The Polish Healthcare System After the Pandemic: the National Recovery and Resilience Plan and Prospects for Reform*

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1. Introductory profiles: the Polish healthcare system and welfare model

The analysis of healthcare systems and policies cannot be separated from a brief survey of the respective welfare model.[1] In this regard, the experience of the Polish system needs to be framed in light of the transition regime in the Eastern countries, which involved the unraveling of the Semashko model – a model involving the provision of healthcare services under a regime of full publicity of healthcare facilities[2] – into different models. Before analyzing specifically how the Polish health service performed during the pandemic crisis and what the future prospects might be in light of the Polish National Recovery and Resilience Plan,[3] it seems appropriate to provide a general overview of the main features of the Polish healthcare system.[4]

Starting from the brief description of the Polish health service during the country's period of socialism, this paper investigates the main features of the current system that stem from the rise of more market-oriented ideas. These ideas have then led to the delineation of a decentralized, competitive insurance system and to the privatization of primary care services with several efforts to privatize public hospitals as well.[5]

First, Poland's health service was partially decentralized, providing for a competitive division between different levels of government through the delegation of certain responsibilities to regional and local authorities. Second, the decentralization of the service provides for public and private services to be mixed. Third, universal coverage has been guaranteed through mandatory health insurance for all workers. Finally, healthcare spending, which is predominantly financed through public funds, is raised through health insurance contributions and tax revenues. The contributions collected through the insurance method represent the largest source of the healthcare system's revenue, which is managed through the National Health Fund (*Narodowy Fundus Zdrowia – NFZ*).[6]

Having contextualized the main characteristics, the paper briefly assesses the impact that the Covid-19 pandemic exercised over the functioning of the health service. Finally, a

[1] R. Siemieńska, A. Domaradzka, *The Welfare State in Poland: Transformation with Difficulties*, in K. Schubert, S. Hegelich, U. Bazant (eds.), *The Handbook of European Welfare Systems*, Abingdon-New York, Routledge, 2009, pp. 378-397.

[2] P. De Angelis, *La partecipazione dei soggetti privati,* non profit *e* for profit*, nella erogazione dei servizi sanitari*, Torino, Giappichelli, 2017, p. 2.

[3] *Krajowego Planu Odbudowy i Zwiększania Odporności*, available in polish at the following url: https://www.funduszeeuropejskie.gov.pl/media/109762/KPO.pdf.

[4] T. Popic, *Health Reforms in Post-Communist Eastern Europe. The Politics of Policy Learning*, London Palgrave Macmillan, 2023.

[5] T. Popic, *Poland*, in E.M. Immergut, K.M. Anderson, C. Devitt, T. Popic (eds.), *Health politics in Europe: A handbook*, Oxford, Oxford University Press, 2021, pp. 745-766.

[6] T. Popic, *Health Reforms in Post-Communist Eastern Europe. The Politics of Policy Learning*, London Palgrave Macmillan, 2023, p. 177.

content analysis of the National Recovery and Resilience Plan is provided in order to give a perspective over the prospects of the health system in light of the National Recovery and Resilience Plan and to assess whether they place themselves in a line of continuity or discontinuity with the reforms traditionally called for to cope with the system's drawbacks.

2. The diachronic development of the Polish healthcare system

Before analyzing the peculiar features of the modern Polish health service, for the sake of this discussion, it is believed essential to outline its diachronic development. An evaluation of the structural changes of those healthcare systems produced by the Covid-19 pandemic and an overview of necessary reforms – called for in national recovery and resilience plans – cannot possibly be properly assessed merely through a detailed depiction of the relevant health system's features and the challenges brought by the pandemic. Indeed, each healthcare system in this series shall be addressed in light of the peculiar context in which it was shaped.

While before the Second World War, the Polish healthcare system was characterized by an insurance model, in the post-war period the health service in Poland was based on the so-called Soviet-style 'Semashko' system.[7] The main features of that paradigm were, on one hand, the nationalization of healthcare facilities and, on the other, a centralized model that provided for planning that was aimed at progressively leading to universal coverage. The crisis of this system was opened up for debate over its organization and functioning in the post-communist era.

