internal medicine, emergency care, paediatrics, general surgery and psychiatry; for the nursing profession, shortages occur in geriatrics, intensive care, cardiology and emergency care (see section 4.2.2) (Węgrzyn et al., 2009). The distribution of health care staff is also uneven in geographical terms (Table 4.8). Medical workforce tends to be concentrated in urban areas (reflecting the distribution of health care infrastructure). The largest concentrations of medical physicians are observed in regions with medical universities and highly specialized medical centres.

The number of physicians per capita is lower in Poland than in most western European countries and has been decreasing since 2003, mostly through migration, which is attributable to better remuneration and working conditions abroad (see section 4.2.2). In 2009, Poland had 2.2 physicians per 1000 inhabitants, which was considerably lower than both the EU15 average of 3.5 and the EU12 average of 2.7 (Fig. 4.7). Most physicians working with patients ("medical employees") were employed in health care institutions of the Ministry of Health and in medical practices[27] and 66.5% of them were specialists (with grade II specialization and with a specialist title). Physicians working for health care institutions of the Ministry of National Defence and the Ministry of the Interior and Administration, and in stationary social care facilities, made up 4.8% of all physician medical employees in 2009 (Table 4.9).

[27] Data presented in this chapter cover solely health care professionals working in health care institutions in which provision of services is financed from public sources.

Table 4.8

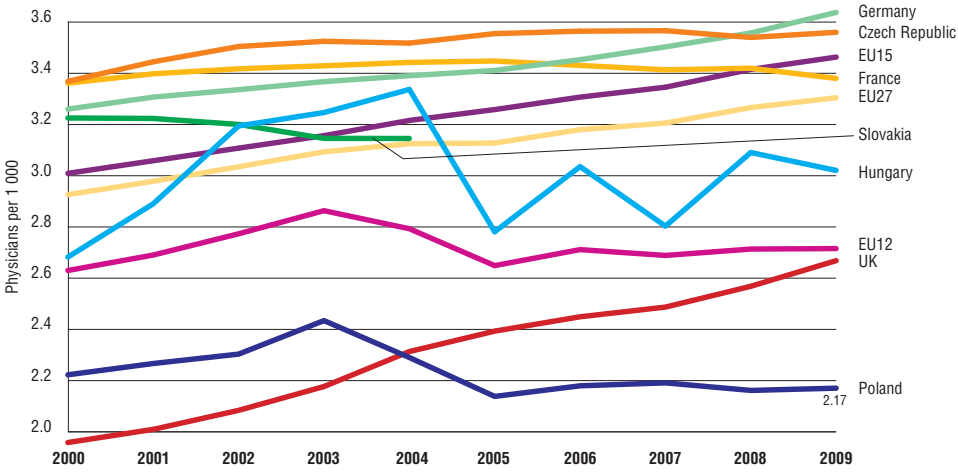
Geographical distribution of health care workers, 2009 (per 1000 inhabitants)

Voivodeship	Physicians	Dentists	Pharmacists	Nurses	Midwives	Physio-therapists	Laboratory diagnostitians	Medical rescuers
Poland (average)	**2.07**	**0.31**	**0.63**	**4.87**	**0.58**	**0.56**	**0.24**	**0.24**
Dolnośląskie	1.91	0.17	0.68	4.96	0.49	0.61	0.23	0.26
Kujawsko-Pomorskie	1.99	0.31	0.50	4.63	0.61	0.62	0.24	0.26
Lubelskie	2.38	0.46	0.84	5.49	0.66	0.52	0.30	0.26
Lubuskie	1.75	0.43	0.49	4.47	0.59	0.42	0.19	0.24
Łódzkie	2.41	0.30	0.84	4.95	0.62	0.52	0.23	0.26
Małopolskie	2.12	0.36	0.70	5.02	0.59	0.64	0.24	0.21
Mazowieckie	2.35	0.28	0.68	4.96	0.54	0.58	0.25	0.13
Opolskie	1.82	0.34	0.49	4.86	0.47	0.50	0.21	0.30
Podkarpackie	1.85	0.42	0.54	5.20	0.72	0.83	0.26	0.36
Podlaskie	2.36	0.38	0.54	5.25	0.72	0.44	0.24	0.34
Pomorskie	2.02	0.26	0.69	4.24	0.49	0.48	0.26	0.20
Śląskie	2.24	0.32	0.59	5.60	0.58	0.58	0.23	0.23
Świętokrzyskie	2.08	0.30	0.57	5.29	0.58	0.65	0.33	0.20
Warmińsko-Mazurskie	1.65	0.31	0.44	4.39	0.55	0.42	0.24	0.28
Wielkopolskie	1.47	0.15	0.66	3.75	0.56	0.37	0.21	0.23
Zachodniopomorskie	2.14	0.49	0.43	4.27	0.52	0.58	0.20	0.34

Source: GUS, 2010b.
Notes: Light shaded areas have the highest numbers of health care workers per 1000 inhabitants; dark shaded areas have the lowest.

Fig. 4.7

Number of physicians per 1000 inhabitants in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

Table 4.9

Physician medical employees[a], 2009

Type of physician	2009
I. Physicians working in health sector institutions and in private medical practices	79 015 (95.22% of total)
General physicians (%)	26 453 (33.48% of I)
Specialists (%)	52 562 (66.52% of I)
Family medicine (%)	5 964 (11.35% of specialists)
Internal diseases (%)	6 989 (13.30% of specialists)
Paediatrics (%)	3 232 (6.15% of specialists)
Other (%)	36 377 (69.21% of specialists)
II. Physicians working outside the health sector[b]	3 734 (4.50% of total)
III. Physicians working in stationary social assistance facilities	234 (0.28% of total)
Total	**82 983**

Source: GUS, 2010b.
Notes: [a]Medical employees: work in institutions where provision of services is financed from public sources; [b]Administration, education, military, police.

Postgraduate training in family medicine was introduced in 1993. In 2009, 11.35% of all specialists were specialized in family medicine (Table 4.9) (see also section 5.2). In 2009, Poland had 21 primary care physicians per 100 000 inhabitants compared with the average of 97 in the EU15 (Table 4.10). Although the number of patients per primary care physicians has nearly halved

since the end of the 1990s, in 2008 there were still close to 6000 patients per primary care physician – nearly six times more than the EU15 average. Primary care physicians represent about one-quarter of all physicians working in health care (Table 4.11).

Table 4.10

Number of primary care physicians per 100 000 inhabitants, 2000–2009

Country	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Poland	7.68	8.84	9.59	11.90	13.28	14.27	13.60	16.33	22.30	20.54
EU12	42.69	42.49	42.24	41.85	41.07	44.05	47.38	58.36	61.89	50.36
EU15	92.75	93.54	93.99	94.70	95.30	96.01	95.99	96.25	96.50	96.89

Source: WHO Regional Office for Europe, 2011b.

Table 4.11

Number of physicians working at different levels of care, 2010–2011

	2010	%	2011	%
Primary health care	31 000	25	32 217	26
Specialist ambulatory care	40 925	33	36 765	30
Hospital care	53 333	42	54 825	44
Total	**125 258**	**100**	**123 807**	**100**

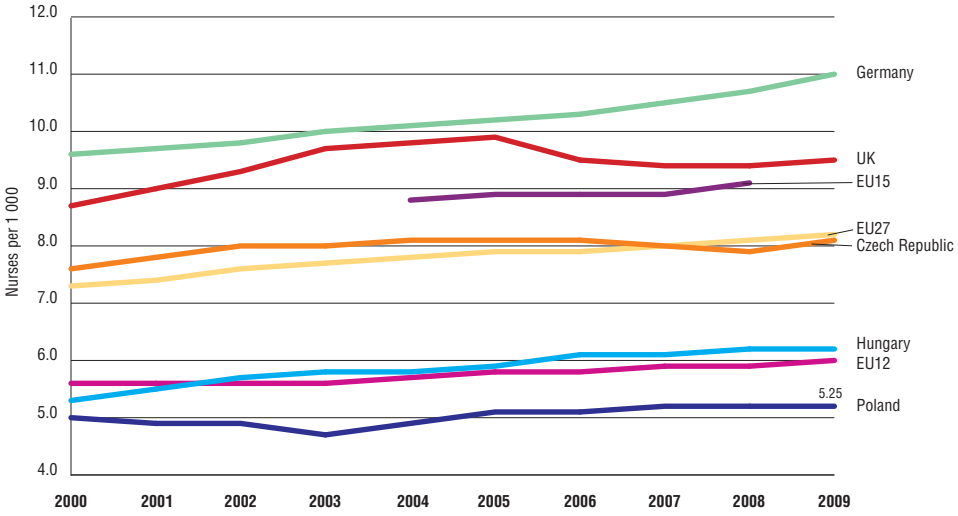
Source: NFZ, 2011a.

In 2009, there were 5.2 nurses per 1000 inhabitants in Poland, which is lower than the EU12 average of 6.0 (2009) and the EU15 of 9.1 (2008) (Fig. 4.8). The ratio saw a steady decrease beginning in the late 1990s but started to increase slowly again shortly before Poland's EU accession in 2004. The new nursing profession of medical caregiver (*opiekun medyczny*) was introduced in 2007 to offset the low number of nurses. In 2009, there were approximately 1600 medical caregivers in Poland. Since they are auxiliary staff, they may not establish individual practices and be directly contracted by the NFZ, and hence there are no data on the exact number of medical caregivers employed within the public health care system.

The number of dentists per 1000 inhabitants was relatively stable until the end of 1990s and has fluctuated considerably since then. In 2009, there were 0.3 dentists per 1000 inhabitants in Poland, which was less than half the EU15 average of 0.7 and lower than the EU12 average of 0.5 (Fig. 4.9). Among all dentists employed in the health care institutions of the Ministry of Health (7635) and in dental practices (4220) in 2009, 22.4% were specialized, mostly in dental

Fig. 4.8

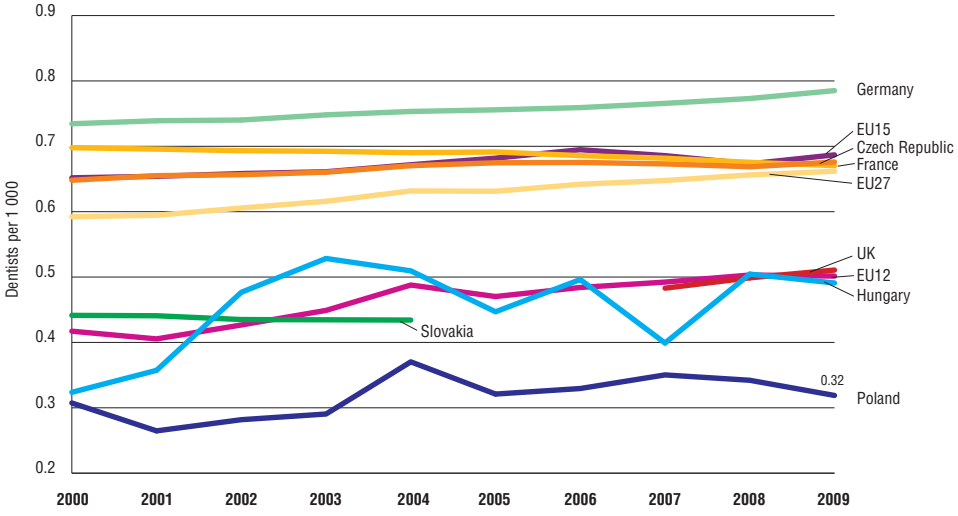
Number of nurses per 1000 inhabitants in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

Fig. 4.9

Number of dentists per 1000 inhabitants in Poland and selected EU countries, 2000–2009



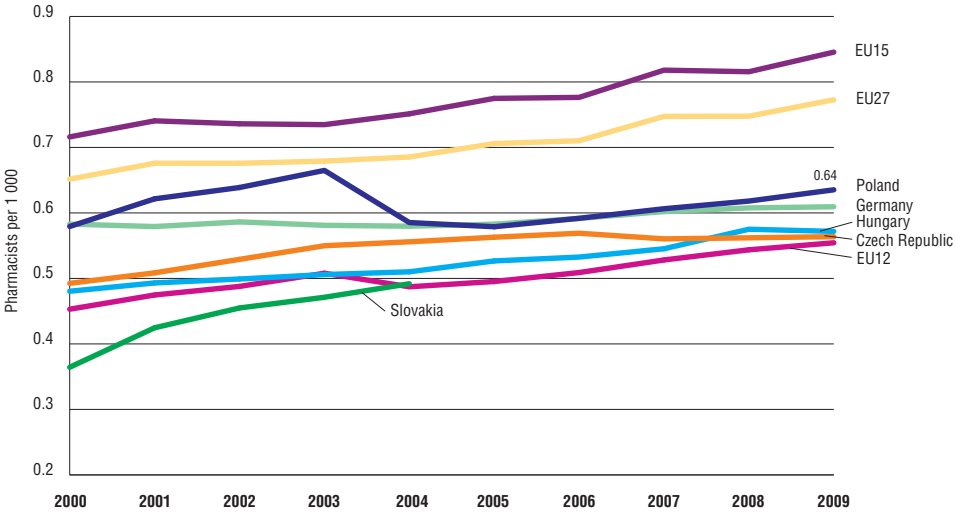
Source: WHO Regional Office for Europe, 2011b.

prosthetics, orthodontics and restorative dentistry (GUS, 2010b). Unfortunately, there is no national register of dental auxiliaries (hygienists and technicians as well as dental nurses) and it is difficult to estimate their numbers. The latest estimates date from 2000: at that time 2500 dental hygienists, 7000 dental technicians and 9725 dental nurses were working in Poland (Kravitz & Treasure, 2009).

The number of pharmacists has been increasing in Poland and other European countries in recent years. In 2009, Poland had 0.64 pharmacists per 1000 inhabitants, compared with the EU12 average of 0.55 and the EU15 average of 0.85 (Fig. 4.10).

Fig. 4.10

Number of pharmacists per 1000 inhabitants in Poland and selected EU countries, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

4.2.2 Professional mobility of health care workers

Although migration of Polish health care professionals was already commonplace before the country's EU accession, health workforce mobility saw a substantial increase after 2004, peaked in 2006 and has decreased slightly since (Kautsch & Czabanowska, 2011). To have an overview of the scale, causes and possible effects of health workforce migration on the Polish health care system, the Ministry of Health launched a programme for monitoring migration

among Polish physicians, nurses and midwives in 2004. The programme tracks the number of professional qualification certificates required for work abroad issued by the Chamber of Physicians and Dentists and the Chamber of Nurses and Midwives. However, these certificates are an imperfect measure of outward migration since not all those who obtain a certificate actually leave the country, and some health care professionals may be able to work abroad without certification (e.g. nurses working in long-term care facilities). The main destination countries are the United Kingdom, Ireland, Germany, Sweden and Denmark. The main factors motivating health care workers to seek employment abroad are low salaries, difficult working conditions and limited possibilities for professional development in Poland (Kautsch & Czabanowska, 2011). The last factor is supported by the comprehensive research by the Centre of Migration Research at the University of Warsaw, which demonstrated that the push factors for outward migration were associated not only with wage differentials but also with low job satisfaction among the junior staff caused by limited prospects for professional development and poor working atmosphere in hospitals, where heads of wards have a dominant role (see section 5.4.2).

A surge in applications for professional qualification certificates occurred after EU accession: between 2005 and 2008, approximately 6.1% of professionally active physicians obtained such certificates, mostly anaesthetists and intensive care specialists, thoracic surgeons, plastic surgeons and specialists in emergency care. The fact that these types of specialist have more limited contact with patients compared with non-surgical specialists (and hence need a lesser degree of language fluency) might have contributed to this trend. Evidence from data collected by the professional chambers suggests that while younger specialists are willing to emigrate permanently, more senior physicians prefer short stays abroad. Evidence also suggests that most physicians work abroad for a set period of time before returning home, or they work part-time in another country (e.g. weekend work) to supplement their income. The rate of certification requests decreased in 2007, and a reverse trend has been observed since, with Polish medical physicians returning home. This trend may be explained by the increase in income levels of health professionals in Poland and the economic recession in western Europe.

Data on professional mobility is also available for nurses and dentists. In 2004, approximately 1.2% of professionally active nurses and 3.6% of professionally active dentists considered emigrating. Also, a relatively low number of nurses and midwives applied for certification between 2004 and 2006, approximately 1.3% of active nurses and midwives. This may be because such documentation was not a prerequisite for finding employment in long-term

care abroad. Emigration is more common among nurses and midwives in the youngest age groups. Around 6.7% of registered dentists obtained professional qualification certificates in 2005–2008, but again, there are no available data on how many of them actually left Poland (Kautsch & Czabanowska, 2011).

Immigration of health care professionals into Poland is far less pronounced. Physicians seeking to train or work in Poland face language barriers, low financial incentives and lack of proactive recruitment policies – it can take up to 18 months to obtain a work permit and recognition of professional diplomas. According to 2009 estimates, less than 1% of all registered physicians and dentists were foreigners. Those who do come are mostly from countries in which the GDP per capita is lower than in Poland, mainly from the Ukraine but also from Albania, Armenia, Belarus, Bulgaria, Iran, Lebanon, Libya, Lithuania, Mongolia, Palestine, Russia and Syria (Zwierzchowska, 2010). However, Poland is usually only a transit country, and once they have acquired qualifications recognized in the EU, professionals seek employment in countries in which they can earn a higher salary.

While it is difficult to evaluate the exact impact of health worker mobility, it can be argued that emigration contributes to staffing shortages in certain medical specialties. A 2009 survey found 4113 unfilled posts for medical physicians across the country, mostly in anaesthesiology and internal medicine: the fields where specialists migrated most often. In the same year, there were 3229 vacant posts available for nurses, 312 for midwives and 86 for dentists (Węgrzyn et al., 2009). Health policy on the issue is not well developed, and government activities are limited to general declarations about the need to keep health professionals at home and some ad hoc policy interventions, including increasing the salaries of professionals providing services contracted by the NFZ (2006); increasing the salaries of resident medical physicians and dentists (since 2009), particularly in priority areas; offering loans to health professionals to start their own practice (2001); increasing admission limits for health and health-related studies as well as residency placements; and simplifying waiting times and qualification processes for specialist training (2008) (Węgrzyn et al., 2009; Kautsch & Czabanowska, 2011). Most recently, the Amendment of the Law on the Professions of Physician and Dentist shortened the time needed to obtain the title of specialist in Poland and is, therefore, likely to reduce the rate of migration, potentially even encouraging physicians to return to the country (see section 4.2.3). Moreover, the managers of health care institutions offer changes in employment status, from full-time employment to fee-for-service self-employment (with smaller obligatory insurance contributions),

allowing self-employed physicians to increase their working hours (beyond the limits of the EU Working Time Directive (2003/88/EC)) and increase income (Kautsch & Czabanowska, 2011).

