CONTEMPORARY POLISH HEALTHCARE SYSTEM REVIEW

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Abstract. *This paper reviews the legal status of medical care system in Poland. The system was greatly improved during last two decades, though it still experiences some deficiencies. Looking ahead, it should be noted that around January 1, 1999, the last decentralized policy came into force, covering the health care system in Poland. In this way previous centrally controlled, budget-based structure was replaced by EU member states style modern medical coordination and administration, formed on several regional fundings and a distinct state funding with nation-wide coverage. The main objective of latest system was introducing the development of the day-to-day health protection services with special emphasis on the special role, played by family physicians. Unfortunately, as mentioned before, new medical coordination and administration didn't worked very well by lacking support from the patients, general public and representatives of local community authorities that captivated active public support. Furthermore, the article examines selected problems, related to the efficacy dilemmas, costs problems and legal issues which demanded to be answered . Therefore, it tends to be argued that the system demands more distant expand of the medical coordination and administration which includes ways of*

employing of more strict budget restriction on publicly funded healthcare and finer describing of minimum.[1]

Key words. *medical care in Poland, policy covering the health care system, treatment costs, NFZ, current healthcare system,*

Healthcare system in Poland.

The Ministry of Health in Poland has to alter its publicly funded healthcare policies and legal environment. Especially the governmental authorities have to take into consideration significant expand in the publicly funded healthcare services providing finances to national healthcare framework because utilizing that only by increasing outlays tends not to solve existing dilemmas in securing suitability. The current governmental authorities tries to avoid introducing latest legislation appropriately regulating reorganization of the publicly funded healthcare services, along with preferring essential expand in municipal expenditures for health.[2] Health care costs per person in this country in 2018 were $ 979, which is 7.6 percent more than in 2017. Healthcare costs in Poland in 2017 were $ 910, up 11.81 percent from 2016. Healthcare costs in 2016 were $ 813, up 11.8 percent from 2015. Poland health protection costs for 2015 were $804, a 11.78 percent decline from 2014.[3] Summing up the state-funded coordination of health care and health management in Poland, urgent restructuring is required in several important areas, such as the

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[1] Girouard, N. and Y. Imai (2000), The Health Care System in Poland , *OECD Economics Department Working Papers*, No. 257, OECD Publishing, Paris, https://doi.org/10.1787/265022143317

[2] Sowada, C., Kowalska-Bobko, I. (2021), *Sustainability of the Polish Health Care System*, [in} Baltagi, B.H., Moscone, F. (Ed.) *The Sustainability of Health Care Systems in Europe (Contributions to Economic Analysis*, Vol. 295), Emerald Publishing Limited, Bingley, pp. 117-137 pp. 117-137

[3] https://www.macrotrends.net/countries/POL/poland/healthcare-spending

volume of medical services, the types and sizes of the structure used, the introduction of control instruments, not limited to justification of current costs.

Existing problems in healthcare system.

It is worth noting that in most EU countries, public health care is free for all citizens, and this country does not deviate from this model. Poland offers the kostenlos system of health coordination and management, under which all Polish citizens and residents of EU member states have the right to affordable health care with the support of National Health Fund (Narodowy Fundusz Zdrowia) [4]. The funds of the national agency consist of obligatory payments of all Polish citizens: deduction of 8.5% from personal income tax. The current and indicated deductions are the main source of funds for the municipal and kostenlos policy, which covers medical expenses. Nevertheless, this country provides private medical policy covering medical expenditures as well. In 2017 91 percent of polish residents had policies covering medical expenditures.

There are problems of Polish health protection in XXI century. Even though hereinafter narrated state's health protection coverage is impressive, organizational dilemmas, politics, underfunding and outdated IT still negatively impacts the health structure. Also, it is essential to notice that the percentage of the residents possession of policy, covering medical expenditures is high, 91 percent, it is still lower than in several another EU member states. This narrated state's organizational system is as well incredibly understaffed in doctors and largely in health practitioners. Under the current governmental agencies in Poland, funds for the NFZ are as well converting into more distant national budget funds,

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[4] National Health Fund - a state legal person operating on the basis of the Act of 27 August 2004 on health care services financed from public funds and on the basis of its statute

entangling the excessively complicated administrative procedure of health protection in Poland.