During the immediate post-war period, Polish history was characterized by the formation of the United Worker's Party (*Polska Zjednoczona Partia Robotnicza*) and by the establishment of socialism. In light of the consolidation of this ideology, it was exactly in this period that the insurance system, that originally characterized the Polish healthcare model, gradually shifted to the Semashko system. The change of its structure, organization and functioning was possible through different amendments to the 1933 Law on Social Insurance,[8] contributed to the formation of a national health service working through a centralized administration.[9] These post-war changes as well as the imprinting of a centralized administration led to the creation of the Ministry of Health and Social Welfare in 1945.

[7] W.A. Zatoński, *One hundred years of health in Poland*, in 5(1) *Journal of Health Inequalities*, 11-19, DOI: https://doi.org/10.5114/jhi.2019.87816.

[8] Act of March 28, 1933 on Social Insurance (Journal of Laws of 1933, No. 51, item 396).

[9] T. Popic, *Poland*, in E.M. Immergut, K.M. Anderson, C. Devitt, T. Popic (eds.), *Health politics in Europe: A handbook*, Oxford, Oxford University Press, 2021, 745-766, 748.

Within this context, healthcare facilities were placed under the ministries, therefore they were directly connected to central State decision making processes. Moreover, the original insurance model, which was based on a system of contributions shared between employers and employees, was replaced by a contribution system paid exclusively by employers. Last, in 1951 two different transformations finally completed the passage toward the Semashko model. One concerned financing and taxation profiles, which provided for the healthcare financing based on general tax contributions and for sick-pay resources to be supplemented by the general budget. The other, from an organizational perspective, provided for the suppression of the Polish Chamber of Physicians and regional medical associations.[10]

Perceived as a useful way to create equity in health, the socialist regime's policy was focused on granting free, universal health care. The main feature of this system was absorbed by the 1952 Constitution,[11] which provided for the universal right to healthcare. By reducing or removing costs for medical goods and services, the policy actually provided for the regime's further legitimization, based on its granting the underprivileged social classes the possibility of benefitting from free access to these healthcare services and products.[12]

These major changes to the structure, organization and functioning of the healthcare system would have required substantial investments in terms of expanding the human medical resources, which, as will be seen below, is still one of the flaws that vex the modern Polish healthcare system. In addition, due consideration should have been given to medical personnel's education as well.

While the Semashko model was fully implemented in the Polish healthcare framework, which thus shared significant analogies with those in the Eastern Bloc, Polish exceptionalism consisted in also maintaining private healthcare services,[13] implying that part of the medical personnel would also be involved in providing for medical services within private medical cooperatives while working in the public system. This characteristic is relevant for understanding the development of the system.

Another problem that has afflicted the Polish healthcare system since its establishment is its vertical fragmentation in the delivery of services. In fact there were forms of centralization that imposed the Ministry of Health's control over the functions of many healthcare facilities, yet, at the same time, some other facilities were functioning in virtual autonomy.[14] This schism lead to significant inefficiencies in the use of resources, mainly due to

[10] M.I. Roemer, R. Roemer, *Health care systems and comparative manpower policies*, New York, M. Dekker, 1981.

[11] W.J. Wagner, *The New Constitution of Poland*, in 2(1) *The American Journal of Comparative Law* (1953), pp. 59-63.

[12] W.C. Włodarczyk, *In search of economic rationality: The experience of the Polish National Health Service*, in 7 (2) *Health Policy* (1987), pp. 149-162.

[13] J.B. Karski, A. Koronkiewicz, J. Healy, *Health care systems in transition: Poland*, Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Care Systems and Policies, 1999.