4.2.3 Training of health care personnel

Accreditation to provide undergraduate medical education in Poland is held by 12 universities and 41 clinical hospitals. Undergraduate dental education may be obtained at 10 universities. Undergraduate education is financed from the state budget, although most medical schools also accept a maximum of 30% of fee-paying students (in the so-called extramural studies). It takes six years to complete undergraduate education for medical physicians, and five years for dentists. In 2008, 2411 students graduated with a degree in medicine and 817 with one in dentistry. All graduates have to complete a postgraduate internship at an accredited hospital, which lasts 13 months for medical graduates and 12 months for dental graduates and culminates in the state medical examination (*lekarski egzamin państwowy*) or the state dental examination (*lekarsko-dentystyczny egzamin państwowy*). Students who pass these state examinations can apply for the right to practise and be included in the registers of physicians and dentists. The related regulation was amended in 2011 and the last postgraduate internships will be offered on 1 October 2017 for graduates in medicine, and on 1 October 2016 for graduates in dentistry. Students starting their studies on 1 October 2012 will follow the new system of postgraduate education. Instead of a separate postgraduate internship, practical training will be included in the undergraduate curriculum and, from 2013, the final medical examination (*lekarski egzamin końcowy*) and the final dental examination (*lekarsko-dentystyczny egzamin końcowy*) will replace the two state examinations. These new examinations will be the prerequisites for obtaining the right to practise and for entering specialist training.

Graduates who obtain the right to practise can apply for postgraduate specialist training in a chosen discipline. The possibility for specialization depends on the availability of vacant training posts (see also section 2.5). Foreign physicians and dentists need to obtain consent from the Ministry of Health to enter specialty training.

Until 1999, Poland had a two-tier system of specialization: level I specialization qualification was awarded after just two to three years of training; those who decided to continue were awarded the level II specialization

qualification after further two years of training.[28] In 1999, the two-tier system was abolished. The specialist qualification is currently acquired after a unified specialist training programme that usually lasts 4–6.5 years for basic specialties, such as internal medicine or family medicine (there are 40 basic specialties in Poland), and a further two to three years for so-called "specific" specialties, such as vascular surgery, endocrinology and geriatrics (there are 28 specialties that fall into this category). There are also nine specialties for dentists, for whom training lasts between four and six years. A 2011 amendment to the Law on the Professions of Physician and Dentist replaced the system of basic and specific specialties with a modular system. Specialist training in a specific area of medicine will consist of a core module, covering basic theoretical knowledge and practical skills in a given field of medical specialization, and a subsequent specialist module, corresponding to the chosen area of specialization. A unified module is also available, integrating the training of both basic and specialist modules. According to the new system, it is possible to obtain specific specialization (according to the 1999 system) within 5–6 years, compared with 6–9.5 years under the 1999 system. This will shorten the time of specialist training and align the time of training to Directive 2005/36/EC.

There are five ways of undergoing specialist training: residency training (financed from the state budget), under an employment contract, training while on paid study leave (granted to hospital employees for the period of training), training as part of PhD studies, and volunteering. Only residency training guarantees employment during the training period, and it also provides the highest remuneration of the five options. Specialty training can be undertaken only in institutions accredited by the Ministry of Health that meet certain educational standards (see section 2.8.3). Specialty training is concluded with the state specialization examination (*państwowy egzamin specjalizacyjny*), which is organized twice a year and awards a specialist diploma. The Centre for Medical Examinations is responsible for the organization of this and other examinations related to postgraduate and continuing education programmes for physicians, pharmacists and other health professionals. Separate provisions are applied to specialist training for physicians and dentists who are soldiers on active duty, and for physicians and dentists on duty or employed in health care centres owned by the Ministry of Defence. Given the financial constraints of the state budget, only a limited number of residency posts can be financed. Therefore, priority specialties and specialties with a higher likelihood of outward migration (as measured by the numbers of professional certificates) are

[28] Level I specialization provided preparation for provision of specialist health services in primary care, while level II specialization provided preparation for provision of inpatient care or highly specialized health services.

endorsed and physicians undergoing residency training in these areas qualify to receive higher remuneration. Recommendations from regional and national health care consultants, as well as the availability of EU funding, is also taken into account.

Physicians and dentists are obliged to acquire new skills and advance their professional qualifications. This obligation can be fulfilled through self-education and participation in various forms of continuing education, for which educational points are awarded. Continuing education obligations are met when a physician collects 200 educational points within a 48-month period. Failing to fulfil continuing education obligations can lead to mandatory courses at the physician's own expense or (in the worst case) to a suspension of the licence to practice.

The traditional three-year study programme at nursing and midwifery colleges, in place since 1969, was replaced in 1995 by a new system based on bachelor and master degrees that conform to EU standards (Directive 2005/36/EC and the European Agreement on the Training and Education of Nurses, signed in 1967). Nurses and midwives who had previously graduated from nursing and midwifery colleges or medical vocational schools (these were gradually closed by 1997) have been able to upgrade their education in the so-called bridging studies (*studia pomostowe*) since 2004. Completion of the bridging studies is equivalent to a bachelor's degree (Directive 2005/36/EC) (Table 4.12). Training of nurses and midwives currently takes place at 63 higher education institutions. By virtue of the Law on the Professions of Nurse and Midwife of 1996 (as amended on 27 September, 2005), nurses and midwives have the duty to continuously update their knowledge and skills and the right to participate in different forms of voluntary postgraduate training. Nurses can

Table 4.12

Number of nursing graduates by types of training, 2003–2008

Field of studies	2003–2004	2004–2005	2005–2006	2006–2007	2007–2008
Nursing (bachelor's degree)	1 885	1 915	1 705	7 157	8 513
Postgraduate nursing (master's degree)	110	243	456	1 740	1 898
Uniform nursing studies[a]	1 001	752	0	0	0
Obstetrics for midwives (bachelor's degree)	510	625	545	1 025	1 117
Postgraduate obstetrics for midwives (master's degree)	0	108	100	660	711
Uniform obstetrics for midwives[a]	119	78	0	0	0

Source: Węgrzyn et al., 2009.
Note: [a]According to the 1969 system.

choose from 19 areas of postgraduate specialist training, midwives from four; there are three areas of training that can be attended by both nurses and midwives (neonatal nursing, epidemiological nursing, organization and management). Specialist training is subsidized by the Ministry of Health. Enrolment limits and subsidies vary from year to year, depending on the demand in the various areas of specialization. Next to specialist training, postgraduate training is also available in the forms of qualification, specialist and continuing education courses, which usually end with a certificate.

According to the Law on Pharmaceutical Chambers (1991, with later amendments), pharmacist licences are awarded to those who have graduated from a five-year (minimum) university-level course in pharmacology, completed a six-month traineeship and obtained the professional qualification of master in pharmacology (or an equivalent diploma granted by an EU country). According to the Ministry of Health's regulation of 2003 on specialization and attainment of a professional title by the pharmacists, graduates in pharmaceutical science can obtain postgraduate specialist training in 12 specialties. Pharmacists working in retail or wholesale pharmacies are required to participate in continuing education. Since there are no sanctions for failing to earn the minimum number of points, not many pharmacists fulfil their continuing education requirements (30% did in 2009).

4.2.4 Career paths for health workers

Following graduation, physicians first work as physician trainees, after which they may become assistants or, if they continue in academia, assistant, assistant professor, associate professor and, finally, professor. Further professional titles, such as head of ward (*ordynator*), may be obtained with additional specialist training and academic qualifications (such as a PhD). The prevailing model of hospital management in Poland is a system based on heads of wards (Krajewski Siuda & Romaniuk, 2008; see also section 5.4.2). Health care workers other than physicians may also advance professionally by undergoing specialty training (which entails the assumption of more responsibilities) or by being promoted to managerial positions. For example, nurses and midwives may be promoted to chief nurse or midwife in a ward, part of a ward, or in a hospital. Promotion is based on competitive selection procedures. Midwives may also establish their own birthing schools or offer home birth services.

5. Provision of services

5.1 Public health

The modern concept of public health began to be systematically introduced in Poland in the early 1990s. The first Polish school of public health educating public health professionals was established in 1990 in Kraków. It was modelled on the Harvard School of Public Health and the French École Nationale de Santé Publique. In 1997, the School of Public Health became part of the Collegium Medicum of Jagiellonian University. In the following year, the function of public health consultant (national and regional) was established. In 2007, the NIZP was formed, based on the PZH (it had been in place since 2002, but was based in other institutes). A law to specify the duties and responsibilities of the state and territorial self-governments in the area of public health was drafted in 2011.

The system of public health services provision developed in the 1950s and 1960s, which then primarily focused on hygiene and infectious diseases, is largely still in place today. Except for the activities carried out under the State Sanitary Inspectorate, there is no separate structure for the provision of public health services, and other public health care activities are carried out by various bodies across different sectors, at both the national and local levels (see section 2.6). The State Sanitary Inspectorate was established in the 1950s to protect the population from infectious and occupational diseases through hygiene monitoring in various areas of life. Other activities include organization of vaccinations (jointly with the Ministry of Health's Department of Mother and Child, the NIZP-PZH and other bodies), health promotion and health education, and collection of epidemiological data.

Every voivodeship in Poland has its own voivodeship sanitary inspector subordinated to the State Chief Sanitary Inspector and a voivodeship sanitary-epidemiological station and laboratories. The voivodeship sanitary inspectorates oversee the border sanitary inspectorates (of which there are 10) and the *powiat* sanitary inspectorates (318). In 2009, the State Sanitary Inspectorate was reorganized and its organizational structure is now more decentralized – the task of appointing and dismissing voivodeship sanitary inspectors was transferred from the Chief Sanitary Inspector to the voivodes. National regulations have also recently been adjusted to comply with EU standards.

The NIZP-PZH is the central public health research institute in Poland and plays a substantial role in monitoring infectious diseases and hygiene standards. It also supervises sanitary-epidemiological stations through regular inspections of their activities and laboratories.

Several departments within the Ministry of Health are involved in public health activities: the Department of Public Health has various tasks in the areas of psychiatric, geriatric, long-term, palliative and hospice care, and in occupational medicine. It is also involved in the implementation of the NPZ and integration of international health regulations into the Polish system. The Department of Mother and Child is, in cooperation with the Chief Sanitary Inspectorate, responsible for vaccinations, and the Department of Health Policy is responsible for the implementation of specific health programmes and the supervision of screening programmes.

Together with the local sanitary inspectorate units described above, several other bodies participate in the organization and provision of public health services at the local level. Public health centres answering to the voivodes operate in each voivodeship. They monitor the implementation of the NPZ and collect statistical data on hospitalizations, which are later used by CSIOZ, the Ministry of Health and the NIZP-PZH. Moreover, there are health departments at the offices of the voivodeship marshals, which supervise health care institutions within the territory of the voivodeships and are involved in the organization of provision of public health services (e.g. vaccinations, health promotion services and preventive examinations).

The monitoring and control of infectious diseases is achieved through a notification and publication system managed since the end of the First World War by the NIZP-PZH. Physicians must notify (within 24 hours) the *powiat* sanitary inspector of suspected or confirmed cases of diseases listed as reportable in the 2001 Law on Communicable Diseases and Infections.

Laboratories in sanitary-epidemiological stations that detect one of the reportable biological pathogens listed in the annex to the 2001 Law must do the same. Each *powiat* sanitary inspectorate keeps a register of reported cases and pathogens and prepares periodic reports for the voivodeship sanitary inspectors. They also keep registers and prepare reports on the incidence of those infections, infectious diseases, deaths,[29] and positive laboratory test results that were reported to them directly. Cases of certain infections or infectious diseases (e.g. tuberculosis, human immunodeficiency virus (HIV), syphilis) must be directly reported to the voivodeship sanitary inspectorate or designated specialized units. Reports from *powiats* are aggregated at the voivodeship level and relayed to the Chief Sanitary Inspectorate, where a national report is prepared. These are then published on NIZP-PZH's website. Reports on the incidence of infectious diseases are issued every two weeks.[30] The infectious diseases requiring monitoring are defined by the NIZP-PZH and monitored in compliance with the EU regulations of 2007. Sanitary-epidemiological stations use these definitions to classify and register disease incidence and to prepare their reports. In the case of an infectious outbreak, voivodeship sanitary-epidemiological laboratories must immediately notify the Chief Sanitary Inspectorate and are in charge of determining possible infection sources.

Family planning and prenatal services are carried out on an individual basis within primary care. Screening of neonates covers hearing, genetic and metabolic diseases and is supervised by a special unit at the Institute of Mother and Child. The Ministry of Health and the Chief Sanitary Inspectorate, in consultation with the NIZP-PZH, are jointly responsible for planning of vaccinations, which are funded from the state budget and distributed in a cold chain to voivodeship sanitary-epidemiological stations and pharmaceutical wholesalers. Obligatory vaccinations are performed according to a vaccination schedule (Table 5.1), which is determined annually by the Chief Sanitary Inspector. The Chief Sanitary Inspectorate, the Institute of Mother and Child and the NIZP-PZH are jointly responsible for the supervision of vaccinations. These are performed in hospitals immediately after childbirth and later in paediatric outpatient clinics. Vaccinations of schoolchildren are often organized in schools. Poland's prophylactic vaccination rate is quite high (see Fig. 5.1 for vaccination rates for hepatitis B3 and Fig. 5.2 for its incidence).

[29] Deaths caused by reportable infectious diseases listed in the Annex to the 2001 Law are reported by physicians directly to the voievodeship sanitary inspectors.

[30] Reports on influenza in the winter are prepared on a weekly basis.

Table 5.1

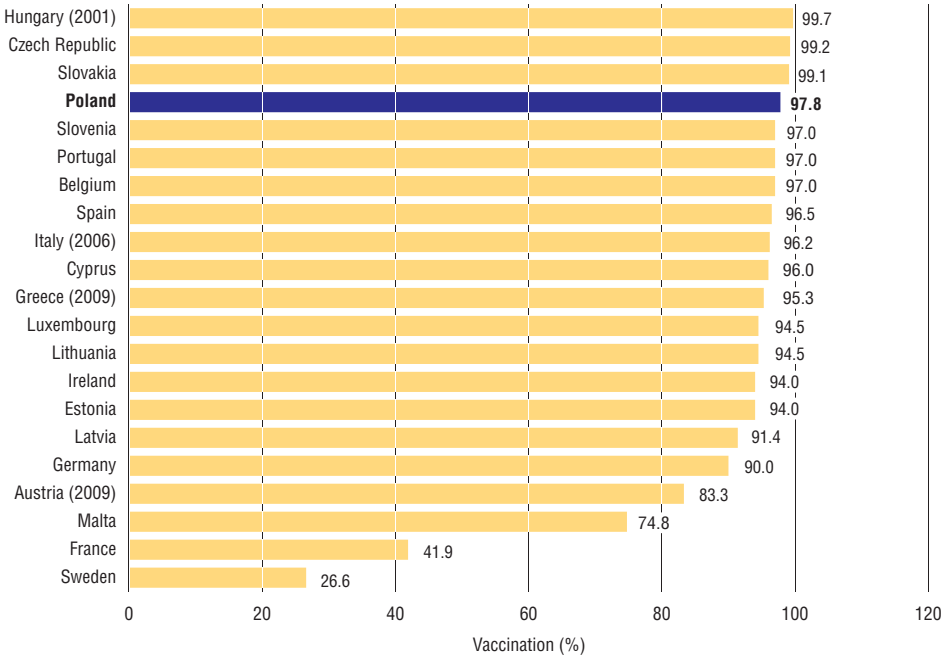
Recommended immunization schedule in Poland in 2011

Age	DTP	Polio	Hib	MMR	HepB	BCG	DT
At birth					●	●	
2 months	●		●		●		
3–4 months	●	●	●				
5–6 months	●	●	●				
7 months					●		
13–14 months				●			
16–18 months	●	●	●				
6 years	●	●					
10 years				●			
14 years							●
19 years							●

Source: Chief Sanitary Inspectorate, 2010.
Notes: DTP, Diphtheria tetanus and pertussis; Hib: *Haemophilus influenzae* type b; MMR: Measles, mumps and rubella; HepB: Hepatitis B virus; BCG: Tuberculosis vaccination; DT: Diphtheria and tetanus.

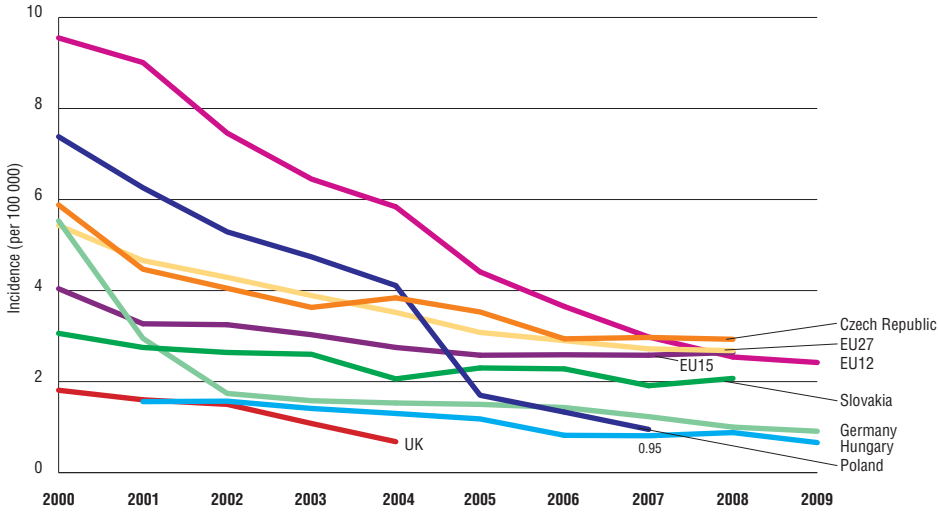
Fig. 5.1

Vaccination against hepatitis B3 among infants (%), 2010 or latest available year



Source: WHO Regional Office for Europe, 2011a.

Fig. 5.2
Incidence of viral hepatitis B3, per 100 000 inhabitants, 2000–2009



Source: WHO Regional Office for Europe, 2011b.

Most of the countrywide health promotion and education programmes are related to or directly result from the NPZ goals (see section 2.5). Local authorities are free to choose the most necessary health prevention programmes for their population among those listed in the NPZ. Monitoring of the implementation of the NPZ in 2007 found that over 400 such programmes were being carried out, notably for cardiovascular diseases, cancer, alcohol consumption, physical activity and nutrition.

Public screening programmes for adults are financed by the NFZ and are voluntary and free of charge for the population. They target cervical cancer, breast cancer and colorectal cancer. Promotional campaigns have helped to increase participation from target groups in recent years. Opportunistic screening possibilities also exist, but participation is again voluntary. Quality control in this area (on equipment and personnel) is carried out by the Centre of Oncology in Warsaw and the regional centres of oncology.