Income inequality and health.

The other dilemma that haunts health protection in Poland is the disparity of medical well-being among higher than moderate income and families earning low salaries. In accordance with hereinafter narrated statistics of health profile in 2017, 71 percent of higher than moderate income inhabitants state that they are in good medical condition, while only 53 percent of families earning low salaries report the same. The aforementioned 18 point difference is sizeable, considering this country residents. Poland's longevity score is also lower than most of the EU member states, ranking 24th in the European Community with approximately 77.5 years. Thanks to the development of the health care system, this country has the potential to increase life expectancy and narrow the health gap. Futhermore, it is important that the state medical coordination and health management described below are effective in providing basic day-to-day health protection for residents. This may be due to both more sophisticated treatment of cardiovascular diseases - the leading death rate in Poland, and the centralization of the structure of medical care in this country since 1999. However, a country should prioritize developing its organizational structure and funding medical coordination and management to maintain the good of its residents.

This country's health structure supports the health of a larger part of the population, although there are more distant important aspects so that ongoing medical coordination and management can improve efficiency and achieve higher health standards. Health protection in this country might not currently live up to the standards of another EU member states, though it has the potential to expand its health protection system to compete with and possibly surpass them in the future, considering its relative economic stability. In pursuit of the aforementioned

goal, this country undertakes steps to expand its health protection system. The Ministry of Health in Poland has begun to use electronic prescriptions and other information services for aggregation of healthcare data to expand coordination among health centers, doctors and patients. Poland's Ministry of Health is also working on plans to further expand the number of doctors and practitioners available in public health services. These legal structural and organizational changes are necessary to remain competitive with other EU member states.[5]

The shortage of health workers is reflected in the small number of nurse practitioners and doctors - 5.2 and 2.3 per 1000 inhabitants, respectively, which is one of the lowest rates in the European Communities. Doctors and other medical personnel in Poland may receive higher remuneration, working conditions and career prospects abroad, so the migration of doctors and nurses abroad is a problem. The recruitment and retention of doctors to work in family medicine (along with other areas, including anesthesiology) is a particular problem in this country, which the current legal structural and organizational changes are trying to solve.

Health protection costs tends to continue to grow, in some cases much faster than the progress in health protection. As a result, simply by increasing the funding, though without the much-needed legal structural and organizational changes, no furtherance tends to be ensured, which includes finer accessibility and higher quality of medical treatment. The operating costs of health protection suppliers include, without limitation (based on sample entities from various segments): health protection professional costs (approx 52 percent of costs), costs of outsourced services, which includes patient meals (approx 24 percent of costs), costs of materials (approx 18 percent of costs), costs of framework depreciation (approx 4 percent of costs), overhead and administrative costs (approx 2 percent

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[5] https://borgenproject.org/healthcare-in-poland/

of costs) and another costs, not quantified at current, exempli gratia costs of indebtedness liquidating[6] . Virtually all the indicated costs seem to be on the expand , formed on an in-depth analysis.

It is important to mention here that a lack of finance has been and tends to remain a dilemma for medical coordination and health management. This leads to the fact that funding intended to provide financial resources is “shifted” to certain areas of medicine. This is done by changing the assessment of NFZ benefits. Until now, the state agency HTAT has recommended, for example, an increase in spending on mental health services by about 20 percent to systematically assess the properties and effects of medical technologies. This is an area where the provision of financial resources is clearly below the demand for many years. In the next two years, there may be a more distant turn towards reallocation of funds spent on treatment (ie two tariff expansions and reductions). The latter may cover mainly areas in which, thanks to a very good level of financial resources provision, there has been dynamic growth over the previous decade, including cardiology or ophthalmology. [7]

There are several strategies and tactics available for the growth of public health services in Poland. At present, it is correctly noted that the financial results of municipal medical centers are poor, and the trend we have observed shows their systematic deterioration. Projections show that, without government intervention, publicly funded health services can operate on a regular basis (mainly because much of the planned increase in health benefit spending tends to be used to meet current payroll commitments through 2018). Another obligation is the planned allocation of funds and other resources to adapt the structure of health centers in