[14] F. Millard, *Health Care in Poland: From Crisis to Crisis*, in 12(3) *International Journal of Health Services* (1982), pp. 497-515.

low productivity levels combined with a lack of proper supervision. Another drawback of the system's organization was in a disproportionate recourse to specialized care, which resulted in an extreme workload for specialists compared to generalist care.
Moreover, the Polish health service has traditionally been underfunded, given that there was an overwhelming belief that it was basically not feasible for it to be a participant in making up the Polish GDP since it had always been contemplated as being among the 'non-productive sectors'.[15] This problem of underfunding coupled with this latter facet naturally led to the phenomena of widespread corruption.[16]
These problems have been constantly addressed in the public debate making them the object of numerous reform proposals, mainly directed at solving both the fragmentation in the healthcare sector organization and the health financing system.[17] Although some of these reforms were actually enacted, the Polish healthcare system has not been able to rid itself of some of its main drawbacks: lack of properly allocated resources, shortages of medical personnel, and scarcity of equipment and basic supplies. Though the health service was generally beset by these drawbacks, some changes were made during the 1980s, when a more flexible organization and some forms of decentralized autonomy were introduced. Regardless, the problem of corruption, which had become a steady feature of both individual healthcare expenses and doctors' revenues, continued to spread.[18]
These systemic deficiencies of such a highly centralized sector were clearly the result of a system that was constantly underfunded, ineffectively managed, and beset by the inefficient distribution of healthcare resources along with an inability to attract competent personnel. With the Law on Healthcare Institutions,[19] passed in 1991, there was a change in the functioning and ownership of healthcare facilities. First, the reform pursued the administrative decentralization of health services by granting greater autonomy to the provincial and municipal administrations. Second, the law introduced the provider-purchaser split,[20] making it possible to have different forms of facility ownership.[21] Third, the legisla-

[15] P. Pieprzyk, *The Polish Health Care System's Endless Journey to Perfection: a Never Ending Story*, in 1 *Social Transformations in Contemporary Society* (2013).

[16] F. Millard, *Health Care in Poland: From Crisis to Crisis*, in 12(3) *International Journal of Health Services* (1982), pp. 497-515; W.C. Włodarczyk, *In search of economic rationality: The experience of the Polish National Health Service*, in 7 (2) *Health Policy* (1987), pp. 149-162.

[17] F. Millard, *Health Care in Poland: From Crisis to Crisis*, in 12(3) *International Journal of Health Services* (1982), pp. 497-515

[18] K. Tymowska, *Health Service Financing in Poland*, in 2(2) *The International Journal of Health Planning and Management* (1987), pp. 147-157.

[19] Act of 30 August 1991 (No. 91, Item 408) on Healthcare Institutions.

[20] T. Popic, *Poland*, in E.M. Immergut, K.M. Anderson, C. Devitt, T. Popic (eds.), *Health Politics in Europe: A Handbook*, Oxford, Oxford University Press, 2021, p. 757.

[21] T. Bossert, C. Włodarczyk, *Unpredictable Politics: Policy Process of Health Reform in Poland*, International Health System Program Harvard School of Public Health, 2000.

tion enacted some significant provisions that granted patients their right to privacy and to informed consent, as well as the right to access their own medical records.

3. The characteristics of the Polish healthcare system before the pandemic

Having contextualized the main stages of the development of the Polish healthcare system, it is essential to depict its main features before the advent of the Covid-19 crisis. Among the models for financing[22] health services,[23] in Poland these were financed according to a compulsory social insurance model, the so-called Bismark model, which stipulates that health services would be financed through the collection of compulsory contributions and insurance funds. This model provided for a part of each worker's salary, up to 9%, to be compulsorily withheld and paid into a fund,[24] while also providing for a national State coverage[25] of the economically inactive and the less well-off who had been excluded from the described forms of social insurance.

Through this compulsory health insurance – which was provided for all categories of workers, including employees, civil servants, and the self-employed, and which was extended to their dependents – health coverage in Poland was nearly universal and covered about 98 percent of the population.[26] The remaining parts of the population that were uninsured included employees on unpaid leave, those engaged in certain types of contract work, volunteers, and foreigners without health insurance, as well as those who were automatically entitled to healthcare (e.g., children under 18 and uninsured pregnant women).[27] This health insurance provided access to a range of services (preventive, diagnostic, medical and outpatient care), while all the benefits that were not covered by insurance fell under the so-called negative list.[28]

The structure of the healthcare system was organized through competitive allocation designed as follows: the regions were responsible for organizing and financing tertiary care,

[22] From the perspective of the financing of the health system, the comparative taxonomy generally includes the following division: competitive model, voluntary private insurance, compulsory social insurance, and universalistic model. According to F. Toth, *Le politiche sanitarie: modelli a confronto*, Bari-Roma, Laterza, 2009, pp. 10-11, these models would represent an evolutionary path and would not stand in stark contrast between each other.