Occupational health services include preventive health care services for employees and monitoring of their health (focusing on occupational diseases and injuries). Voivodeship occupational health centres provide examinations for secondary school and university applicants who may be exposed to harmful or hazardous agents during their studies and outpatient medical rehabilitation for patients with occupational diseases. The provision of occupational health

services is supervised by the Nofer Institute of Occupational Medicine in Lódź, the Institute of Occupational Medicine and Environmental Health in Sosnowiec and the Institute of Agricultural Medicine in Lublin. These institutions provide relevant scientific research, expertise and training, as well as treatment and rehabilitation. Moreover, the Chief Sanitary Inspectorate is responsible for examining both the hygienic conditions at workplaces and occupational health. Regular inspections take place annually and are announced in advance. Additional inspections can be carried out following complaints submitted by employees. Furthermore the National Labour Inspectorate and Central Labour Protection Institute under the Ministry of Labour and Social Policy control and assess working environments and risk factors at workplaces.

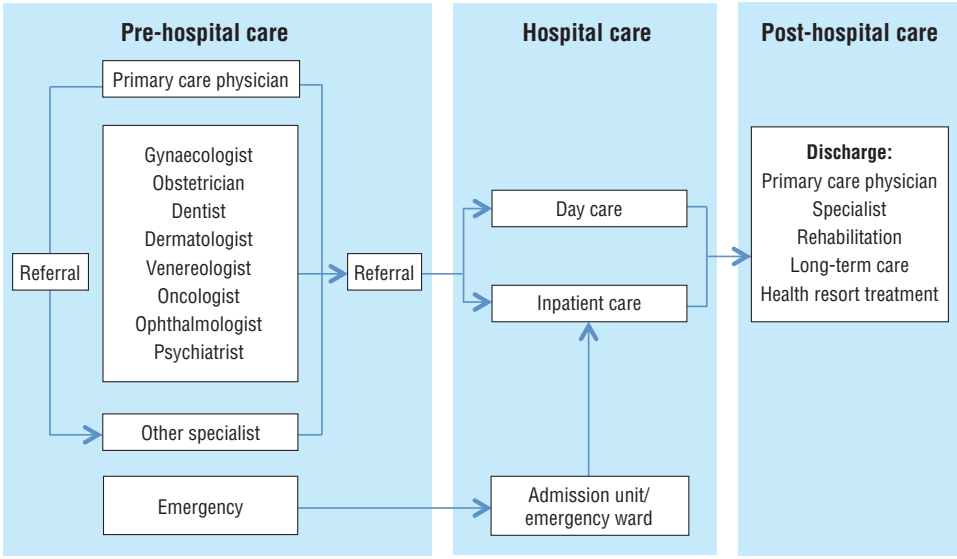
The quality of public health services is monitored by voivodeship and national consultants for public health. Evidence on the effectiveness of public health services includes positive changes in health indicators, such as life expectancy, infant mortality or the incidence of selected diseases (see section 1.4).

5.2 Patient pathways

A primary care physician is usually the entry point to health care services in Poland and a referral from a primary care physician is needed to access specialist care, with the exception of certain medical specialists that can be accessed directly and life-threatening situations (Fig. 5.3). Primary care physicians also issue referrals for diagnostic examinations and inpatient treatment. Patients can choose which primary care physician contracted by the NFZ to register with and may change twice a year (see section 2.9.2).

Patients can also choose any specialist outpatient clinic in Poland. Referred, non-emergency patients are seen by specialists according to a waiting schedule. On the consultation day, patients need to bring the results of all diagnostic examinations; this helps the specialist to decide on the further course of treatment. If hospital treatment is necessary, the specialist issues a referral and informs the patient about the estimated waiting time. There are no formal clinical pathways in place and the entire course of care depends on the attending primary care physician or specialist.

Fig. 5.3
Provision of health care services



For elective surgery and/or further diagnostics, patients have a choice of hospital. In order to set a date for hospitalization, patients must present their referrals and are entered into the waiting list on medical consultation at the hospital. They are also referred for any additional examinations that need to be conducted before admission. Once treatment is complete, the patient is discharged with an information card that describes undergone hospital procedures and follow-up recommendations. If necessary, the primary care physician refers the patient for rehabilitation or orders home nurse visits.

All persons covered by the public health insurance system are also entitled to apply for sanatorium treatment, for which cost-sharing applies (see section 5.7). Applications for sanatorium treatment are issued by the primary care physician and are then filed with regional NFZ branches, which decide on eligibility.

5.3 Primary/ambulatory care

Primary care is a separate part and is the entry point to the Polish health care system. Primary care physicians are gatekeepers in the system, steering patients to more complex care, and may be freely chosen by way of registration. Before 1989, primary care was part of an integrated and hierarchical system and access was determined geographically. The scope of primary care has been systematically reduced compared with the first half of the 1990s, following demands on pay and working conditions of primary care doctors put forward by the Zielonogórskie Agreement (*Porozumienie Zielonogórskie*) – the employer organization of primary care physicians.

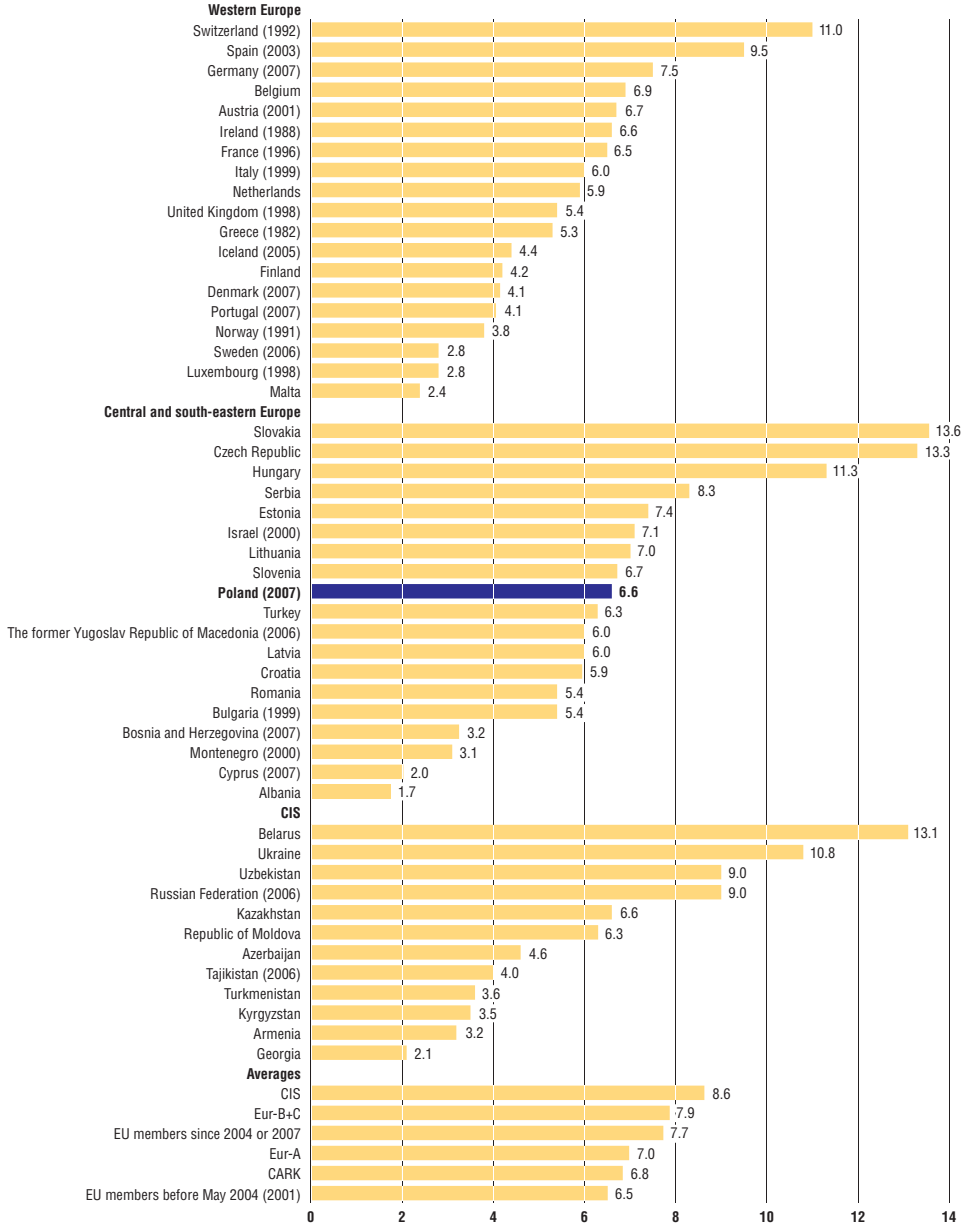
Primary health care comprises preventive health care services and diagnostic (first-line diagnostics are carried out by the primary care physician, while more specialized examinations are provided within specialist ambulatory care, following specialist referral), therapeutic and rehabilitative care in the area of ambulatory general, family and paediatric care. These services include obligatory vaccinations, health promotion and disease prevention (see also section 5.1). Services are provided by primary care physicians, nurses and midwives. Specialization in family medicine was introduced in 1993 as part of a general strategy to improve the role and quality of primary care in Poland. It is not very popular among medical students and the shortage of specialists in family medicine allows for paediatricians and internists to also work as primary care physicians.

On average, Polish people had approximately 6.8 outpatient contacts per person per year in 2008. This is similar to the level recorded in the EU as a whole (6.2 visits) and lower than the EU12 average of 7.8 (Fig. 5.4). In 2009, 54% of all ambulatory care consultations took place in the primary care and 46% in specialized care, 4.2% less than in 2008, which might reflect a growing importance of primary care in Poland (GUS, 2010b).

According to a 2007 *Eurobarometer* survey (European Commission, 2007), satisfaction with family care services in Poland is substantially higher than for other types of care. A vast majority of respondents found access and availability to primary care easy to fairly easy, and quality of such care fairly to very good (see section 7.3.1).

Fig. 5.4

Outpatient contacts per person in the WHO European Region, 2008 or latest available year



Source: WHO Regional Office for Europe, 2011b.
Notes: **European Region:** the 53 countries in the WHO European Region; **Eur-A:** 27 countries in the WHO European Region with very low child and adult mortality (see WHO definition); **Eur-B+C:** 26 countries in the WHO European Region with higher levels of mortality (see WHO definition).

5.4 Specialized ambulatory care/inpatient care

5.4.1 Specialized ambulatory care

All patients covered by the public health insurance system in Poland are entitled to free specialist ambulatory care. With the exception of certain specialties, certain conditions (such as HIV, tuberculosis and addictions) and medical emergencies, a referral from a primary care physician or another specialist is needed to access specialized ambulatory care. Certain types of patients, such as honorary blood and organ donors and war veterans have priority within the waiting list system.

Specialist outpatient services are provided by therapeutic entities (clinics or specialist dispensaries) and by specialist medical practices. At the end of 2009, there were 16 200 therapeutic entities in ambulatory health care providing ambulatory care services financed from public funds, out of which 18.2% were public and 81.8% non-public (the number of non-public therapeutic entities has been growing steadily since 2000, while the number of public therapeutic entities has been decreasing). In the same year, there were 6900 medical and dental practices providing ambulatory care services financed from public funds (75.7% of these practices were dental practices). The number of dental practices has been increasing since 2000 (from approximately 2800 in 2000 to approximately 5230 in 2009) and the number of medical practices has been falling since 2004 (from approximately 4340 in 2004 to approximately 1680 in 2009). Individual practices prevailed among medical (92%) and dental (98%) practices (Table 5.2).

Table 5.2
Types of medical and dental practices, 2009

Type of practice	Medical practices (%)	Dental practices (%)
Individual	19	66
Individual specialized	73	32
Group	8	2

Source: GUS, 2010b.

Specialist medical consultations accounted for 76% of all specialized ambulatory care consultations; specialist dental consultations made up the remaining 24%. Most specialist medical consultations were surgical (17%), gynaecological–obstetric (14%) and ophthalmological (11%) (GUS, 2010b).

Therapeutic entities provided 93% of all ambulatory care consultations. Both the number of ambulatory care therapeutic entities and consultations taking place there have been growing steadily since 2000 (GUS, 2010b).

5.4.2 Inpatient care

Until 2003, hospitals in Poland were classified into three "reference levels", depending on the types of service offered. These reference levels roughly corresponded to the hospital's founding body: most of the first reference level hospitals were owned by *powiats*, most of the second reference level by voivodeships and most of the third reference level by universities or ministries (see section 4.1.1). Although reference levels are no longer used officially, they are still relevant for contracting for services in gynaecology and obstetrics, intensive care and neonatology, and for determining whether a contract for these services can be signed with the NFZ: only third reference level hospitals are eligible to provide highly specialist services in these areas.

Today, hospitals are classified in several ways: according to their territorial coverage (*gmina*, *powiat*, voivodeship or over-voivodeship), their scope of services (general or specialist), the type of condition or population they serve (psychiatric hospitals, military hospitals, industrial hospitals, resort hospitals) or their founding body. The last classification is the most commonly used. Most hospitals provide health care services in several types of specialization and single-specialty hospitals are rare.

The prevailing model of public hospital management is based on heads of wards, who manage all physicians working in their ward and are responsible for all patients treated therein. They decide on the admission of patients, on the order of surgical procedures, and on the allocation of specialization training posts. Heads of wards are elected for six years in a competitive selection procedure but often remain in this role indefinitely. Replacing this system with the British model of health care consultants[31] was proposed by the PiS-led coalition government (2005–2007) but did not find its way into legislation. However, some (mainly non-public) health care institutions have independently adopted it.

Day care is not well developed in Poland. Contracts for day care surgeries may theoretically be signed by the NFZ but are currently very rare. However, this may change in the future following the introduction (in July 2011) of

[31] Health care consultants are largely independent. They assemble their own teams of assistants (and lead their specialization training) and are responsible for the treatment of patients assigned to them. Several consultant teams may work in a single hospital ward, allowing the patient to choose among competing teams. They are paid according to the number of procedures performed and are evaluated according to strict criteria.

DRGs for certain specialized ambulatory care services. DRGs are meant to shift less serious conditions that do not require hospitalization from inpatient to outpatient care, allowing for the development of one-day outpatient care in Poland.

Information on the accessibility, adequacy and quality of ambulatory and inpatient care in Poland is scarce. Some insight is offered by the 2007 *Eurobarometer* survey (European Commission, 2007): satisfaction with specialized ambulatory and inpatient care was lower than with primary care (see section 7.3.1).

The geographical distribution of ambulatory care providers varies substantially between rural and urban areas and across voivodeships (Table 5.3), as does the distribution of medical practices. For further information on health care units and infrastructure see sections 4.1.1 and 4.1.2.

Table 5.3

Number of inhabitants per ambulatory care therapeutic entities, 2009

Number of persons per therapeutic entity in *urban* areas	**1530–1750**	**1750–1980**	**1980–2520**	**2520–2630**
Voivodeships	Łódzkie Podlaskie Warmińsko-Mazurskie	Lubelskie Lubuskie Małopolskie Opolskie Podkarpackie Śląskie Wielkopolskie Zachodnio-Pomorskie	Dolnośląskie Mazowieckie Świętokrzyskie	Kujawsko-Pomorskie Pomorskie
Number of persons per therapeutic entity in *rural* areas	**2470–3400**	**3400–3730**	**3730–4310**	**4310–4750**
Voivodeships	Lubuskie Łódzkie Śląskie Podkarpackie	Dolnośląskie Lubelskie Małopolskie Mazowieckie Podlaskie	Opolskie Pomorskie Świętokrzyskie Warmińsko-Mazurskie	Kujawsko-Pomorskie Wielkopolskie Zachodnio-Pomorskie

Source: GUS, 2010b.

5.5 Emergency care

The 2006 Law on the National Medical Emergency Services regulates the organization and operation of emergency care services in Poland. Medical emergency services comprise both life-saving health care services performed in non-hospital settings by medical emergency teams and such services in hospital emergency wards.

The national medical emergency system is supervised by the Ministry of Health, while voivodes are responsible for the design, organization, coordination and supervision of emergency medical services in their voivodeships. Since voivodes are accountable to the Ministry of the Interior and Administration, the medical emergency system is also subordinated to this Ministry. Services provided by medical emergency teams and the medical emergency dispatch services are funded from those portions of the state budget that are administered by the voivodes. The regional branches of the NFZ administer these funds by negotiating the provision of services directly with medical emergency teams and dispatchers. Emergency medical services provided in hospital emergency wards, by comparison, are reimbursed separately by the NFZ from its funds, based on the regional medical emergency care plans. These plans are prepared by each voivodeship and should include an assessment of potential health risks; the number and geographical distribution of emergency units; coordination plans for these units; an estimation of costs of services and cooperation plans with other emergency systems, such as the police or fire-fighting service; and the process for emergency notification. Regional emergency plans must be approved by the Ministry of Health. They are analysed based on the demand for emergency services and the median response time. A separate Ministry of Health regulation (2010) sets out the basic framework and information requirements for regional emergency plans as well as the criteria to calculate costs for medical emergency teams.

The emergency care system consists of emergency care hospital departments and medical emergency teams. A basic emergency team consists of a nurse and a medical rescuer; a specialized emergency team must additionally include a medical physician. According to the regional medical emergency care plans, in 2011 there were 1448 medical emergency teams, 416 medical dispatch positions (i.e. jobs in medical dispatch units),[32] 224 emergency care wards and 14 trauma centres in hospital wards. The Polish Medical Air Rescue is supervised by the Ministry of Health and financed from the state budget. According to the 2011

[32] There are no data on the number of medical dispatchers employed in that year.

Budget Law, there were 17 air medical emergency teams operating in Poland in 2011. *Powiat* emergency call centres and voivodeship emergency call centres receive 112 (EU-wide emergency number), 999 (medical emergency), 998 (fire brigade) and 997 (police) calls and redirect them to the relevant dispatcher (medical, fire brigade or police). Medical emergency teams are subsequently sent to the site of emergency (Box 5.1).

Box 5.1
Example of a patient pathway in an emergency care episode

In Poland, a person with acute appendicitis on a Sunday morning would take the following steps:

- the person (or someone else) calls the 999 or 112 emergency number; the call will be answered by the nearest medical dispatcher (999 calls) or the nearest voivodeship or *powiat* emergency call centre (112 calls);
- the medical emergency dispatcher will analyse the case to decide whether an emergency medical team should be dispatched*, and in case the decision is affirmative, a team will be sent to the location of the call;
- once the medical emergency team arrives, it transports the patient to the nearest hospital emergency department, regardless (at least in theory) of whether the hospital is under contract with the NFZ **;
- at the emergency department, the person responsible for triage estimates the urgency of the case;
- after undergoing diagnostic tests, the patient is transported to prepare for surgery – waiting time depends on the level of urgency.

Another possibility is that the person goes directly to the hospital emergency department or contacts a primary care physician, who can refer him/her to a hospital (primary care physicians are obliged to assure access to care between 6 pm and 8 am, on Sundays and during national holidays, by referring patients to outpatient emergency clinics where physicians are on duty (see section 5.3).

* In order to improve the operation of the medical emergency care system, emergency centres often (informally) divide the area of their operation into zones, which determine the dispatch origin of the ambulance and the emergency hospital ward to which the patient is sent.
** In reality, hospitals that are not contracted by the NFZ do not establish emergency care wards.