[6] https://www.pwc.pl/en/publikacje/2017/trendy-w-polskiej-ochronie-zdrowia-2017-pwc.html
[7]https://www.pwc.pl/en/articles/2016/10-trends-in-polish-healthcare-2016.html

accordance with the provisions of the decree of the Minister of Health. State budget intervention may have been necessary earlier. This could be due to the potential results of raising the threshold of non-taxable personal income tax to PLN 8,000 (Polish currency) per year, which would reduce NFZ premium income by about PLN 2 billion per year. In terms of patient experience in healthcare, it will be prudent to ensure that all patient interactions and outcomes are simple, convenient, timely, streamlined and consistent so that health naturally fits into the "life stream" of every day of the family and local community.

It is important to emphasize that the current healthcare system requires operational coordination and scaling, as well as transformation of the delivery of medical and non-medical services through partnerships and collaboration between professional services provided by doctors and local organizations to overcome barriers, including social determinants of health, to achieve better results. It will be recommended that innovative medical and non medical data (exempli gratia history, labs, medical prescription , utilizing of mobile and wireless technologies to support the achievement of health objectives,) might be executed in order achieve desire outcome, including reducing monetary value of expenditures in healthcare coordination and administration and fore the larger part finer assistance for patients, health suppliers and medical staff. In addition, the health care structure in Poland requires improved exchange of data, not limited to one patient, which can be tracked over time, by organization and / or by some other parameters and systems (including EHR data for all patients, as well as data from the national health system and electronic the exchange of health information, allowing health professionals, medical personnel and patients to access a person's medical history), formed on the basis of a cost-effective mechanism applicable to all participants in the health care system. Another issue that needs to be addressed is the need to improve the overall health of the participant / patient, lifestyle /

behavior, socioeconomic, cultural, financial, academic, geographic and environmental well-being to ensure uninterrupted and related health care.

With regard to national health policy, the authorities should work on the latest types of subsidies and health care centers, as well as on a complete health care reform law in line with specific state programs to support the regions. To achieve this goal, priority should be given to local health and well-being strategies, preventive and chronic treatment, clinical and administrative integration, and existing barriers to health services (long queues, labor shortages, aging midwives and nurses, whose average age is 53).

However, it is important to recognize that the sector's medium to long term perspective is to improve the efficiency of health centers, which has been postponed several times. This is the best direction for change, given the limited funding and the fact that the revenue side of medical centers is almost limited by default (at least for organizations that rely on limited contracts with the NFZ - Narodowy Fundusz Zdrowia). Coordination and administration mechanisms that provide the opportunity to expand operations / save money by improving the health system, which includes centralized procurement goals, centralized support goals, streamlined coordination and administration procedures, consolidation of organizations and the introduction of pay-for-performance. Consideration should also be given to initiatives to consolidate support goals across municipal health center networks, which will critically contribute to their profitability.

The present situation of healthcare.

Health coverage for all of the people in this article is almost universal within a publicly funded public health structure, although there are key gaps in the scale and depth of public coverage. Another noteworthy point can be noted in relation to the Polish Ministry of Health, which shares the management and responsibility for

professional services provided by doctors with three types of territorial state administration: municipalities (called gmina) supervise day-to-day health care, counties (called powiat , the second-level unit of territorial self-government and administrative division), in charge of county health centers, and the provinces (known as voivodeships - the highest administrative division) are mainly responsible for the larger health centers at the second level of the territorial unit of self-government and administrative division. The Ministry of Health is the Sheppard of the national health agencies and the government-funded health system, and is empowered to oversee and supervise the clinical trial centers of medical universities. Private institutions provide mainly health care services that are carried out without an overnight stay in a hospital (medical care is provided on an outpatient basis), while most of the health centers are public. The aforementioned diversity of qualifications requires significant efforts to effectively coordinate the entire system of professional services provided by physicians. Much of the important source of funding for health care comes from the structure of social health insurance that covers health care costs. It is interesting to note that non-public sources account for 30 percent of current health spending, and their share in this country is higher than in most of the EU member states. The bulk of out-of-pocket expenses are related to two reimbursable pharmaceuticals and non-prescription drugs, two of which have very high consumption rates. [8]