[23] M. Ferrara, *Modelli di solidarietà. Politica e riforme sociali nelle democrazie*, Bologna, il Mulino, 1993, pp. 63-102.

[24] H. Boulhol, A. Sowa, S. Golonowska, P. Sicari, *Improving the health-care system in Poland*, OECD Economics Department Working Papers, No. 957, Paris, OECD Publishing, 2012.

[25] T. Popic, *Poland*, in E.M. Immergut, K.M. Anderson, C. Devitt, T. Popic (eds.), *Health Politics in Europe: A Handbook*, Oxford, Oxford University Press, 2021, p. 748.

[26] *Ibid.*

[27] A. Sagan et al., *Poland. Health system review*, in *Health Systems in Transition*, Vol. 13, No. 8, 2011, pp. 1-193.

[28] T. Popic, *Health Reforms in Post-Communist Eastern Europe. The Politics of Policy Learning*, London Palgrave Macmillan, 2023, p. 182.

while local governments were responsible for primary and secondary care, provided specifically by hospitals run by each county. There were also provincial specialized hospitals or highly specialized teaching hospitals.[29]
The administration of healthcare financing was based on a central National Health Fund. This Fund, which had its headquarters in each of the sixteen regions and offices at the local level, was the body responsible for the collection of healthcare financing resources paid through the insurance scheme, as well as for funding services and the reimbursement of medicines. As anticipated, the delivery of healthcare services to citizens, on the other hand, was decentralized, as both the government and territorial administrative units, i.e., counties (*powiats*), would be in charge of managing and administering their own healthcare facilities.[30]
One consideration is essential for the sake of the analysis. Polish healthcare spending had been relatively low in recent decades,[31] well below the EU average. The number of doctors and nurses within the population was still among the lowest in the EU,[32] and the workforce of healthcare professionals was unevenly distributed across the country.

4. The pandemic emergency in Poland

The pandemic emergency that arose as a result of the spread of the Covid-19 virus generated a global health and economic crisis, which had major repercussions in the Polish system from the perspective of economic and health system resilience. With regard to this latter profile, the pandemic required the adoption of unprecedented measures. Indeed, huge expenditures were made to purchase equipment and health supplies, as well as to increase the capacity of hospital and laboratory facilities, which clearly envisaged a strategy of reinforcement in terms of staffing. This extraordinary effort was somewhat forced by some critical issues in the sector that were structured before the pandemic event.
Public spending on the health sector, which was quite low and amounted to only about 4.8 percent of GDP in 2018, well below the European average, was instead at about 7 percent. In addition, the Polish health service was faced with a significant staffing problem. On the one hand, the number of practicing physicians and nurses in relation to the population

[29] T. Popic, *Poland*, in E.M. Immergut, K.M. Anderson, C. Devitt, T. Popic (eds.), *Health Politics in Europe: A Handbook*, Oxford, Oxford University Press, 2021, p. 749.

[30] C. Włodarczyk, D. Karkowska, *Decentralizing the Healthcare Sector in Poland in the 1990s*, in G. Shakarishvili (ed.), *Decentralization in Healthcare: Analyses and Experiences in Central and Eastern Europe in the 1990s*, Budapest, Open Society Institute, 2000.

[31] In 2021, 5.8% of the gross domestic product (GDP). See the resource available at the following url: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Government_expenditure_on_health#:%7E:text=General%20government%20expenditure%20in%20the,8.0%20%25%20of%20GDP%20in%202020.

[32] 8.1%. See *ibidem*.

was among the lowest in the European Union and, on the other hand, the distribution of these healthcare professionals was rather unevenly organized in the country. Even before the advent of the Covid-19 pandemic, these aspects were already contributing to the significant inefficiencies in the healthcare system functioning and in the public's access to it. In fact, the Polish healthcare system relied too heavily on hospital facilities, which had budgets that were plagued by a high rate of debt and low occupancy rates. Such care is particularly expensive, especially in the face of the fact that many medical procedures can also be performed at outpatient levels of care and at lower costs. In addition, as pointed out above, the hospital system was chronically underfunded, including in terms of human resources, the conditions of which, in terms of pay and workload, were unfavorable. This circumstance, moreover, created a systemic problem that fueled attitudes of disfavor toward the health professions, which contributed to the underfunding of the workforce and to the need to retain incumbent operators and professionals beyond retirement age.