The national medical emergency care system is supplemented by collaborating emergency systems, the statutes of which include assistance to patients in life-threatening conditions, such as the state fire-fighting service and the water rescue and lifeguard service. These services are free for all persons, regardless of insurance status or any other characteristics. Between 2005 and 2010, the Ministry of Health substantially increased the number of contracted emergency medical teams, thus improving access. As of 2006, voivodes are obliged to monitor median response times of medical emergency

units according to the criteria set out in the respective legislation. In 2010 target median response times were reached in all voivodeships. In 2010, the CMJ was mandated by the Ministry of Health to assess quality of care in hospital emergency wards and publication of the report is currently pending.

Enactment of the Law on National Medical Emergency Services in 2006 and creation of a network of 14 trauma centres in 2009 aimed to integrate various elements of the medical emergency care system and shorten emergency response times. Currently, further efforts are being made in this direction, in particular with the aim of improving the operation of and cooperation between medical dispatchers and voivodeship or *powiat* emergency call centres. To improve provision of air medical emergency services, the government recently purchased a modern helicopter fleet equipped to cover 95% of Poland. Moreover, EU structural funds are being used to modernize and equip hospital emergency wards, increase the number of landing facilities for the Polish Medical Air Rescue, purchase new ambulances, modernize and equip bases for the helicopter fleet of the Polish Medical Air Rescue, develop an emergency notification system and to fund capital and investment equipment for trauma centres (see section 4.1.1).

5.6 Pharmaceutical care

According to the registry of manufacturers and importers compiled by the Chief Pharmaceutical Inspectorate, in September 2011 there were 348 authorized manufacturers and 46 authorized importers in the pharmaceutical market in Poland. Out of 10 125 pharmaceuticals authorized for sale by the URPL,WMiPB, an estimated 42% is produced by Polish manufacturers. Domestic manufacturers produce mainly generic drugs, while the majority of imported drugs are non-generics. Concentration in the pharmaceutical market is not very high – no manufacturer has more than 10% of the market (in terms of value of sales). Permission for parallel imports has so far been granted to 866 pharmaceuticals, that is, approximately 8.5% of the total number of drugs authorized for sale in Poland.

Compared with other European countries, Poland has a large number of pharmaceutical wholesalers in relation to the number of both producers and retail sale units. In September 2011, there were 633 wholesalers (GIF, 2011), most of them private with local or regional outreach. In 2009, 11 989 pharmacies and pharmaceutical outlets operated in Poland, of which 2924 were located in rural areas (GUS, 2010b). On average, there are around 3200 inhabitants per

pharmacy (ranging from 1000 to 5000 depending on the *powiat*), making Poland one of the EU countries with the densest network of pharmacies. Pharmacies are almost entirely under private ownership.

Drugs used for inpatients and prescription drugs in the outpatient sector are reimbursed by the NFZ while the rest are paid fully OOP. Certain patient groups (e.g. those suffering from certain chronic diseases or mental disorders, or rare conditions requiring costly medication) are eligible for modified or no cost-sharing (see also section 3.4). Special reimbursement privileges also apply to certain population groups (e.g. war veterans, honorary blood or organ donors, etc.). Drugs administered during inpatient treatment are free of charge. They are financed by the NFZ through various schemes, including the DRG system, health programmes and standard chemotherapy schemes. The most expensive drugs are sometimes reimbursed through health programmes, which cover only a limited number of patients fulfilling strict criteria. Chemotherapy and drug programmes for rare diseases have been one of the most rapidly growing parts of NFZ drug expenditure in recent years.

According to GUS data, pharmaceuticals were used by 54% of the population in 2004 and 71% in 2009 (GUS, 2010b). Based on the database maintained by the Ministry of Health, consumption is currently estimated at approximately 456 million packs and about 200 million prescriptions filled in 2009, placing Poland among the countries with the highest level of pharmaceutical consumption per capita in Europe. Excess prescribing contributes to the increasing trend in pharmaceutical consumption, which coupled with high prices of imported drugs and restrictions on reimbursement explains high private expenditure on pharmaceuticals in Poland.

Given that Poland has one of the densest networks of pharmacies in Europe, access to pharmacies should be easy (although there may be differences between rural and urban areas). However, actual access to pharmaceuticals, particularly to innovative drugs, may be less easy. The Ministry of Health seeks to ensure access to expensive innovative drugs through implementation of therapeutic programmes. However, according to a recent W.A.I.T. (Waiting to Access Innovative Therapies) analysis (EFPIA, 2010), the number of newly introduced medicinal substances between 2003 and 2007 in the Czech Republic and Slovakia was eight times higher than in Poland. Although the report noted that more new drugs were included in the reimbursement lists in 2007 and 2008, it concluded that the share of innovative drugs in the reimbursement lists is very low. At the same time, the share of private expenditure on drugs is quite significant, implying that access to drugs may be difficult in Poland. Indeed,

a recent CSIOZ survey (2008) confirmed that 8% of respondents could not afford to purchase any of the prescribed drugs and 26% of respondents could not afford to purchase some of prescribed medications (see also section 7.2.1).

Substantial changes to the Polish drug reimbursement system were introduced by the 2011 Law on Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices, including a unified procedure for pharmaceutical reimbursement in the outpatient sector, health programmes and chemotherapy schemes. Reimbursement will be based on the drug's therapeutic application, and applications previously not reimbursed will be evaluated. The 2011 Law caps pharmaceutical expenditure at 17% of the NFZ's total health expenditure. Responsible entities must ensure that the reimbursement limit set by way of an administrative decision is not exceeded (otherwise they have to pay back a certain amount, based on the structure and dynamics of the increase in the reimbursement amount). Those entities also have the option to negotiate an individual risk-sharing agreement with the NFZ, which may be based on the drug's effectiveness, turnover or discounts. To ensure the prompt and regular publication of reimbursement lists, the Ministry of Health will utilize announcements (and not issue regulation). The 2011 Law fully implements Council Directive 89/105/EEC of 21 December 1988 on the transparency of measures regulating the pricing of medicinal products for human use and their inclusion in the scope of national health insurance systems.

5.7 Rehabilitation/intermediate care

Medical rehabilitation has had a long tradition in Poland and is based on the internationally recognized model of rehabilitation developed by Professors Wiktor Dega, Adam Gruca, Kazimiera Milanowska and Marian Weiss. The model is based on four principles: early start, completeness, comprehensiveness and continuity of the rehabilitation process. It was endorsed by the WHO Regional Office for Europe in the 1970s. Rehabilitation care is mainly provided within the health sector and is financed by the NFZ. Rehabilitation care is also provided within the social care sector, in which case it is financed by the social security funds (ZUS and KRUS) and the State Fund for Rehabilitation of Persons with Disabilities (*Państwowy Fundusz Rehabilitacji Osób Niepełnosprawnych* (PFRON)). Rehabilitation can be divided into medical rehabilitation and health resort treatment in health resort hospitals and sanatoria, which offer rehabilitation services based on natural therapeutic resources, such as thermal

water or climate.[33] Both medical rehabilitation and health resort treatment are included in the guaranteed health benefits basket. Treatment in health resort hospitals is usually a continuation of hospital treatment, and patients with less-severe conditions are treated in sanatoria. Stays in health resorts last a maximum of 28 days and cover at least three physiotherapy treatments per day. Health resort treatment is also available in the ambulatory setting and lasts between 6 and 18 days.

A valid referral from a NFZ-contracted physician is required to access rehabilitation care. Consultations in the outpatient or home settings are carried out by physicians specialized in rehabilitation or other related fields, such as orthopaedic surgery, traumatology and rheumatology, depending on the setting and type of care needed. They plan rehabilitation regimens and may issue referrals for physiotherapy or health resort treatment.

The NFZ finances different rehabilitation regimens depending on the setting and the patient's condition and fully or partially reimburses certain rehabilitation treatments, equipment and aids. In 2010, 1.16 million people underwent medical rehabilitation cycles in ambulatory settings, 176 896 in day care and 189 705 in inpatient settings, while 1772 persons used rehabilitation services at home (NFZ, 2011a). Patients staying in sanatoria must cover their travel costs and part of the costs of accommodation and food. Waiting times for health resort hospitals are about 3–4 months and for sanatoria 12–18 months. Patients can monitor their place on the waiting list on the NFZ website. In 2009, there were 266 health resorts in Poland subordinated to the Ministries of Health, National Defence and the Interior and Administration. They had a total of 40 100 beds, out of which 30% were in health resort hospitals and 70% in sanatoria (GUS, 2010b). Their distribution is uneven and is related to the geological and climatic characteristics of their locations. In 2010, 353 091 persons used balneotherapy and other treatments in health resorts financed by the NFZ. The majority of those patients (273 854) were treated in sanatoria (NFZ, 2011a).

Analysis of the National Health Accounts demonstrates that spending (public and private) on rehabilitation is much lower than spending on curative health. In 2008, spending on rehabilitative care accounted for less than 3.5% of individual health care spending (GUS, 2010b). In October 2010, the NFZ introduced JPGs in stationary neurological and cardiac rehabilitation, differentiating the costs for various categories of patients and thus achieving fairer provider reimbursement. The aim of this measure was to improve the quality and accessibility of these types of rehabilitation care.

[33] Poland has a long tradition of balneotherapy, spa treatment and physical medicine.

In 2009, the NFZ contracted with 2439 providers of medical rehabilitation. The geographical distribution of these providers is uneven and causes substantial differences in waiting times (these vary greatly with the function or type of provider) (NFZ, 2011b). A good example of regional disparities in the accessibility of services is in the area of cardiac rehabilitation. In the Opolskie voivodeship, over 75% of all patients with acute coronary conditions or who underwent cardiac surgery were given cardiac rehabilitation in 2008, but this share was lower than 40% in all other voivodeships.[34]

Rehabilitation services for those who are at risk of becoming fully or partially unable to work and who are likely to recover after rehabilitation are financed by ZUS and KRUS. ZUS has financed rehabilitation since 1996 within its programme of preventing disability pensions and it has contracts with around 60 rehabilitation centres per year in order to ensure the availability of such services. In 2009, 73 389 patients benefited from medical rehabilitation services financed by ZUS (ZUS, 2009b). KRUS's programme of rehabilitation covers musculoskeletal and cardiovascular rehabilitation and has been in place since the early 1990s. It covers rehabilitation for approximately 14 000 patients per year (KRUS, 2011).

The PFRON is a targeted fund that finances mainly professional and social rather than medical rehabilitation for people with disabilities and supports their (re)employment. It is financed by earmarked mandatory contributions from employers who have at least 25 full-time employees but fail to achieve the required rate of people with disabilities employed (6% of the total number of employees). In 2009, a total of 65 300 people received PFRON grants to cover stays in rehabilitation centres and sanatoria (GUS, 2010b).

The availability and accessibility of rehabilitation services for persons with disabilities in Poland depend largely on their place of residence, the awareness and willingness of the treating physician and on the perseverance of the patient in seeking care. Efforts are made to improve the availability of rehabilitation services by looking for systemic solutions to existing problems. Standards for medical rehabilitation have yet to be developed. Key requirements for providers are currently defined by regulations on the guaranteed health benefit basket and the ordinances of the President of the NFZ. In 2010, Guidelines for medical rehabilitation were prepared by the national consultant in medical rehabilitation in cooperation with the Polish Rehabilitation Society and the Committee on Rehabilitation, Physical Education and Social Integration from the Polish

[34] Based on the Map of Demand for Cardiac Rehabilitation in voivodeships and *powiats* in 2008 prepared within the National Programme for Prevention and Treatment of Cardiovascular Diseases 2006–2008 (POLKARD).

Academy of Sciences. If these guidelines are accepted by the Ministry of Health, they may serve as the basis for development of standards in rehabilitation care. Evidence on the quality of rehabilitation services in Poland is scarce.

The lack of sufficient financing for infrastructure development and modernization of medical rehabilitation facilities is one of the major problems in the area of rehabilitation. Privatization of health resorts was introduced as a potential solution to this problem in 1998 (when public health resorts were transformed into Commercial Code companies) and was intensified in 2009. However, the exact impact on accessibility, availability and quality of privatized sanatoria has not yet been analysed.

5.8 Long-term care

The proportion of people aged over 65 years old is expected to double by 2035 (GUS, 2010c), signalling a rapid increase in future demand for long-term care. At the same time, because of sociodemographic changes, the role of the family is likely to decrease, putting more pressure on formal long-term care services. According to the authors of the 2010 *Green Book on Long-term Care in Poland*, one of the main disadvantages of long-term care provision is the division of responsibilities and tasks among various bodies (the Ministry of Health, the NFZ, the Ministry of Labour and Social Policy, the ZUS, the KRUS and territorial self-governments) and the lack of cooperation between them. Depending on the definition of long-term care used, estimates on long-term care financing range from 0.1% to 0.7% of GDP, with the top estimate including care supplements from ZUS (accounting for over 50% of long-term care spending) (Augustyn, 2010).

Publicly financed long-term care services are financed and provided both within the health care system and within the social assistance sector. The NFZ covers health care services provided in stationary long-term care settings and nurse home visits. Stationary long-term care facilities include ZOLs and ZPOs. Until the end of 2009, stationary long-term care for the chronically ill was also provided in long-term care hospital wards, but these ceased to exist after hospital long-term care services were removed from the benefit basket in 2009. The system of social assistance in Poland provides both in-kind (shelter, meals, clothing) and cash (permanent, temporary or targeted) benefits. It also organizes both community-based services and stays in either social assistance homes (*dom pomocy społecznej* (DPS)) or day social assistance homes (*dzienny dom pomocy*

społecznej). These services can be free or partially subsidized or be paid for in full by the beneficiary (based on their income and the *gmina*'s eligibility decision). Table 5.4 summarizes the long-term care options within the various sectors.

Table 5.4
Long-term care settings in Poland

Setting	Health care sector	Social assistance sector	Private sector/informal care
Inpatient care	Chronic medical care homes (ZOLs), nursing homes (ZPOs; LTC in hospital wards until end 2009)	Social assistance homes (DPS)	Care homes run by NGOs; private (profit-making) care homes
Home care	LTC nurse, LTC home care team for mechanically ventilated patients, community nurse in liaison with a primary care physician	Community care services, specialist care services (nurse or therapist), material and financial assistance	Informal carers (family, friends, neighbours)
Semi-inpatient care	n/a	Day-care, assistance homes	n/a

Source: Based on Augustyn, 2010.
Note: LTC: Long-term care; n/a: not available.

The number of patients receiving stationary long-term care is substantially higher than that for non-stationary settings. In 2008, approximately 0.9% of the Polish population over the age of 65 received long-term care in a stationary setting, well below the OECD average of 4.2% (OECD, 2010a). Stationary long-term care in Poland is available in ZOLs or ZPOs for the chronically ill and for those who after completing hospital treatment require further inpatient supervision (because of general state of health, disability, lack of independence, need for constant medical supervision, or need for professional nursing or rehabilitation). In practice, there are few differences between ZOLs and ZPOs and the names are derived from the historical founders of these institutions (ZOLs were originally founded by physicians and ZPOs by nurses). Referrals to public ZOLs and ZPOs are issued by their founding bodies (these are usually *powiats*), while the decision to admit a patient to a non-public facility is taken by its director in consultation with a physician. The NFZ finances only the cost of health care services provided in ZOLs and ZPOs (including the cost of medical tests, pharmaceuticals and medical devices), but not food or accommodation. In December 2009, there were 18 778 beds in 284 (mainly non-public) ZOLs and 121 ZPOs, with the ZOLs accounting for the majority of beds (75%) (GUS, 2010b). The ZOLs served 33 043 and the ZPOs 11 310 patients in 2009. Based on a 2009 NIK inspection of a sample of 19 public and 14 non-public ZOLs, all of the sampled ZOLs were overcrowded and did not meet relevant social and living standards (NIK, 2009).

Public DPSs are established and managed by local self-governments (usually *powiats*). Non-public DPSs are established by the Catholic Church, religious and other associations, foundations, physical and legal persons. Public and non-public DPSs must be authorized by the voivode and provided services must meet relevant standards. There are several types of DPS: for seniors, for serious chronic conditions, for chronic mental disorders, for cognitive impairment (for adults and children separately) and for people with physical disabilities. Admission to a public DPS is conditional on the existence of disability and a compromised social situation (limited financial means, no family support); applications forms must be filled out by a physician and a social worker and consent is required from the patient or their legal representative. Stays in a public DPS are partly financed by the residents and partly by the families or *gminas*. In 2009, there were 829 DPSs and 45 DPS branches, out of which 604 were public and 225 were non-public. Since 2007, DPSs have been allowed to provide care to more than one type of resident (e.g. to both seniors and chronically ill persons or to both chronically ill persons and persons with disabilities). *Gminas* may refer patients to non-public DPSs if the capacity of public DPSs has been exceeded. In 2009, non-public DPSs provided care to a total of 13 608 patients (GUS, 2010b).

Day-care assistance (semi-stationary) homes provide care for people with cognitive impairment and mental disorders and for seniors with mild psychophysical conditions. Few such homes offer services for patients with dementia. Care is provided free of charge and includes various therapeutic workshops and classes.

Home care is provided for patients with chronic conditions who require to be mechanically ventilated and patients requiring nursing care who are not covered by any other form of care. Home assistance is also provided for persons in need of help in meeting everyday needs; this is usually delivered by organizations such as the Polish Red Cross. Home or community-based long-term care is financed by the NFZ or local self-governments.

The private profit-making sector plays a minor role in provision of long-term care services. In cases of fully private DPSs, admissions and terms of stay (including range of benefits and fees) are determined by the directors on an individual patient basis. Public DPSs may not offer commercial places to patients. Informal (unpaid) care by family members is by far the largest source of long-term care in Poland (Golinowska, 2010b; see also section 5.9).

To respond to the increasing demand for long-term care services and the shortage in nursing personnel, a new medical profession – the medical caregiver – was introduced in 2007. Medical caregivers provide long-term care services under nursing direction in facilities such as DPSs or in patient homes (see section 4.2). Also in 2007, a group of experts was appointed by the Ministry of Health to develop strategies for the development of geriatric care and improvement of its quality through development of standards. A draft decree on geriatric care standards and their application was submitted for external consultation in mid-2010.A reliable source of long-term care financing is still lacking and in 2008, a team of experts was appointed to work out a proposal for an additional insurance against the risk of dependency. Their report (the so-called *Green Book on Long-term Care*) was published in July 2010 starting an extensive social debate, which will determine whether long-term care is to be funded from the state budget or from an additional insurance (Augustyn, 2010).