The day-to-day health care is the starting point in the structure of professional services provided by physicians in the country discussed in the article, with medical service providers serving as gatekeepers for more specialized health care. Physicians who provide outpatient care that have been separated from hospital care since the early 1990s are transferred now back to health care centers:

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[8] https://www.euro.who.int/__data/assets/pdf_file/0006/355992/Health-Profile-Poland-Eng.pdf

networked health care centers are encouraged to provide health care services without hospital overnight stays (and therefore, a decrease in the number of treatment beds, including not only beds in intensive care units, but also beds in the surgical department). This analysis of the publicly funded health care structure in Poland examines the ongoing changes in organization and management, the provision of financial resources for the health care system, the provision of public health services, legal structural and organizational changes in health care, and the functioning of the health care system. At the end of 2017, the Polish authorities pledged to increase the share of public health spending to 6 percent of gross domestic product by 2024. Assuming GDP growth in the near future, this tends to offer a chance to address growing health problems, including socioeconomic inequalities in health, high obesity, a growing burden of mental disorders, and aging populations that put a strain on publicly funded health resources. It is also a chance to overcome long-standing imbalances in public health services, which include overdependence on health care in clinical centers compared to other types of care, which include outpatient care and long-term care; HRM disadvantages; a small proportion of health promotion and disease protection measures compared to treatment and therapy provided to all patients and poor financial position in the publicly funded health care system. Finally, additional financial reserves are urgently needed to implement important ongoing legal structural and organizational changes in health care, which include reform of day-to-day health care. Financial reserves should be spent wisely and losses should be minimized. Implementation in 2016 of a special system (IEIAHS) for assessing the allocation of money and other resources within the framework of public health services, which require the provision of public financial resources (including from the European Community) along with the work done by the Polish State Agency for Assessment and Tariffing of Health Technologies AHTAT for the systematic assessment of the properties and

effects of medical technologies [9]. AHTAT assesses medical technology and the adoption of publicly funded public health policies, and sets the monetary value of spending on health goods and services needed to ensure that current and identified goals are met. Current legal structural and organizational changes in health care, including the ongoing reform of day-to-day health care, which aims to expand the coordination of health care services and introduce a network of health centers, are going in the right direction. Nevertheless, a amount of longstanding unresolved dilemma s, including clinical centers debt, must be resolved.[10]

The publicly funded health care services discussed in this article are dominated by public supply systems, which have modestly accounted for about 70[11] percent of total cash expenditures over the past decade, according to data from the Central Statistical Office (*Główny Urząd Statystyczny)*. The structure of financial resources provided should shift towards non-government spending in the near future, as the compound annual growth rate was estimated at about 7.0 percent between 2016 and 2021. As for publicly funded health care providers, health centers are the largest sponsors of all public health services, collecting more than 35 percent of total expenditures (PLN 37 billion in 2013), unsurprisingly, mostly funded by the public sector (96 percent). Outpatient health care providers received an impressive 26 percent (PLN 27 billion), with dental surgeries demanding over PLN 4 billion and non-public clinical practices PLN 2 billion of the above cost. As

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[9] The Agency for Health Technology Assessment and Tarification - a state organizational unit with legal personality, supervised by the Minister of Health. The Agency performs advisory and consultative functions for the Minister of Health in Poland

[10] Sowada C, Sagan A, Kowalska-Bobko I, Badora-Musial K, Bochenek T, Domagala A, Dubas-Jakobczyk K, Kocot E, Mrozek-Gasiorowska M, Sitko S, Szetela AM, Szetela P, Tambor M, Wieckowska B, Zabdyr-Jamroz M, van Ginneken E. Poland: Health System Review. Health System Transit. 2019 Jun;21(1):1-234. PMID: 31333192