5.9 Services for informal carers

In Poland, family has traditionally occupied the dominant role in caring for seniors and persons with disabilities or chronic conditions. This practice is rooted both in the culturally determined strong family ties and the limited possibilities for care outside home. According to a 2007 survey on professional, educational and family activity, more than 80% of households with dependent adults addressed their care needs by enlisting the unpaid services of family members; in the countryside, this percentage was even higher (GUS, 2007a). This evidence is consistent with earlier surveys on the matter (CSIOZ, 2004). In 2005, the co-residence index was 50% for women and 66% for men; while the inactivity rate index for women was 76%. The inactivity rate index is made up of two components: (1) the index for women aged 15–64 and (2) the index for women aged 55–64. These indices were 66% and 97% in Poland, respectively, compared with the EU27 average of 41% and 61%, respectively. These indicators rank Poland very high compared with other EU Member States in terms of family commitment to care functions (Reimat, 2009).

Financial assistance for family caregivers is rather limited. There is no formal system to support family carers, who receive only modest financial benefits for providing care, even if they give up employment to do so. A care benefit of PLN 520 per month may be granted to parents, those who are legally obliged to pay alimony or to a child's adoptive guardian when they resign from

employment to care for a person with disabilities. This benefit was contingent on income until January 2010. In 2008, an average of about 70 000 people per month received care benefits (PLN 401 on average per month) (Augustyn, 2010).

A caregiver who is granted sick leave to care for a family member is entitled to a nursing allowance (*zasiłek opiekuńczy*) of 80% of their income base used for the calculation of social security contributions. This allowance is granted for a maximum of 60 days per calendar year for care provided to a healthy child under 8 years of age or a sick child under 14 years of age, and for a maximum of 14 days per calendar year for care provided to a child over 14 years of age or to another family member. In 2008, 1.2 million sick leaves were granted for care provided to a child and 148 000 for care provided to other family members (ZUS 2009a,c). Under certain conditions specified in the 2004 Law on Social Assistance, social assistance centres can pay old age and disability pension contributions on behalf of caregivers who give up employment to care for family members.

To a certain extent, caregivers may also take advantage of the financial assistance granted to the person to whom they provide care (Błędowski et al, 2006). This assistance may take the form of a monthly care allowance (*zasiłek pielęgnacyjny*) (granted to all persons above 75, children with disabilities and adults with severe disabilities), a monthly care supplement (*dodatek pielęgnacyjny*) (granted to persons aged over 75 and those who are younger but cannot function independently) or tax breaks for expenses related to nursing care or rehabilitation (granted to people with disabilities or those with dependents with disabilities). The inadequacy of the level of financial support available for family carers is apparent and well known, but the scarcity of financial resources limits improvements. In fact, a recent initiative of the Ministry of Labour and Social Policy to increase the amount of care allowance to the level of the care supplement has been shelved.

Family caregivers also receive support from their communities in the form of respite care services. These services include housework help, personal care, meal services and other home care services, such as transport, laundry or shopping. The services are organized by *gminas* and financed from their budgets. Temporary help from volunteers may be available in larger urban communities (e.g. in the form of "granny-sitting"), while in rural areas neighbours may take on these duties. Informal care outside the family (particularly in large cities) also includes home care by undocumented household help (often immigrants from Belarus or Ukraine) (Golinowska, 2010b). Families with higher incomes may also employ private nurses, including from the recently established nursing

agencies. Psychological assistance and legal counselling for carers is offered by social welfare centres, *powiat* family help centres or NGOs. Support is additionally provided by self-help groups, which are usually organized around various conditions. For example, support groups for persons providing care for people with Alzheimer's disease exist in most large cities and organize training for family carers. Such training may also be organized by *gminas* and various associations (Błędowski et al, 2006).

5.10 Palliative care

Hospice and palliative care in Poland started developing in the early 1980s and has since seen substantial organizational advancements. Palliative care societies, initially informal, have been formally registered since 1981. Institutional hospices and home hospice care developed in all larger cities in Poland, and in the 1990s palliative care was formally included in the health care system (among guaranteed services). A national health care consultant for palliative care was appointed in 1994, followed by regional health care consultants in 1999. A National Programme for the Development of Palliative and Hospice Care in Poland was adopted in 1998, with the aim of improving access to palliative care across the country, assuring continuity of care and quality. One year later, in 1999, postgraduate specialization in palliative medicine was introduced for physicians and nurses.

Palliative and hospice care is defined as a separate part of long-term care and is also contracted separately by the NFZ. To access palliative care, patients need a referral from a physician contracted by the NFZ and must consent to it in writing. Length of stay in palliative and hospice care units is not limited and the 2009 regulation of the Ministry of Health (one of the 13 regulations on the benefit baskets) lists all diseases that qualify patients for palliative care, without assigning quotas for particular diseases. Apart from health insurance contributions, palliative and hospice care may also be financed by local self-governments (some funding may come from the NPZs) and NGOs (foundations, associations and churches). The latter also provide other forms of support to patients and their families, such as legal advice, psychological and financial assistance (however, the amount of funding provided from these sources is not known) (Ciałkowska-Rysz, 2009).

Inpatient care is provided in hospices and in palliative hospital wards (there should be one inpatient hospice or one palliative care unit per two to three *powiats*). Home care is provided by home care teams for adults and children.

These patients are entitled to physician consultations (at least twice per month), nurse visits (at least twice per week) and visits by other members of the home care team, as determined by the case physician (there should be one adult home hospice team per *powiat* and one or two child home hospice teams per voivodeship) (Ciałkowska-Rysz, 2009). Ambulatory palliative care is provided in outpatient palliative care clinics, which exist alongside inpatient or home care units or within oncology hospitals. Patients may access them twice per week. Palliative health care teams are multidisciplinary and trained in terminal care. Such teams can comprise palliative care physicians, specialist nurses, physiotherapists and psychologists. They may also be supported by volunteers, social workers and clergymen. According to the 2009 regulation of the Ministry of Health delineating the guaranteed benefits in the area of palliative care, there should be (an equivalent of) one full-time palliative care physician per 10 beds in stationary care settings (hospices and palliative hospital wards) and (an equivalent of) one full-time physician per 30 adult patients (or 20 children) in palliative home care.

Hospital support teams providing care for terminally ill patients in non-palliative hospital wards and palliative day-care units are types of palliative and hospice care that are not financed by the NFZ. Hospital support teams assist medical personnel in pain relief and addressing other symptoms and provide medical advice and psychological support to the patients and their families. While in 2006 there were only two such teams in Poland – in Bydgoszcz and in Warsaw – there was no such team in mid-2011. Palliative day care is usually organized by religious organizations and associations and day-care units are often situated within hospices or nursing centres to complement stationary and home care (e.g. by providing psychological support or spiritual counselling). In mid-2011, there were only 10 palliative day-care teams in Poland (CSIOZ, 2011).

The network of palliative care units is well developed and the range of available services is broad. In 2006, the International Observatory on End of Life placed Poland at fifth place in Europe in terms of the development of palliative care (Wright et al., 2006). However, the distribution of palliative care provision is uneven, with 100 out of 379 *powiats* without any form of palliative care in 2007 (Buss & Lichodziejewska-Niemierko, 2008). The most developed form of care is palliative home care for adults, since the establishment of a palliative home care unit does not require substantial financial resources. As a result, the number of these units has been growing steadily (Ciałkowska-Rysz, 2009). In 2010, there were 277 home teams for adults and 41 home teams for children. In the same year, there were 1056 beds in hospices and 1165 beds in

palliative hospital wards. Out of a total of 66 hospices in 2010, 17 were public and 49 non-public (CSIOZ, 2011). Hospices rely fully on voluntary service (in 2005, 45 out of 113 non-public hospices relied solely on voluntary work, but the number of such hospices has been decreasing), on paid work (if they have contracts with the NFZ for provision of guaranteed services) or on a mix of the two (Swietlik & Doboszynska, 2009). In 2010, there were 273 outpatient palliative care clinics (CSIOZ, 2011). Other forms of palliative or hospice care (hospital support teams and day-care units) were very scarce, since they are not financed by the NFZ.

According to the respective professional chambers, there are currently 214 registered physicians and 147 registered nurses specializing in palliative care, numbers that are far below those estimated as necessary (De Walden-Gałuszko, 2007). A 2010 study on paediatric palliative home care found that children's hospices met, on average, 81% of the minimum standards of care defined by the researchers, mainly because of a lack of specialized personnel (Dangel, 2008). Another problem is insufficient financing, particularly for stationary palliative care. In mid-2008, the amount of financing for palliative and hospice care was raised, allowing the regional NFZ branches to raise the amounts (per patient per day) reimbursed.

5.11 Mental health care

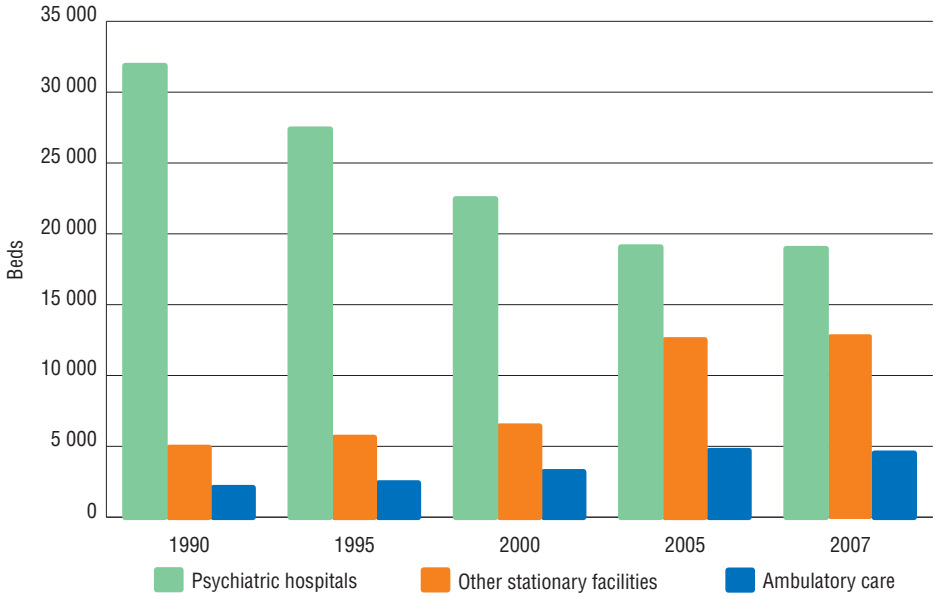
Publicly financed psychiatric care and addiction treatment are directed at persons with mental disorders and addictions and their families. Depending on the need and condition of the patient, mental care may be provided in outpatient mental health clinics, by home or community care teams, in day-care psychiatric wards or in inpatient settings (psychiatric hospitals, psychiatric care wards in general hospitals, psychiatric ZOLs and ZPOs). Some services are provided in primary care (mainly to patients with non-psychotic disorders) and social assistance (in DPSs, hostels, sheltered housing, support centres or self-help clubs) settings. Mental care services within the social assistance and health care sectors are poorly integrated. Addiction treatment is also provided in ambulatory addiction clinics (prevention, treatment and rehabilitation clinics), in day-care centres or wards for addiction treatment, and inpatient addiction wards in general hospitals, addiction treatment centres and rehabilitation centres. Support may also be obtained in MONAR establishments[35] and within the social assistance sector.

[35] MONAR is a Polish NGO that was established formally as an association in 1981. It provides support to drug addicts, the homeless, those with HIV or AIDs and other groups in need of help.

Relatives are not legally obligated to care for persons with mental disorders. However, persons living in poverty with diminished capacity (as confirmed by a court verdict) may demand maintenance money from their immediate family. The number of beds in psychiatric hospitals has been falling continuously since 1990, while at the same time, the number of beds in other types of stationary facilities and in ambulatory care has been increasing, bringing mental health care closer to the patient (Fig. 5.5). Although there is a general shift from institutionalized care towards community-based care (Fig. 5.6), institutionalized care is still the dominant form of mental care in Poland.

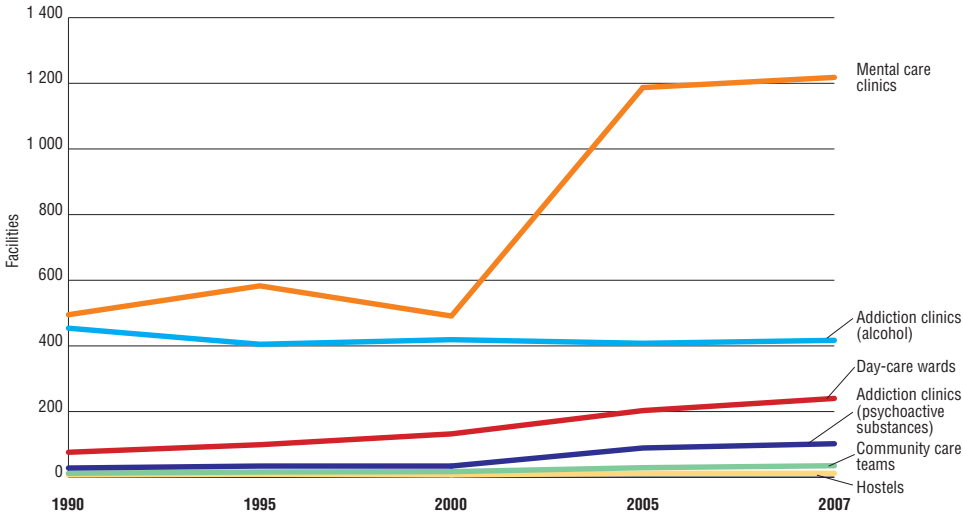
Fig. 5.5

Number of beds in ambulatory and stationary mental care settings (excluding addiction treatment), 1990–2007



Source: Council of Ministers, 2011.

Fig. 5.6
Number of community care facilities, 1990–2007 (selected years)



Source: Council of Ministers, 2011.

Persons with mental disorders are usually treated in mental care clinics, which have doubled in number between 2000 and 2007 (Fig. 5.6). However, access to this type of care varies across the country. In 2007, mental care clinics provided 4.9 million consultations (an increase of 110% compared with 1990), alcohol addiction clinics provided 1.3 million consultations (an increase of 62%) and clinics treating addictions to psychoactive substances provided 232 000 consultations (nearly 10 times more than in 1990) (Council of Ministers, 2011). In the same year, community care teams provided care to 5192 patients, compared with 1206 patients in 1990. However, care provided by community care teams and hostels is still marginal compared with other types of care – under 1% of patients received such care in 2007.

Persons with mental disorders who have committed a crime can be placed in national or regional centres for forensic psychiatry. War veterans experiencing health problems after service abroad, and their families, have free access to psychological care. Veterans also have the right to stay in the House of Veterans (functioning as a ZOL). Stays are not free of charge but may be subsidized from the state budget. Foreigners with a refugee status who suffer from mental disorders can stay in sheltered housing.

In 2007, there were shortages in all categories of mental care professionals, most pronounced for social workers and occupational therapists (Table 5.5). The accessibility of mental care services is further obstructed by the still low number of community care teams and other types of community-based care. The number of psychiatric hospital beds per 1000 inhabitants (0.6) is relatively low compared with other EU Member States (see section 4.1.2). Moreover, since the regional distribution of facilities is uneven, patients in certain regions may find it harder to access mental care. In 2009, psychiatric beds were concentrated in the Mazowieckie (3000), Śląskie (2400), Wielkopolskie and Lubelskie voivodeships (1500 each) (GUS, 2010b). Community-based care is also unevenly distributed and is mainly available in large cities.

Table 5.5

Targets of employment for mental care workers, 2007

Type of worker	Targeted No. workers per 100 000 population	Targeted total No. workers	Actual employment compared with target (%)
Psychiatrists	10	4 000	68
Psychiatrists for children and adolescents	1	400	52
Clinical psychologists	9.5	3 800	37
Social workers	10	4 000	8
Nurses	35	14 000	71
Occupational therapists (*terapeuci zajęciowi*)	8	3 200	18
Certified psychotherapists	2	800	63
Certified specialists and instructors in addiction therapy	5	2 000	70

Source: Council of Ministers, 2011.

A crucial amendment to the 1994 Law on Mental Health was made in 2008 to allow for the implementation the National Mental Health Programme. The Programme was commenced in 2011 and will run until 2015. Its key goals are to promote mental health and prevent mental disorders; to ensure comprehensive, easily accessible care, allowing patients to maintain their family and social life; to improve social integration of persons with mental disorders; and to promote the development of research and information systems in the area of mental care. It is hoped that the programme will aid the shift from institutionalized to community-based mental care, allowing patients to remain at home during both remissions and exacerbations of their illness. For the same purpose, services by community therapists were introduced to the benefit basket in 2009. Community therapists can work in all mental health care settings and their training is shorter and less expensive than that of clinical staff.

5.12 Dental care

Dental services available to the insured population are listed in the 2004 Law on Health Care Services Financed from Public Sources and the 2009 regulation of the Minister of Health delineating guaranteed dental benefits. These services can be accessed free of charge in any dental care institution contracted by the NFZ and include general dental care for children and adults, oral surgery and periodontics, orthodontic care for children under 18, dental prostheses, emergency dental care and preventive dental services for children and youths under 19. Some services, such as check ups, tooth radiography, removal of dental plaque and dental prostheses are subject to frequency limitations. Reimbursement for endodontic treatment depends on the type of tooth and the number of canals. The Law also lists dental materials that are covered. Costs of dental treatments or materials that are not included in the list of guaranteed benefits (the so-called non-standard items) have to be paid for OOP. Symptomatic patients must be treated immediately.

In 2009, there were 22 885 dental practices in Poland. The majority were individual practices (21 805 (95%)). General individual practices constituted almost 60% of all practices (Table 5.6). Only 5227 dental practices had contracts with the NFZ in 2009. Therefore, dental care provision is largely private. However, the number of dental practices providing services financed from public funds has been growing in recent years (Fig. 5.7). In mid-2011, there were 4628 non-public and 546 public dental clinics registered in Poland (CSIOZ, 2011).