[11] https://blackpartners.pl/wp-content/uploads/2016/08/Rynek-medyczny-raport-Blackpartners.pdf

expected, while the entire outpatient care segment is funded primarily by government financial reserves, the dental medicine sub-segment is largely dependent on non-government spending. [12] In the country referred to in the article, there are about 800 health centers and about 220,000 beds in health centers that accommodate patients admitted to hospitals, which gives about 6 beds in health centers to accommodate patients admitted to hospitals per 1000 residents. This is one of the highest results in the EU member states.[13] Health centers need to be reorganized because of a number of factors, for example: demographics, procedures that will be carried over into the health care system without hospital overnight stays, or required operating costs (adjusting to the latest requirements). In some cases, restructuring can lead to: a change in the use of some departments (for example, with the replacement of obstetricians and gynecologists, as well as obstetric or pediatric departments with departments of neurologists, endocrinologists). In the country discussed in the article, there are 198 long-term health facilities, 52 spa and wellness centers, and about 1,800 long-term health care facilities offering 172,000 beds specifically destined for hospitalized patients in these institutions. The current and the indicated establishments are less expensive, whilst often providing very high quality health services and waiting for full using of their potential. The daily stay in such institutions costs the system from PLN 100, while the fees required at the clinical center range from PLN 300 to 500.[14] The number of doctors 2.4 per 1000 residents is one of the lowest in Europe; this also applies to registered nurses, at 5.1 per 1000 residents. The proportion of physicians who are general practitioners (physicians treating acute and chronic diseases) is second in the European Community at 9 percent

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[12] https://blackpartners.pl/wp-content/uploads/2016/08/Rynek-medyczny-raport-Blackpartners.pdf , p. 6
[13] https://www.pwc.pl/pl/pdf/trends-in-polish-healthcare-2017-en-pwc.pdf
[14] PWC report Trends in Polish Healthcare 2017

(moderate proportion in EU member states is 23 percent). To mitigate this situation, government agencies allow pediatricians and therapists to provide other health services. The distribution of health professionals varies widely: for example, the density of doctors varies by almost 70 percent from one unit of the second level of territorial self-government and administrative division to another. Several provinces also experienced a shortage of specific practitioners, including immunologists, anesthesiologists, cardiologists, colon and rectal specialists, surgeons, intensive care specialists, and dermatologists. The current and reported weakness in non-hospital health care and the shortage of medical practitioners lead to long waiting times and partly explain why certain signals, including unmet health care needs, are worse in the country discussed in the article than in states with similar stages of medical expenses. The median waiting time for medical practitioners was 3.4 months in 2018, with the longest reported in hormonal imbalance medicine (11 months period) and dental medicine (8.5 months period). Only in 2017 coordinated health practitioners post-heart-attack recovery wasn't realized in seven provinces.[15]

Publicly funded healthcare governance is fragmented. The above explains the slow progress of legal structural and organizational changes in the health sector aimed at reducing the number of beds dedicated to hospitalized patients and paying off the debts of clinical centers. The highly fragmented ownership of clinical centers contributes to the lack of initiatives to reduce the amount of hospital beds. Much of the controversial legal structural and organizational changes in health care in the period 2011–2015 consisted of the transformation (known as "commercialization") of state-funded health care providers operating as

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[15] OECD/European Observatory on Health Systems and Policies. 2019. Poland: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels

commercial enterprises in Poland. Initially, this was carried out under the so-called Plan B "Rescue of Medical Centers in Poland", introduced in 2009, and then under the 2011 Law on Medical Activities. [16]. It was hoped that commercialized medical centers would adopt the governance rules set out in the Polish CCC, including strict control by the coordinating and administrative council over the financial resources of clinical centers, and that this would help resolve the debt dilemma in publicly funded medical services. [17]. In general, due to numerous obstacles, the aforementioned legal structural and organizational changes have been limited.

Healthcare regulations.

Act of 10 June 2016 amending the Act on medical activity and some other acts[18], amended the 2011 Act on Medical Activity. The amendment introduced a ban on the sale of most of the shares of commercial companies owned by the state or municipal units; it banned the sale of capital companies, most of which belong to the State Treasury. The amendment as well allowed governmental authorities to finance publicly funded healthcare services and the IPHCF s to cover their losses from their own capital fund. If capital funding is exhausted, the parent organization is required to cover the losses or may liquidate the IPHCF. In practice, the introduced turnaround made the "commercialization" of IPHCF unattractive for their founders, and the more distant one slowed down the already low rate of

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16 Ustawa z dnia 15 kwietnia 2011 r. o działalności leczniczej (Dz. U. nr 112, poz. 654

17 See more Autorzy: Katarzyna Dubas-Jakóbczyk, Iwona Kowalska-Bobko, Christoph Sowada. The 2017 reform of the hospital sector in Poland - The challenge of consistent design. Czasopismo: Health Policy Szczegóły: 2019 : Vol. 123, nr 6, s. 538-543

18 Ustawa z dnia 10 czerwca 2016 r. o zmianie ustawy o działalności leczniczej oraz niektórych innych ustaw (Dz. U. 2016, poz. 960 . ze zm.)

transformation of IPHCF into business structures in accordance with the Code of Commercial Companies (*Kodeks spółek handlowych*) CCC [19] Instrument for Evaluation of allocation of money and other resources, Instrument for the Appraisal of Investment Proposals in the Health Sector Applications, IAIPHC Instrument (*Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia*), system for estimating allocation of money and other financial reserves in the healthcare segment were introduced. In 2016, the IAIPHC structure was created with the aim of evaluating proposals for the allocation of money and other financial reserves in public health services and therefore ensuring an efficient use of resources that is cost-effective (for example, there is no similar distribution of money and other funds in neighboring regions) and adapted to the needs of the community (taking into account the requirements of health care for legal structural and organizational changes in health care and priorities of public health policy) [20]. Prior to the legal structural and organizational changes, there was no internal system for evaluating the latest allocation of money and other publicly funded health resources. In accordance with the structure of the IAIPHC, all allocations of money and other resources that lead to the creation of a modern medical facility, or any major allocation of money and other resources, is subject to prior assessment. Obtaining a positive opinion under the IAIPHC scheme is also an important condition for obtaining financial resources from EU funding. [21]

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[19] Ustawa z dnia 15 września 2000 r. Kodeks spółek handlowych Dz. U. 2000, nr 94 poz. 1037 ze zm.)
[20] On 30 August 2016, the Law of 21 July 2016 amending the Law on health care services financed from public funds came into force. Among other things, the law introduces the Instrument for the Assessment of Investment Applications in the Health Sector (IOWISZ), which aims to rationalize the spending of public money and organize investments in health care.
[21]*Health Systems* in *Transition*; *Vol. 21 No. 1 2019; Poland*, *Health system* review, p. 175

Solution.

All regulations for an integrated health care system that aims to be effective should include planning for the provision of care to people to increase the number of general practitioners and address the existing imbalance in the combination of skills between practitioners and general practitioners, treating physicians in acute and chronic cases and also help to cope with the shortage of health professionals in the nursing and allied health professions. It should be a fully functional and interoperable online communication platform structure that takes into account pragmatic conditions and caters to the needs of multidisciplinary teams. The effective use of information and communication technologies in the complete structure of the medical history should be a high priority for the public health service. The newest primary care units must be focused on addressing major public health problems, including cancer, diabetes, frailty and road traffic accidents, as well as risk factors such as smoking, obesity, driving behavior and high sugar and alcohol consumption. health promotion interventions that aim to change health-care seeking behavior, protection, screening and early diagnosis, and coordination and management of health risks and diseases, along with protective (readmission) hospitalizations. Actions for integrated chronic disease care and fundraising beyond health systems, including joint community-based initiatives, need to be coordinated. From a public health policy perspective, this includes a substantial allocation of money and other resources for IT and coaching, firmly linking the latter approach that it suggests with professional medical and allied health education and public opinion campaigns. Basic skills development and coordinated continuing education courses for primary health care practitioners: these focus on the obvious need to retrain primary health care practitioners in order to develop groups of general practitioners and foster a culture of interdisciplinary collaboration. Interprofessional training as part of a national plan to restructure coaching programs in primary health care with a focus on general learning (curriculum structure, content, assessment methods and teaching) and

other medical disciplines. Coordination of health care by local and regional health authorities to link publicly funded health services with other areas and spheres that affect disease protection and health promotion. Services must continually adapt to the health care needs of residents, and public health policy planning must take into account public perceptions of primary health care. [22]

Conclusion.