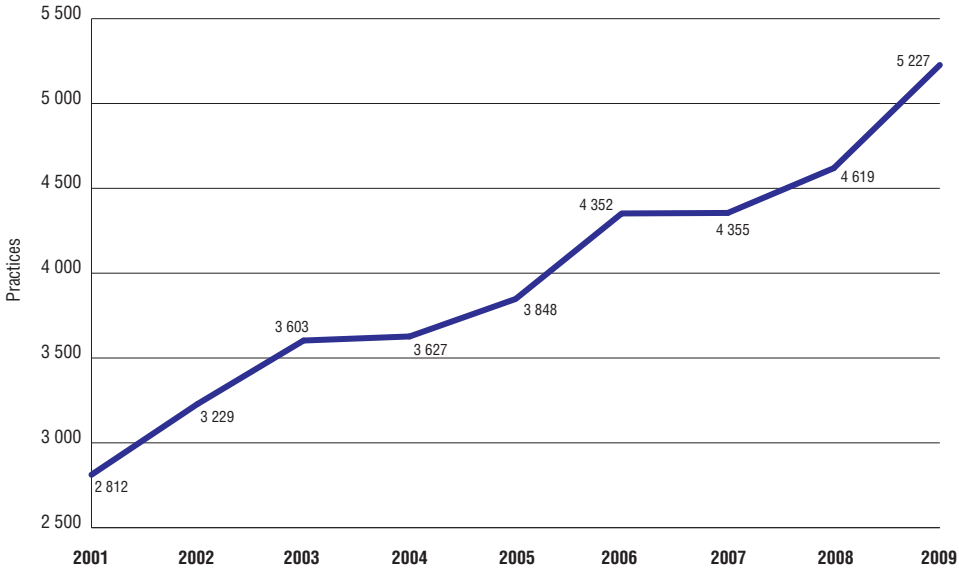
Table 5.6

Types of dental practice in Poland, 2009

Type of practice	No. of dental practices (% of total)[a]	No. of dental practices with NFZ contracts (% of practice type)[b]
General individual	13 550 (60.5%)	3 442 (25.4%)
Specialized individual	8 255 (36.9%)	1 655 (20.0%)
Group	583 (2.6%)	130 (22.3%)
Practice provided at place of call[c]	497	0
Total	**22 388 (excluding practice provided at place of call)**	**5 227 (excluding practice provided at place of call)**

Sources: [a]CSIOZ, 2010 (p. 26); [b]GUS, 2010b (p. 103).
Note: [c]Dental services may not be performed exclusively at a place of call, which means that dentists who perform such services must also practise in an individual or group practice or provide such services within an employment contract with a medical entity. NFZ does not sign contracts for provision of services at the place of call.

Fig. 5.7
Dental practices providing services financed from public funds, 2001–2009



Source: GUS, 2010b.

Dental health care in Poland can be divided into primary dental care, provided mainly by dental practitioners with no specialization, and secondary dental care, provided by specialists (see also section 4.2). Tertiary dental care is provided at wards of maxillofacial surgery (located mainly in public hospitals). In mid-2011, there were 150 maxillofacial surgery wards (CSIOZ, 2011). Some public and non-public dental care entities provide overnight services as well as care during public holidays, including emergency care. However, their availability is very limited within the system of public financing (only 41 NFZ contracts were concluded in 2010 overall). Certain preventive dental care services for schoolchildren are financed by the NFZ as part of the guaranteed health care benefits or special programmes (such as fluoridation or prevention of malocclusion and congenital malformations). There are no centrally coordinated preventive dental care programmes.

Fees for dental services in the private sector are not regulated and are freely set between dentists and their patients. Guaranteed dental services listed in the 2009 Regulation are provided free of charge as long as the provider has a contract with the NFZ. Providers are then reimbursed by the NFZ according to agreed fee schedules. Fees for dental services used by the NFZ

for reimbursement are determined every year. The President of the NFZ, in consultation with the AOTM, determines the point value assigned to each dental procedure. Stakeholders, such as the Chamber of Physicians and Dentists, may submit their opinions. Unit prices for these points are then set by regional NFZ branches. How much is actually paid ultimately depends on the bids submitted to the NFZ by service providers – this means that different providers may receive different remuneration, even within the same voivodeship. Contracts with the NFZ are awarded on the basis of tenders organized by the 16 regional branches of the NFZ, in which both price and non-price factors are taken into account. The NFZ finances dental care in the same way as general health care, that is, from insurance contributions. The amount of available financing is set annually in the NFZ financial plan and usually accounts for 3–4% of the total cost of all reimbursed health care benefits. Specialist dental care and dental care programmes may also be financed from the state or local budgets.

Even though dental coverage is comprehensive, access to care may be compromised given the low number of contracted dental practices. This is particularly true during public holidays and outside regular office hours. Because of financial constraints, the most advanced dental procedures (such as prosthetic crowns and bridges) and materials (such as titanium implants or porcelain crowns) are only available in the private sector. Limited public financing also results in lower quality of reimbursed services (e.g. use of the cheapest reimbursed materials, shortened consultation times) and may encourage dishonest practices (e.g. reclaiming reimbursement for services of higher value than those actually provided) (Terka, 2008).

Quality assessment for dental care is difficult in Poland since there are no regulations specifying which methods should be used for particular dental procedures. The only related document – *Standards of Medical Services, Dentistry, Materials for Providers and Payers* – was published in 1999 by the Ministry of Health but is not used by the NFZ any longer. Procedural standards for particular types of dental care are defined by some scientific organizations, such as the Polish Society of Endodontics, but general guidelines for dental procedures are still lacking. The Chamber of Physicians and Dentists monitors the validity of the right to practise, but the provision of dental care services is not routinely monitored. Controls usually result from patient complaints to a professional liability officer or medical court. The provision of services refunded by the NFZ is routinely controlled by the Fund but only on an administrative level.

According to a 2007 *Eurobarometer* survey on health and long-term care (European Commission, 2007), 37% of Polish respondents thought that the quality of dental care was bad (25% thought that it was very bad); 41% of respondents judged it as fairly good and only 9% as very good (see also section 7.3.1). Moreover, 24% of respondents thought that it was difficult to access dental care, as opposed to 71% who found it easy; 28% of respondents said dental care was not affordable, whereas 56% thought otherwise. Several indicators reveal that provision of dental care is not adequate in Poland: there is a low number of dentists per 1000 inhabitants compared with western Europe (see section 4.2.1), a low number of children with zero decayed, missing and filled teeth and high numbers of seniors without teeth (Jodkowska et al., 2008; Jodkowska, Wierzbicka & Szatko, 2009). Moreover, the stability of the latter two indicators in time suggests that preventive measures implemented in the last decade have not been very effective.

5.13 Complementary and alternative medicine

The role of complementary and alternative medicine (CAM) was marginal during Communist times, but since the introduction of the free market economy in 1989, there has been a rapid increase in the number of CAM practitioners. According to some estimates, there were more than 70 000 CAM practitioners in 2004 (i.e. over half the number of medical physicians at that time) (Sterkowicz, 2004). In 2002, the Council for Unconventional Therapies was reactivated and tasked with developing guidelines for the regulation of the CAM market. However, the Council was heavily criticized in the academic community and was ultimately dissolved in 2008.

The following CAM professions are formally recognized in the labour market in Poland: acupuncturist, biological energy therapist, biological massage practitioner, chiropractor, homoeopathist, hipotherapist (horse riding), canine therapist, music therapist, naturopathist, osteopathist, and reflexologist. However, these professions are not recognized as medical professions. There are no regulations or any other mechanisms controlling CAM practice and it is unlikely to be regulated in the near future. The only CAM therapy that can be reimbursed by the NFZ is acupuncture for chronic pain treatment. It is accessible only with a referral from a physician contracted by the NFZ. However, the acupuncturist profession is not well regulated and it is unclear who may exercise it or under what conditions. Acupuncture is not taught in medical schools nor is it recognized as a medical profession. The Polish

Society of Acupuncture provides training and issues diplomas in acupuncture to physicians already licensed by traditional medical schools. Currently, 1112 physicians accredited by this Society deliver over 2 million acupuncture treatments in Poland annually (Garnuszewski, 2011).

5.14 Health care for specific populations

The 2004 Law on Health Care Services Financed from Public Sources includes a special entitlement to health care benefits for certain population groups in Poland. These groups include voluntary blood and organ donors, soldiers with disabilities, war invalids and their dependent spouses, widows/widowers of fallen soldiers and deceased war invalids, combatants and persons subjected to repression during war and in the post-war period. Additional entitlements are also granted to pregnant women and children. Other legal provisions ensure free access to certain health care services to other population groups independent from insurance status. These services cover treatment, rehabilitation and reintegration for persons with alcohol or substance addictions, health care benefits for persons with mental disorders and services aimed at combating infectious diseases.

The Ministry of National Defence, the Ministry of Interior and Administration, the Ministry of Justice and the Internal Security Agency used to have their own health care establishments providing health care services to their active and retired employees and their families. In 1999, a separate sickness fund was created for all uniformed workers, but soon after was transformed into one of the 17 health insurance funds that everybody could join. At present, all people insured in the NFZ may access any health care institution that signed contracts for services with the Fund, including those health care institutions that were previously reserved for uniformed workers.

All prisoners have the right to free health services, medicines and sanitary articles. Health services for prisoners are provided in facilities established within the organizational structures of the penal institutions by the Ministry of Justice and are financed from this Ministry's budget. The Health Care Office in the Central Board of the Prison Service is in charge of organizing services, while one head physician supervises and coordinates operations in each of the 15 inspectorates of the Prison Service. There are 157 outpatient clinics in penitentiary institutions across the country. The Prison Health Service also

has 13 prison hospitals (with 37 specialized wards) throughout the 15 regional inspectorates. Highly specialized procedures (such as neurosurgery or thoracic surgery) are performed in civilian health care facilities.

Persons with refugee status who are subject to mandatory health insurance or are voluntarily insured with the NFZ are entitled to the same health care benefits as Polish citizens insured by the NFZ. Persons seeking refugee status are also entitled to the same health care benefits (except for health resort treatment and rehabilitation), but these benefits are granted on the basis of agreements between health care providers and the President of the Office for Repatriation and Foreigners and are usually financed from funds available to this office.

6. Principal health reforms

This chapter summarizes reforms and policy initiatives that took place between 2005 and 2010[36] and outlines current policy proposals and ongoing debates. While the majority of the reforms described here were initiated by the government or the Ministry of Health, some reforms were induced by spontaneous, bottom-up initiatives. The impact of reforms on health and health service provision is not continuously monitored and is, therefore, not always known.

6.1 Analysis of recent reforms

Reform agenda from 2005 to 2007

Shifts in the composition of the government in 2005 and 2007 marked changes in health policy priorities and there was little continuity in reform efforts. In 2006, the new Minister of Health presented an assessment of the Polish health care system and a plan of action to the parliament (Religa, 2006). The plan did not propose a systemic overhaul but rather specific changes to the existing structure and financing of the health care system. These included the introduction of a positive basket of guaranteed services (based on evaluation of medical effectiveness); state funding for most medical emergency services; the improvement of the geographical distribution of hospitals based on a hospital network; the introduction of VHI; the introduction of nursing insurance to ensure nursing care for people who are unable to live independently because of illness, injury or old age; the introduction of an obligatory third party liability insurance to cover the costs of treatment for victims of road accidents; the amelioration of the functioning of the mandatory health insurance system (e.g. introduction of central monitoring of waiting lists or improvement of the

[36] For a discussion of the earlier reforms see Kuszewski & Gericke (2005).

allocation of funds between regional NFZ branches); the creation of a health information system, which would include the piloted Medical Services Register (*Rejestr Usług Medycznych*); the inclusion of sickness insurance in the health insurance system to increase financing; and the definition of powers and competencies of the public authorities, legal forms for health care providers and relationships between all the actors in the system as well as patient rights to improve effectiveness of the health care system.

Reform agenda from 2007 to 2011

In early 2008, the government elected in late 2007 initiated consultations (the so-called "White Summit") to discuss reform priorities with stakeholders, including representatives of the trade unions, territorial self-governments and patient groups. The final list of priorities was not approved by the largest trade unions and the initiative failed. At the end of the year, the Ministry of Health published a list of its legislative priorities (including as many as 16 laws and 41 decrees). One of the key proposals was to give more autonomy to SPZOZs and transform them into companies governed by the Commercial Code (the underlying goal was to improve the financial situations of hospitals); other proposals included the introduction of complementary VHI, strengthening of patient rights and the establishment of the Office of Patient Rights Ombudsman. It is worth noting that the National Report on Social Protection and Social Inclusion 2008–2010, developed in 2008 by the PO-led government, contained all priorities proposed in 2006 by the former government.

6.1.1 Reforms and reform initiatives 2005–2011

Table 6.1 summarizes all major reforms and policy initiatives between 2005 and 2011, sorted by major policy areas. All policies are discussed in more detail below.

Health care information system

The idea of a Medical Services Register was conceived in the early 1990s by a number of expert groups as an efficient tool to collect and aggregate information on health care provision. It was initially tested as a pilot study in Czarnkowo in 1994 and subsequently implemented in one of the Silesian sickness funds (Sienkiewicz, 2002). Because the results were very encouraging, a countrywide implementation of the Register was recommended and found its way to the amendment of the 1991 Law on Health Care Units passed in 1997. Attempts to advance the implementation of the Medical Services Register between 2001 and 2007 failed. The current government (elected in 2007) included the Medical Services Register in its legal proposal on an information system in health care.

Table 6.1
Major reforms and policy initiatives, 2005–2011

Year	Reform / policy initiative	Status
Health care information system		
2001–2007	Initiatives to implement Medical Services Register	Failed
2011	Law on the Information System in Health Care	Implementation phase
Improving access to health care		
2005	Executive regulation on waiting lists	Implemented
2006	Law on National Medical Emergency Services	Implemented
2009	Executive regulations (13) on guaranteed benefit baskets	Implemented
2011	Law on Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices	Implementation phase
Improving organization and financing in the hospital sector		
2006, 2007	Draft Law on Hospital Network	Failed
2008	Draft Law Proposing Compulsory Commercialization of Hospitals	Failed
2009	Plan B for hospital commercialization	Implemented (limited success)
2011	Law on Therapeutic Activity	Implementation phase
Fighting corruption in health care		
2005	Prolongation of the anticorruption strategy for 2005–2009	Implemented (partial success)
2001–2008	Anticorruption initiatives within Stefan Batory Anticorruption Programme	Implemented (partial success)
Strengthening policy expertise		
2005	Establishment of AOTM	Implemented
2008	Establishment of NIZP-PZH	Implemented
Strengthening patient rights		
2004	Establishment of the Office of Patient Rights and Patient Education	Implemented
2009	Law on Patient Rights and Patient Rights Ombudsman	Implemented
Improving health care funding		
2008, 2011	Draft laws on VHI	Failed
Improving reimbursement of providers by NFZ		
2008	Introduction of DRGs in hospital care	Implemented
2010	Introduction of DRGs in stationary neurological care and cardiac rehabilitation	Implemented
2011	Introduction of DRGs in certain specialized ambulatory care	Implemented
Quality of care		
2008	Law on Accreditation in Health Care	Implemented
Addressing shortage and outward migration of health care professionals		
2007	Introduction of the profession of medical caregiver	Implemented
Since 2006	Increases in salaries of doctors and medical doctors undergoing residency training and increases in admission limits	Implemented
2008	Amendment of the regulation on specialization of doctors and dentists	Implemented
2011	Amendment of the Law on the Professions of Doctor and Dentist	Implemented
Mental health care		
2008	Amendment of the 1994 Mental Health Law allowing for implementation of the National Mental Health Programme 2011–2015	Implemented
2009	Inclusion of community therapist in the guaranteed benefit basket	Implemented

According to the Law on the Information System in Health Care, which was passed in 2011, a Register of medical entities will be created, comprising all entities involved in therapeutic activities (as defined in the 2011 Law on Therapeutic Activity). The Law also introduced the possibility of using many innovative solutions, such as making appointments online and online monitoring of queues to doctors, and it allowed for a more efficient detection of counterfeit prescriptions and medical records. Patients will have access to information on completed and planned health services and it will be possible to electronically exchange patient data for the purposes of diagnostics, issuing e-prescriptions or e-referrals. The Law will come into force on 1 January, 2012.

Improving access to health care

The obligation to maintain waiting lists was imposed on all hospitals and outpatient institutions providing specialist care by the 2004 Law on Health Care Services Financed from Public Sources, and the medical criteria that had to be followed by service providers while putting patients on waiting lists were defined in a separate regulation of the Ministry of Health one year later. Given the nearly general consensus on the need for waiting lists, there were no major obstacles in the reform implementation. The previous differentiation between two categories of patients – those in "urgent" need of care to be treated immediately and those in a "stable" condition to be placed on a waiting list – was maintained. The scope of health needs and their urgency were to be the key determinants for placing a patient on a waiting list, and waiting should not lead to deterioration in a patient's health. Other factors, such as quality of life with disease as well as social and financial situation of the patient, may in the future be added to the criteria for prioritizing patients. Waiting lists are supervised by special teams set up for that purpose in most institutions, with the exception of lists for particularly specialized procedures such as transplantation surgery, which are supervised by the Ministry of Health.

On 25 June, 2009 a law on amending the Law on Health Care Services Financed from Public Sources introduced the concept of a positive health benefit basket into the Polish health care system. The main purpose of the Law was to establish detailed lists of health care services guaranteed within the public system, which would serve as a source of information for both patients and providers, and to set the criteria for inclusion of services into these lists. The Ministry of Health, supported by the AOTM (see section 2.7.2), was tasked with preparing the lists and in late-2009, as many as 13 executive regulations comprising positive lists of health benefits financed from public sources

(see section 3.3.1) were published. Most of the regulations were amended shortly after their release and it became obvious that the actual content of the basket was not determined by needs, clinical factors or cost-effectiveness, but rather in the process of purchaser–provider negotiations of contracts.[37]

Access to pharmaceuticals in Poland is relatively limited, mainly because of the low level of public reimbursement. Additionally, the availability of innovative drugs among those reimbursed is not particularly high. Significant changes to the Polish drug reimbursement system were introduced by the 2011 Law on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices, including a unified procedure for pharmaceutical reimbursement in the outpatient sector, health programmes and chemotherapy schemes (see section 5.6).

Improving organization and financing in the hospital sector

The problem of hospital bed composition – surplus of acute care beds and a deficit in long-term care beds – has been raised many times in the course of health care reforms. The 2006 draft law on the hospital network aimed to improve geographical distribution of hospitals, improve hospital bed composition and reduce the number of small hospitals. A hospital's inclusion in the hospital network was to be predicated on its epidemiological profile, health needs of the population and the size and composition of hospital resources. Inclusion in the hospital network would, in turn, guarantee a contract with the NFZ; non-contracted hospitals would be deprived of NFZ financing and would most likely be closed down. Following a change of government after the 2007 parliamentary election, the concept of the hospital network was abandoned. It has been brought up again since but has again been rejected at the parliament level by the political opposition.

Poor financial situation was another problem plaguing the Polish hospital sector. It resulted from lack of SPZOZs' responsibility for their debts (which was confined to their owners, i.e. usually territorial self-governments) and their poor financial management. To improve hospital finances, the new government (elected in 2007) proposed (in 2008) obligatory transformation of all SPZOZs into companies governed by the Commercial Code companies (limited-liability or joint-stock companies). The president vetoed the proposal and decision on the transformation of hospitals was left to the discretion of territorial self-governments. After the notion of compulsory transformation failed, another plan, titled "Save Polish Hospitals" (the so-called plan B) was announced

[37] If the NFZ decides not to pay for a certain service, it is not included in the contract and is, therefore, not available to patients.

in April 2009, offering state assistance to territorial self-governments that decided to transform hospitals into commercial companies, which would be responsible for their finances. The success of plan B was limited and territorial self-governments adopted it rather reluctantly. According to data from the second half of 2010, only 212 hospitals were transformed in 2010 and 17 in 2009 (Waszkielewicz, 2010).