Over the past two decades, the state-funded healthcare structure in Poland has undergone several profound systemic changes. The country discussed in the article spends more of its budget on treating patients treated in hospitals than comparable countries, indicating an area of effectiveness that requires major legal, structural and organizational change ahead of demographic trends. Ownership of municipal clinical centers is fragmented among different groups of government agencies, resulting in multiple stakeholders and a lack of accountability. The country discussed in the article has made significant progress in rationalizing its hospital scheme and reducing the number of beds, although the agenda for legal structural and organizational changes remains unfinished, as evidenced by the problem of ongoing debt. That outlines a way to improve the financial suitability of public health services in Poland. The debt dilemma is analyzed and the main barriers to the provision of financial resources to the health system are systematically examined. The root causes of the barriers are analyzed from a management perspective, as well as from a health care structure, which includes the role of regulators and constraints on the supply of financial resources. In justifying the need for change, the report also discusses how to take secular trends, for example, in the health of residents and service delivery, into account when

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[22] Kurpas D. *Challenges in Implementing Integrated Care in Central and Eastern Europe – Experience of Poland. International Journal of Integrated Care*. 2020;20(2):7

developing plans to restructure clinical centers. Several distinguishing features should differ the changes at the systemic level of Primo, which typically require intervention by public health policies at the national level. Secundo empowers provincial and health center management staff to perform better within the existing scheme and increase the chances of choosing the most appropriate tools, including the allocation of money and other resources. However, there is still a significant gap in life expectancy between Poland and other EU member states, as well as between life expectancy in general and the number of years expected without illness or disability. Considering the modest financial, human and material resources of medical services and the corresponding results, the overall financial efficiency of the scheme in Poland is satisfactory. Although the modern term "hospital network" is used to describe publicly funded health care reforms in this country, its actual meaning does not correspond to the generally accepted definition (since it does not include an element of collaboration between health centers). The main feature of this decree was the change in the rules for the provision of financial resources for a predetermined volume of services. The public health policy adoption process has been characterized by a relatively short time frame, with dilemmas of misinformation and misunderstanding. A significant contradiction of the latest legislative acts is the lack of an assessment of the quality of medical care, medical results and / or performance indicators in the criteria for inclusion in the network. The enacted legislative acts provided a powerful mechanism for the reorganization of public health services in Poland. Nevertheless, it is generally important to closely monitor its impact, adjust the regulation if necessary and include it in a more comprehensive strategy for the future development of public health services in Poland.

In conclusion, with legal, structural and organizational changes in the structure of health care in the near future, public health policymakers in the

European Union need to keep in mind that public health policies must be based on a careful analysis of dilemmas and needs, be shaped by real and affordable solutions and workable information systems. In addition, there is a continuing danger that inertia in public health policies and decisions will become a dilemma. Elements of professional services provided by agreement of physicians, both among primary care physicians and among practitioners (outpatient care and treatment provided to patients in hospital) and as part of day-to-day health care should be introduced with some financial instruments to stimulate it. Implementation of a network of health centers, which (among other things) stimulates the provision of medical care provided on an outpatient basis in medical centers, and therefore stimulates a reduction in the number of beds (of which there is a surplus in public health in Poland) and an increase in coordination between medical care provided to outpatient basis, and medical care provided to inpatients. The dilemma of poor financial performance of municipal health centers acting as IPHCF and the associated debt for publicly funded health care services has not been resolved. The process of commercialization of medical centers of the Independent Public Health Institution (*Samodzielny publiczny zakład opieki zdrowotnej)* IPHF was not successful and was stopped without any alternative solution to increase financial resources in public health services. Medical centers have longstanding overcapacity of beds specifically designed for hospitalized patients. Ongoing efforts to encourage health centers to provide more outpatient care for patients visiting for diagnosis or treatment are welcome, although should be made to further reduce hospital beds and expand the provision of daytime professional services provided by physicians. There is a need to expand support for adults and children. There has long been a shortage of a employed labor force in the medical field, especially physicians (including primary health care practitioners, medical practitioners) and registered nurses. Despite current and identified long-standing

shortcomings, a recruitment strategy for public health services is still lacking, and sufficient measures have not been taken to improve working conditions for all medical personnel, including doctors, nurses, medical practitioners and other medical personnel.

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3. National Health Fund - a state legal person operating on the basis of the Act of 27 August 2004 on health care services financed from public funds and on the basis of its statute

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