The 2011 Law on Therapeutic Activity transfers the responsibility to cover negative financial results of hospitals to territorial self-governments (within three months of having approved the financial plan) or else transform them into Commercial Code companies or budgetary units (within 12 months). However, the Law does not specify any new financial sources from which the self-governments could cover the financial losses (sources available under plan B have been exhausted), making commercialization a more compelling case. Expert opinions on the Law differ substantially: some see it as outright privatization and some claim that the transformed entities will remain public, since they will be still owned by local self-governments (Kowalska, 2010). The transformation of the legal status is seen as a useful tool for improving financial management of SPZOZs. The Law requires further implementing legislation and its impact on the health system remains to be seen.

Fighting corruption in health care

The publication of Transparency International's 2004 Corruption Perception Index, ranking Poland at position 67 (among 145 countries analysed), gave the government a vital impetus for tackling the long-standing problem of corruption. Under-the-table payments have had a long tradition in the Polish health care sector (see section 3.4.3), giving patients better or faster care (or were offered to underpaid health care professionals as signs of gratitude for obtained care). Corruption was also linked to distribution of medical equipment and pharmaceuticals as well as prescriptions and included attempts by representatives of medical goods manufacturers to encourage/entice providers – mostly physicians – to prescribe and use indicated brands. Following the publication of the Corruption Perceptions Index, the Programme to Combat Corruption – Anticorruption Strategy, originally adopted in 2002 by the Ministry of the Interior, was prolonged in January 2005 (for the next four years). A part of it was specifically devoted to health care. At the end of 2006, the Ministry of Health established the Committee for the Elimination of Fraud and Corruption in Health Care, with the task of identifying areas of fraud and corruption in the health care sector. Highly publicized measures

undertaken within the Anticorruption Strategy[38] had both beneficial and detrimental results, damaging trust between patients and doctors (see also section 3.4.3).

An example of a bottom-up anticorruption initiative was the Stefan Batory Anti-Corruption Programme, which was established in 2000 (Stefan Batory Foundation, 2011). Between 2001 and 2008, the Programme collaborated with a Medical Task Force – a group of individuals committed to fighting corruption within the health sector. The initiative has been shown to have succeeded in reducing the amount of informal payments (Golinowska, 2010a). However, despite its success, the Programme has not had a significant influence on the legislative process.

Strengthening policy expertise

New technologies used to be approved with little or no consideration of their effectiveness or cost. In 2005, the AOTM was established to provide the Ministry of Health with recommendations in order to ensure an evidence-based purchasing process and pricing of services and drugs (see section 2.7.2). An important role in the decision to set up the Agency was the European Transparency Directive, which recommended that decisions about pricing of medicines be made in a transparent way (European Council, 1989).

To address the lack of expertise felt throughout the reform process, in 2008, the National Institute of Hygiene was transformed into the National Institute of Public Health (NIZP-PZH) to provide research expertise in the area of public health. The Institute has had a long tradition of research and teaching activities and has for years focused on issues related to the prevention of infectious diseases and key non-infectious diseases, monitoring population's health, improvement of hygiene and sanitary conditions and safety of the natural environment. Since 2008 the NIZP-PZH has participated in the creation of key public health programmes, such as the NPZ. Nevertheless, expertise in other areas is still lacking in the Polish health system, such as governance, public health care management, legal evaluation and health financing and economics. Ad hoc expert groups are put together to inform the policy formulation process or no expertise is used at all, endangering the quality of undertaken initiatives.

[38] In February 2007, one of the best-known cardiovascular surgeons was arrested and officially confessed to accepting bribes and manslaughter.

Strengthening patient rights

The Law on Patient Rights and the Patient Rights Ombudsman was passed in April 2009. The purpose of this Law was to strengthen the patient's position by gathering all patient rights (until then dispersed across many different legal sources) in one well-defined legal act, define patient rights and introduce a set of new extrajudicial procedures. A new post of an ombudsman responsible for patient interests was to be set up. The effects of the Law are ambivalent: on the one hand, the importance of patient rights has been endorsed; on the other hand, the positioning of the ombudsman within the government (subordinated to the prime minister) resulted in it having a rather weak position.

As a result of a bottom-up initiative for patient rights, the Institute of Patient Rights and Health Education was set up in 2004 with the aim of making the concept of patient rights popular in Poland (through workshops, media campaigns, etc.) and contributing to strengthening the position of the patient within the health system.

Improving health care funding and financing

Reforms in the area of health care financing have been traditionally focused on identifying new sources of revenue and at improving efficiency and cost-containment in the existing financing system. The concept of VHI has frequently appeared on the health policy agenda since 1989. In January 2008, a draft law on additional insurance was submitted to the parliament. It did not allow for opting out from the compulsory public insurance system but allowed the insured to move certain services from public coverage to complementary insurance. Additional insurance could also cover services requiring co-payments and services excluded from the guaranteed benefit baskets. The range of services covered was to be decided in the contracts between the insurer and the policyholders. All activities of private insurers – negotiations of contracts, rules of accountability and liability – were to be run according to provisions of the 2003 Law on Insurance Activity. The proposal was shelved on grounds of contradicting other laws. In March 2011, a draft law on additional health insurance was presented by the Ministry of Health but it was met with criticism from almost all sides and ultimately not adopted (see section 3.5). Another potential solution that emerged in the debate on health care financing has been the expansion of patient cost-sharing, an idea that has been largely supported by the medical profession (see also section 3.4.1).

Prior to the introduction of DRG-based hospital payment in Poland (i.e. JPG), hospitals were paid based on a *Catalogue of Health Care Products* that was annually updated by the NFZ. Similar to DRGs, health care products were

defined through specific diagnoses or procedures, and hospitals received a flat payment per admission based on the point value of a given product. However, in contrast to DRGs, the system was not based on systematic coding of diagnoses and procedures. Consequently, information was available only for the specific services defined by the *Catalogue*. Since the definitions of products changed every year, and the number of items in the catalogue continued to increase, the system lacked transparency. In addition, because of the constantly changing product definitions, hospital performance could not be assessed across time. Furthermore, the NFZ used its position of power to negotiate hospital payment rates that were often below the costs of service provision. This led to a deterioration of service quality and compromised access to hospital care through the emergence of waiting lists. Since July 2008, all hospitals (public and private) that have contracts with the NFZ must classify their patients using JGPs in order to receive JPG-based hospital payment for services they deliver. The NFZ has also started to introduce JPGs in other areas of care, such as neurological and cardiological rehabilitation. In October 2010 and in mid-2011, JPGs were also introduced for certain services in specialized ambulatory care. Parallel to the process of introducing JGPs, Poland experienced a period of sustained high economic growth, which resulted in increased revenue for the NFZ. As a result, the NFZ had sufficient funds to increase total expenditure for hospital care and to raise payment rates for previously underfunded services. These additional revenues were an important positive influence in the process of introducing DRG-based hospital payment in Poland, since they helped to assure support from providers for the new payment system (Busse et al., 2011).

Quality of care

The 2008 Law on Accreditation in Health Care was the result of over a decade of experience with accreditation standards in Poland (see section 2.8.2). Although voluntary, accreditation is taken into account in allocation of NFZ contracts and contributes to improvement of the quality of care in Poland.

Addressing shortages and outward migration of health care professionals

Human resources planning is not well developed in Poland. There is no strategic planning of the supply of human resources and government interventions to counteract shortages and outward migration are limited to general declarations and some ad hoc policy interventions (see section 4.2.2).

Mental health care

Transition from a predominantly institutional mental health care system to a community-based model has been progressing very slowly. It is hoped that the recently introduced National Mental Health Programme will aid the shift

from institutionalized to community-based mental care, allowing patients to remain at home during both remissions and exacerbations of their illness. For the same purpose, a new profession of community therapist was included in the guaranteed services basket in 2009 (see section 5.11).

Final remarks

The multitude of problems plus the lack of pragmatic "road map" and expertise resulted in many failed reform initiatives since transformation began in 1989. The process has been marked by continuous adjustments and learning, and many attempted solutions are still a subject of debate (e.g. the monopsonic position of the NFZ and the legal and economic status of public health care providers). New ideas for implementation have arisen (formulating a health care "basket" under the public insurance scheme; elaborating safe, clinically effective and efficient technologies; developing private health insurance schemes), yet traditional problems still persist (public health care provider debt, ineffective allocation of funds, unsatisfactory health care quality, lack of care continuity and barriers to access).

The direction of future health care reforms depends strongly on the political configuration of the government. Until 2010, conflicting political agendas were not conducive to conceiving and implementing reforms, and clarity with regard to the evolution of the system seemed to be lacking. However, several key reforms were passed in 2011 (for example, the Law on Therapeutic Activity and Law on the Information System in Health Care) and following the success of PO in the parliamentary elections in October 2011, one can expect that the reform agenda will be broadly continued.

6.2 Future developments

Commercialization of hospitals was probably the most important item on the reform agenda prior to the parliamentary election in October 2011. Following the electoral success of PO, it can be assumed that transformation of hospital ownership will be continued and the share of non-public hospital beds will increase. The prospect of hospital commercialization arouses fears that the newly created companies can arbitrarily limit the range of medical services provided. Under the new regulation, unprofitable medical procedures can be eliminated when the hospital's financial balance is jeopardized. It is, therefore, important to ensure that sufficient access to services for everyone remains guaranteed, particularly with regard to equity.

Other areas of health that require further improvement and may be the subject of future reforms are primary care, where advantages expected from the introduction of family medicine in the 1990s have largely failed to materialize, ensuring that proposed reforms are informed by relevant expertise and application of health impact assessment.

The question of how the system will respond to the financial crisis remains open. Although Polish economy was unaffected by the first wave of the crisis in 2008–2010, it may still be hit by the second wave, which started in mid-2011 (sovereign debt crisis). Should this happen, the health care sector will inevitably have to adjust its activities to the limited availability of financial resources, also by means of reforms.

7. Assessment of the health system

The ultimate aim for policy-makers and other stakeholders in the health sector is to construct and secure a health system that improves population health, protects service users from financial burden and responds to citizen expectations and social needs (WHO, 2000). Despite methodological disputes associated with cross-national rankings of health systems, this approach is becoming increasingly common because it allows multinational studies to evaluate the overall performance of a country's entire health system compared with others. In 2009, the Euro Health Consumer Index (Björnberg, Cebolla Garrofé & Lindblad, 2009) evaluated 33 national health systems in Europe, using 38 indicators based on a service-user perspective. The Polish health system was ranked 26th (together with Malta). According to this study, the strengths of the Polish system included legislation protecting patient rights, involvement of patient organizations in decision-making processes, patient access to medical records and the inclusion of dental services within the public health insurance scheme. In the category "health outcomes", cardiological care and childhood immunization were also positively appraised.

7.1 Stated objectives of the health system

National health strategies serve as important instruments for achieving clarity and consistency among different components and activities of health institutions and entities. These are described in two documents: the NPZ 2007–2015 and the Health Care Development Strategy in Poland 2007–2013. The government formally approved the NPZ first in May 2007. Its stated aim was the "improvement of society's health and health-related quality of life by fostering a healthy lifestyle and promoting a healthy environment at

home, in the workplace and in educational settings". The Programme consists of eight strategic goals, supported by a number of other operational goals (see sections 2.5 and 2.6).

The Health Care Development Strategy accompanies the State Development Strategy and contains sector-specific strategies and operational plans. Its main aim is the "improvement of society's health as a factor contributing to national socio-economic development". Four wide-ranging strategic goals are described:

- improving the population's health protection and safety;
- adapting the health care sector to long-term demographic trends;
- filling the gaps between the Polish population's health indexes and the EU average; and
- increasing the overall effectiveness of the health system.

These broad aims are divided into 16 operational goals, tasks and activities (e.g. reducing the harmful impact of chemical and biological agents, optimizing pharmaceutical utilization, and developing the medical rescue system). This multidimensional and multisectoral strategy engages many institutions; however, despite it being constantly reviewed and updated, there are no systematic year-to-year analyses showing how activities contribute to health care outputs or to what degree strategic health gains are achieved. It was primarily developed to detect and pinpoint the main health care problems and needs and is utilized as a conceptual base for projects within the EU's Operational Programme 2007–2013 (see sections 3.6.2 and 4.1.1).

The Ministry of Health's 2009 Regulation on Health Priorities, comprising 12 strategic health care goals, provides a general direction for the health policy. These goals include decreasing morbidity and premature mortality caused by cardiovascular diseases, malignancies and chronic respiratory conditions; reducing the negative health consequences of injuries caused by accidents (mainly through rehabilitation); prevention, treatment and rehabilitation of psychiatric disorders; reducing premature morbidity and limiting the negative consequences of chronic diseases of the musculoskeletal system; increasing effectiveness of prevention of infections and infectious diseases; limiting health damage caused by consumption of alcohol, psychoactive substances and tobacco; prevention of obesity and diabetes; reducing the negative health consequences caused by work and living conditions; improving clinical effectiveness and quality of mother and child health care; preventing the most

frequent health problems as well as physical and psychosocial development disorders in children and youths; developing long-term care; improving quality and effectiveness of geriatric care.

7.2 Equity

Equity is a general, multidimensional goal in health systems, entailing the minimization of differences in coverage, access, use, quality and utility of health care between groups of the population categorized by income, age, sex, nationality, ethnicity, geography and other characteristics. With regard to health financing, equity is achieved by the use of progressive sources of revenue.

7.2.1 Financial protection

An important macroeconomic indicator to take into account when considering equity issues is the proportion of public to private health care expenditure. Private expenditure accounts for 30% of total health care expenditure in Poland, with the largest burden falling on private households. However, the share of OOP spending has been decreasing, from 30.8% in 2004 to 25% in 2008 for individual health care and from 28.1% to 22.4%, respectively, overall (see section 3.3.4). Compared with Europeans from other countries, Poles have relatively high OOP costs. Over 60% of this consists of household expenditure on pharmaceuticals, while more than 30% is spent on ambulatory care. The health care services portfolio in the Polish health insurance system is wide, and only a few categories of services require co-payments. This is in part the result of strong opposition from wide sectors of society to the introduction of any additional payments or co-payments for health care, and to date, all governments, both left and right, have abandoned the idea of increasing their extent and magnitude. Given the limited public resources, however, patients and their families are not protected from OOP spending for health care services in the private sector or from informal payments in the public sector used to obtain quicker access and better quality care.

According to research on household budgets conducted by the GUS in 2010 (GUS, 2011a), average per capita health care expenditure represented approximately 4.8% of the average household budget. This figure nearly doubled for retirees; on average, pensioners spent over 8% of their household budget on medical care. With regard to inpatient care (provided mainly in public hospitals), per capita OOP expenditure was generally low in nominal terms and as a percentage of household budgets but it was substantial for households

where hospitalizations took place. OOP costs included spending on medicines, diagnostic tests, better nursing care, informal gratitude payments to medical personnel, gifts and transportation costs.

According to research on access to health care in 2006 and 2008, about 10–12% of respondents reported that they had to give up health care or withdraw from further treatment because of financial constraints (CSIOZ, 2006b, 2008). This mainly affected pharmacotherapy (61%), dental services (47%), specialist medical care (39%), and rehabilitation, diagnostics and health resort treatments (21–22%). Low income, pension as the main source of income, unemployment and low education level were important socioeconomic determinants of households the members of which reported financial barriers to health care access. Expenditures on medicines were a significant burden for nearly 45% of households, and 14% of households could not afford to purchase prescribed medicines from time to time or often (GUS, 2006a). The latest GUS research (2010a) showed that about 8–12% of respondents did not seek health care when they were in need as a consequence of financial barriers (e.g. 9% did forego a physician consultation and 33% dental treatment). Paying for medicines prescribed or recommended by doctors was a financial burden for 58% of all households, but this percentage increased to 80% for pensioner households (GUS, 2010a).

7.2.2 Equity in financing

Nearly 98% of the population has health insurance coverage through the NFZ, and contributions are linked to personal income tax. Since 1999, they have risen from 7.5% to 9% of a calculation base that includes certain elements of individually taxed income (wages, pensions, contracts, etc.). Contributions are paid entirely by the insured (no employer participation). However, an equivalent of 7.75% of the calculation base is reimbursed through the annual personal income tax settlement. There is no upper limit of income when calculating health insurance contributions, nor is there any possibility of opting out of the system. Hence, financing from contributions can be characterized as proportional. However, two important exceptions are worth noting. First, completely different rules are applied to farmers because they are exempt from personal income tax. A special formula, which considers the market value of rye as well as acreage, is used to calculate their contributions (see section 3.3.2). As a result, revenues from farmers' contributions are much lower than from other social groups. In 2010, the Constitutional Tribunal declared these rules unconstitutional, since they do not reflect real income and ability to pay. As a

result, a new formula that connects health contribution calculation with land tax amounts is currently being discussed. Second, declared income is used as the calculation base for self-employed individuals,[39] and, in fact, the vast majority of the self-employed pay the lowest contributions permissible. Public health insurance contributions constitute the main bulk of public health care expenditures, while the rest comes from budgetary expenditures of the state and territorial self-governments, which are financing sources of progressive character (see section 3.1).

Balanced against this, financial shortages, certain unclear regulations, lack of standards and poorly adjusted allocation mechanisms for real health needs have led to relatively high OOP expenditures for households, resulting in private regressive financing, particularly in some areas such as medicines. In conclusion, public health financing in Poland is overall not progressive but at best proportional.

7.3 User experience and equity of access to health care

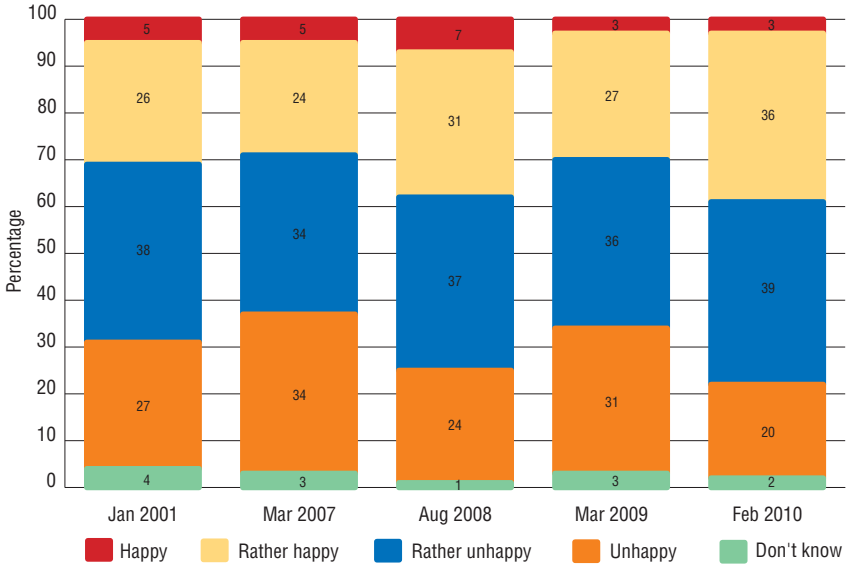
7.3.1 User experience

In 2006, about 40% of the population visited a primary health care physician at least once, while over 20% received specialist outpatient treatment and 13.5% used dental services (GUS 2007a). Since 2004, a series of research studies on health care access has shown that the vast majority of the population finds it "easy" to obtain primary health care. However, the percentage of patients assessing access in these terms dropped substantially between 2006 and 2008, from 92% to 83% (CSIOZ, 2006b, 2008). In comparison with primary health care, access to publicly financed specialist outpatient services was assessed much more poorly. In some medical specializations, such as neurology, cardiology, allergies or orthopaedics, access difficulties are particularly acute, and long waiting lists (more than three months) were experienced by 10–20% of patients (depending on the specialty). General satisfaction with the health care system fell in the last survey of the Public Opinion Research Centre compared with what it had been one year earlier (Fig. 7.1) and the 2007 *Eurobarometer* survey showed that, except for one indicator, perception of the health care system was lower in Poland than in the EU27 (Table 7.1).

[39] This income cannot be lower than 75% of the average remuneration.

Fig. 7.1

Patients' satisfaction with the health care system, 2001–2010 (selected years)



Source: Public Opinion Research Centre, 2010.

Table 7.1

Perception of the health care system, 2007

Type of health care	Poland (%)	EU27 (%)
Hospitals		
Fairly good to very good quality	58	71
Fairly easy to very easy access and availability	69	76
Dental care		
Fairly good to very good quality	50	74
Fairly easy to very easy access and availability	71	74
Medical or surgical specialist services		
Fairly good to very good quality	57	74
Fairly easy to very easy access and availability	52	62
Family physician services		
Fairly good to very good quality	73	84
Fairly easy to very easy access and availability	90	88
Care services for dependent people		
Fairly good to very good quality	28	42
Fairly easy to very easy access and availability	34	41
Nursing home services		
Fairly good to very good quality	17	41
Fairly easy to very easy access and availability	25	39

Source: European Commission, 2007.

Foregoing the public system in favour of purchasing services in the private health care sector was the most common solution to quickly gain access to these services. In 2008, 30% of respondents paid for private primary care physician consultations and diagnostic services, and 40% for specialist outpatient care (CSIOZ, 2008). This dramatic rise in OOP spending on diagnostics and treatment is symptomatic, attributable to payment mechanisms in the public health care system. Primary health care providers are mostly paid according to capitation formulae that cover the entire treatment, including diagnostic services. Since money for diagnoses is included in the capitation fee, providers have a strong financial incentive to "save" on laboratory tests and other external diagnostic expenditures. Conversely, access to hospital treatment is generally well perceived. Most of the reported hospitalizations were planned, and the ratio between planned hospital admissions and emergency admissions has increased. Quite often, access to inpatient treatment was obtained through the intervention of physicians or other people (14% of respondents) or through private physicians' visits (9%).

7.3.2 Equity of access to health care

In the 2007 GUS survey (GUS, 2007a), no major differences were observed in patients' social or economic status at the primary health care level; the same cannot be said for specialist or dental care, where urban patients with a higher income and more education used these services more often. In all cases, women accounted for the majority of service users. Unsurprisingly, the percentage of health care users also increased in older population groups. One out of ten Polish citizens was admitted to hospital or other inpatient health care institution, whereas only about 1% received health services at home (home visits, home kidney dialysis, injections, post-surgery care, etc.). Surprisingly, access to primary health care is perceived as more difficult for inhabitants of big cities than for residents in rural areas. This is mainly a consequence of organizational barriers (no possibility of phone or e-mail registration, limited working hours of physicians, inconvenient admission hours (for working patients), impossibility of same-day appointments, etc.) (CSIOZ, 2009b).

7.4 Health outcomes, health service outcomes and quality of care

7.4.1 Population health

Life expectancy at birth was 75.9 years in Poland in 2009, 80.2 for women and 71.6 for men. These figures were slightly higher than in other countries of similar economic development (Hungary, Slovakia, Estonia) and reflect an improvement of 4.8 years for both sexes since the transition to democracy began in 1989. The potential years of life lost shows the scope of premature mortality (an estimation of the number of years that people would have lived if they had not died prematurely from disease or injury). In 2008, the potential years of life lost for all deaths occurring in people under the age of 70 in Poland amounted to 3127 per 100 000 women and 7801 per 100 000 men. These figures were substantially higher than in all other European OECD countries except Hungary, Slovakia and Estonia (OECD, 2010a).

Infant mortality rate in Poland – 5.6 per 1000 births in 2009 – was the highest among European OECD countries (together with Hungary), but it is important to note that this represents dramatic progress since 1989, when the rate was 19.1. With regard to the improvement of this particular health measure, the health care sector has played a crucial role. Childhood vaccinations (against measles; diphtheria tetanus and pertussis; hepatitis B, etc.) and the very high immunization ratio among children (98–99%) place Poland at the top of OECD rankings.

Substantial improvements are also apparent in the treatment of cardiovascular diseases. Through systemic changes (in organization, training, financing, management, etc.), the Polish health sector was able to notably lower mortality from acute myocardial infarction. The age- and sex-standardized mortality rates per 100 patients were even better than those in some much more developed countries (e.g. Germany and Spain). The in-hospital case-fatality rates within 30 days after admission for acute myocardial infarction were also low. Moreover, they reduced meaningfully and quickly from 6.5 in 2003 to 5.7 in 2005 and 4.5 in 2007, falling below the OECD average (4.9) (OECD, 2010a).

Other medical specialties have not managed to deliver such impressive health gains. The rate of diabetes among the adult population was higher in Poland than in the EU, and although cancer survival rates have increased in recent years, they are still low compared with other OECD countries. The Polish health care sector also needs to make more efforts towards health gains

in other areas, particularly in relation to alcohol consumption, obesity among children and adults, and the high numbers of injuries and mental disorders (see also section 1.4).

7.4.2 Health service outcomes and quality of care

Since the early 2000s, a series of efforts to improve health care quality has been undertaken in Poland. Although no obligatory licensing of health care providers has been introduced to enforce required standards for human resources, equipment or infrastructure, the NFZ does award additional points to providers that have obtained accreditation and/or ISO9001 norm certification. These are voluntary but have been popular among hospitals and primary health care providers seeking to ensure and monitor quality of care. The ISO9001 norm places emphasis on improving managerial and decision-making procedures, whereas accreditation is more oriented towards care processes – safety, equipment efficiency and patient treatment.

It is also worth noting that Polish health care providers have participated in an increasing number of international initiatives and programmes on quality improvement, coordinated by the CMJ. One such programme has been the OECD Health Care Quality Indicator Project, which was launched in 2003 and has continued as an ongoing research and development effort. A number of health care quality indicators have been elaborated over the course of the project, related to certain chronic conditions and their exacerbations, mental disorders, cancer and vaccination. Indicators are regularly reported in OECD *Health Data* and have become the most important source for comparative studies on health care improvement and quality. Although Poland is a participating country, it still needs to fill gaps in data on quality in some health care areas.

Polish hospitals also participated in PATH, designed by the WHO Regional Office for Europe to support hospitals in defining their quality improvement strategies. PATH has provided tools for performance assessment, supporting hospitals in the evaluation of their own results and their translation into actions for improvement and enabling collegial support and networking. Performance assessment encompassed six dimensions: clinical effectiveness, staff orientation, efficiency and responsive governance, safety, and patient centredness. Implementation of the WHO Surgical Safety Checklist in Poland, quality assessment of highly specialized medical procedures (financed directly by the state budget) and assessment of hospital emergency wards also stand out among the most important national projects on quality improvement. Finally, in 1997, the Polish Hospital Infection Control Society started a voluntary

programme on infection control in Polish hospitals. This was followed up in 2005 by legislation mandating regular registration of hospital infections (see section 5.1) in accordance with EU standards.

Quality is also assessed by measures of service-user satisfaction. For this purpose, a set of standardized questionnaires on patient satisfaction, called PAST, was developed by the CMJ for health care providers and all other entities interested in subjective quality measurement. Different questionnaires were distributed to hospital patients (PASAT HOPSPIT), parents of treated children (PASAT PEDIATRIA) and primary health care receivers (PASAT PHC). In addition, household research on health care conducted by the Chief Statistical Office was recently expanded by a set of questions on health care quality.

7.5 Health system efficiency

Given that Poland has modest financial, human and material health care resources at its disposal and achieves satisfactory outcomes, the overall financial efficiency of the health system is not bad. As in most other EU and OECD countries, the Polish system is able to provide a comprehensive set of health services for the population at a relatively low total expenditure (see section 3.1). While the level of health care expenditure is relatively low in comparison with other EU countries, health care expenditure has risen substantially throughout the last two decades (except for the first and the last years), coinciding with a period of substantial economic growth and political transformation. Poland recorded a 216% growth index on total health care expenditures in PPP US dollars from 1989 to 2008. Relatively high pharmaceutical expenditures (22.6% of total health expenditure in 2008) are characteristic of the Polish health system, reflecting a high level of consumption with a tendency to overuse combined with relatively expensive prices. Both tendencies are similar to those in neighbouring post-socialist countries, such as Slovakia, the Czech Republic and Hungary, and should be carefully considered in any attempt to increase the overall system efficiency by different measures (prices regulation, refunding policies, etc.).

7.5.1 Allocative efficiency

By replacing the 17 sickness funds, the NFZ (with its voivodeship branches) has become the predominant public payer, responsible for allocating over 90% of all public health care revenues collected from obligatory health insurance premiums. It also manages a portion of other public health care expenditures transferred by public entities (central and local administration). Thus, the NFZ

has effectively assumed a monopsonistic position in the allocation of public funds for health care. The administrative costs of its operation are low, not exceeding 1.5% of total revenues from insurance contributions. Within total NFZ spending on health care, hospital care represented just under half of all expenditures, whereas ambulatory care (primary and specialist health care) accounted for less than 25%.

The NFZ can change the structure of health care expenditures as well as implement new payment mechanisms, and thus alter allocative efficiency. However, there is currently no needs-based allocation formula to support national, regional or local decision-making with regard to distribution of funds among regions and/or different types of health care (see section 3.3.3).

7.5.2 Technical efficiency

Value for money refers to the efficient use of resources by health care providers (technical efficiency). Technically ineffective providers produce suboptimal health outcomes and/or use too many resources in relation to those results. A number of indicators can measure technical efficiency at different levels of the health system.

Human and infrastructural indicators in the Polish health system are low or moderate compared with other EU and OECD countries (see sections 4.1.2 and 4.2.1). Inpatient infrastructure is used quite effectively. The ratio of 4.4 acute inpatient beds per 1000 inhabitants in 2009 is considerably lower than the EU15 average of 3.6, but it has been falling, indicating a rise in economic efficiency in hospital care.

The Polish inpatient sector saw 17.2 hospital discharges per 100 inhabitants in 2008, an increase from previous years. The acute care occupancy rate, an efficiency indicator for inpatient service utilization, was estimated at 69.7% of available hospital beds in 2009. There is, therefore, some room for efficiency improvement, although it is at the edge of being within the range prevalent among other EU countries (usually 70–80%).

With respect to the average length of stay for infant deliveries, this decreased from 4.6 days in 2007 to 4.4 in 2008. This fact, along with a substantial year-to-year decrease in infant mortality, demonstrates a rise in efficiency in gynaecology/obstetrics and neonatal care. The average length of stay calculated for all acute inpatient treatment in Poland was quite short (5.1 days in 2009), but this alone cannot be interpreted as an indicator of efficiency as it may be influenced by shifts in health care provision from cheaper ambulatory care to more expensive hospital care of a diagnostic nature. Indeed, difficulties

in obtaining specialist outpatient care have been conducive to unnecessary hospitalizations of that type. Studies on avoidable hospital admissions support that assessment, showing that, compared with other countries, Poland has a high rate of avoidable hospital admissions among patients with chronic diseases, particularly hypertension (440 admissions per 100 000 population, twice the OECD average), asthma, chronic obstructive pulmonary disease and acute complications of diabetes (OECD, 2010b). Avoidable hospitalizations are interpreted as a shortcoming in primary health care and other less-intensive health services.

In 2009, the average waiting time for specialist outpatient visits oscillated between one and two months, depending on medical specialty, but it was much longer for cardiology and ophthalmology (about three months). As far as inpatient treatment is concerned, waiting times were also very long, even for urgent cases requiring surgical interventions.

In an attempt to solve the above problems and improve technical efficiency, the NFZ has implemented substantial reforms in health care spending. In 2009, it decided to shift additional funds to primary health care physicians by tripling capitation rates for patients with diabetes and chronic cardiovascular diseases. Although expenditure on primary health care increased, the measure relieved inpatient and specialist care of the burden of the least complicated cases. The NFZ had also introduced a new payment mechanism in 2008, the JPGs, modelled after the British "healthcare resource group" system. The new arrangement, together with the other changes in payment mechanisms, contributed to a modest decrease in average length of stay, but it also increased the average cost of hospitalization.

7.6 Transparency and accountability

Several initiatives have been taken in the past few years to increase the transparency of the system, focusing on provision of information, evidence-based process and tackling corruption. The NFZ provides comprehensive information on health insurance and service delivery, both itself and by obligating providers to do so (see section 2.9). The establishment of the AOTM in 2005 aimed, among other things, at ensuring an evidence-based and transparent process for the inclusion of technologies in the health basket (see section 2.7.2). Several anticorruption measures have been applied, mostly around the issue of financing, to tackle both soliciting on behalf of pharmaceutical companies and the matter of increased OOP spending (see section 3.4.3 and Chapter 6).

8. Conclusions

Extensive reform efforts have taken place in Poland since the start of political and economic transformation in 1989, including the first systemic changes in the health sector. Initial reforms were haphazard and there was little continuity in the reform process (e.g. introduction of sickness funds and their replacement by the centralized NFZ), which could be explained by varying political agendas of the parties in power and by lack of expertise and capacity to precede reforms by in-depth analysis. However, policy expertise has since been significantly strengthened (e.g. establishment and/or activities of the Institute of Public Health of Collegium Medicum at the Jagiellonian University, the AOTM and the NIZP-PZH) and its impact is clearly felt (e.g. in the developing of the guaranteed benefits baskets in 2009). Moreover, continuity of the reform agenda is highly likely given the parliamentary success of the same political party (PO) in two consecutive elections (last one in October 2011).

Limited financing seems to be the biggest barrier in achieving accessible and good quality of health care services and in improving patient satisfaction with the system. VHI has often been proposed as a source of additional financing, but the idea of paying for health care is not widely accepted in a population used to "officially" free health care under Communist rule and, although the share of private health expenditure in Poland is substantial, all initiatives in this area have so far failed. Nevertheless, measures have been put in place to improve allocation of NFZ financing between various types of care in order to better reflect their actual costs (JPGs for hospital care and some specialist ambulatory care). This may, if balanced by complementary measures such as the allocation of resources to the NFZ regional offices, translate into improved and more equitable accessibility of care. Accessibility could also be improved by increasing cooperation between various bodies within the

health care and social care sectors (e.g. Ministry of Health, NFZ, ZUS, KRUS, territorial self-governments) since patients may presently find it difficult to obtain financial assistance or care (e.g. in the area of long-term care).

A significant number of public hospitals have suffered from insufficiently effective financial management and the accumulation of debts. The proposed solutions to overcome these problems by privatizing public hospitals have been strongly opposed and politicized – based on fears of paying for health care and worse access to care for the poor. Nevertheless, privatization of health care institutions has been taking place (most of the ambulatory care is now in private hands) and the 2011 Law on Therapeutic Activity is likely to induce more territorial self-governments to commercialize hospitals. Time will show how commercialization of hospitals (at the time of writing in late 2011 more likely than ever) impacts on the accessibility, affordability and quality of care in Poland.

Substantial activities have been undertaken in the area of quality control, including HTA and the introduction of accreditation standards for hospitals and primary care. Nevertheless, standards of care are still missing in many areas of care (e.g. rehabilitation), making it difficult to assure and monitor quality of care. The increasing shortage of health care personnel poses another threat (see section 4.2) and may require complementing the ad hoc interventions practised so far with a more strategic approach.

Finally, significant efforts have been made to improve the health care information system, but the goals are far from being achieved and innovative solutions have been piloted on a very small scale. A reliable health information system should improve management and planning of human resources and infrastructure, minimize waste of financial resources, improve quality of care for patients and aid policy-making.

9. Appendices

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2008 Law on Patient Rights and the Patient Rights Ombudsman, dated 6 November 2008 (*Journal of Laws*, 2009, No. 52, 417, with later amendments) (*Ustawa z dnia 6 listopada 2008 r. o prawach pacjenta i Rzeczniku Praw Pacjenta*).

2008 Law on Accreditation in Health Care, dated 6 November 2008 (*Journal of Laws*, 2009, No. 52, item 418) (*Ustawa z dnia 6 listopada 2008 r. o akredytacji w ochronie zdrowia*).

2008 Law on Public–Private Partnership, dated 19 December 2008 (*Journal of Laws*, 2009, No. 19, item 100) (*Ustawa z dnia 19 grudnia 2008 r. o partnerstwie publiczno–prywatnym*).

2009 The Law on Concession for Construction Works or Services, dated 9 January 2009 (*Journal of Laws*, No. 19, item 101) (*Ustawa z dnia 9 stycznia 2009 r. o koncesji na roboty budowlane lub usługi*).

2009 Regulation of the Minister of Health on Health Priorities, dated 27 August 2009 (*Journal of Laws*, 2009, No.137, item 1126).

2010 Law on Medical Devices, dated 20 May 2010 (*Journal of Laws*, 2010, No. 107, item 679) (*Ustawa z dnia 20 maja 2010 r. o wyrobach medycznych*).

2011 Law on the Information System in Health Care, dated 28 April, 2011 (*Journal of Laws*, 2011, No. 113, item 657) (*Ustawa z dnia 28 kwietnia 2011 r. o systemie informacji w ochronie zdrowia*).

2011 Law on the Reimbursement of Pharmaceuticals, Foodstuffs for Special Nutritional Use and Medical Devices, dated 12 May 2011 (*Journal of Laws*, 2011, No. 122, item 696) (*Ustawa z dnia 12 maja 2011 r. o refundacji leków, środków spożywczych specjalnego przeznaczenia żywieniowego oraz wyrobów medycznych*).

2011 Budget Law for 2011, dated 20 January 2011 (*Journal of Laws*, 2011, No. 29, item 150) (*Ustawa budżetowa na rok 2011 z dnia 20 stycznia 2011 r.*).

2011 Law on Therapeutic Activity, dated 14 April 2011 (*Journal of Laws*, 2011, No. 112, item 654) (*Ustawa z dnia 15 kwietnia 2011 r. o działalności leczniczej*).

9.3 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.

2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other OOP payments, VHI and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learnt from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.4 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

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A series of the European Observatory on Health Systems and Policies

The Health Systems in Transition (HiT) country profiles provide an analytical description of each health system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health systems and reforms in the countries of the WHO European Region and beyond. The HiT profiles are building blocks that can be used:

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- to highlight common challenges and areas that require more in-depth analysis; and
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in countries of the WHO European Region.

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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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