5. The National Recovery and Resilience Plan: a content analysis and perspectives for the Polish healthcare system

The Polish National Recovery and Resilience Plan[33] includes a combination of complementary reforms and investments, which are organized into six macro areas of development[34]. Specifically, Part D is dedicated to ensuring and improving the efficiency, accessibility, and quality of the healthcare system. As outlined above, the Polish healthcare system has traditionally showed drawbacks and inefficiencies. The system was organized by placing a significant burden on hospitals, which are based on the most expensive type of care. Therefore, the first requirement would be to focus on uplifting primary and outpatient care, as a way of lowering the burden on hospitals while simultaneously coping with the expected rise of the expenditure through public finances. Performing some services at lower levels would imply lower costs and the subsequent relief of public expenditure, especially given that a significant rise of healthcare spending has been estimated for the near term. As of now, many services that have been traditionally performed in hospitals – with high costs and the resultant strain on the healthcare system – could be performed more efficiently at a lower level of care.

[33] *Krajowego Planu Odbudowy i Zwiększania Odporności*, available in polish at the following url: https://www.funduszeeuropejskie.gov.pl/media/109762/KPO.pdf.

[34] The six abovementioned areas are the following: A. Resilience and competitiveness of the economy; B. Green energy and energy intensity reduction; C. Digital transformation; D. Efficiency accessibility and quality of the health system; E. Green, smart mobility; F. Improving the quality of institutions and the conditions for the implementation of the RRP.

Thus, the necessity to rethink the structure and organization of the Polish health system in order to shift some services and procedures from hospitals to outpatient care is eminently clear. While all the levels of care have been found to be underfunded, understaffed and overburdened, the hospital system has traditionally suffered the most, given the complexity of the organization, the high costs of carrying out services at that level, and the difficulties encountered when seeking competent personnel since, traditionally, these professions have not been adequately remunerated in terms of income, working conditions or social recognition.

The five reforms and six investments, under this component of the National Recovery and Resilience Plan, focus on the healthcare sector, including long-term care services. The planned measures are aimed at improving the financial situation and making hospital management more efficient through infrastructure development and digital transformation, increasing the number of medical staff, as well as through improved research in the field of medical and health sciences and increased production of drugs and active ingredients.[35] As mentioned, healthcare spending will experience considerable growth in the medium to long term, resulting in an increased burden on public finances. For the reasons outlined above, the Polish healthcare system needs to provide for an expansion of primary and outpatient care with a parallel shift away from placing that burden on hospital facilities, which could allow the same services to be performed at a lower cost. Since Poland will receive about 35 billion euros from the Recovery Plan,[36] the Polish healthcare system will thus enjoy additional resources through an increased spending level coming to about 6 percent of GDP by the 2023 deadline and rising to 7 percent by 2027.

5.1. Reforms and investments for grant subsidies

In order to improve the effectiveness, accessibility and quality of healthcare services, the reform has been directed at revamping the entire hospital sector by restructuring hospital facilities (by means of consolidating, reprofiling and changing the scope and structure of healthcare services provided by hospitals). This includes rationalizing healthcare by performing certain services at lower levels of care, making the financing system more efficient (reducing hospital debt and developing sound hospital financing systems, the establishment of a professional supervision system over hospitals and the strengthening of human resources as well as the application of specialized health management systems). The development and modernization of particular types of infrastructure consisting of highly specialized treatment centers and other health service providers through forms of support

[35] For the breakdown in each component, see the table in the *brief* of the EPRS | European Parliamentary Research Service, available at the following url: https://www.europarl.europa.eu/RegData/etudes/BRIE/2022/733665/EPRS-Briefing-733665-NRRP-Poland-FINAL.pdf.

[36] See https://www.consilium.europa.eu/it/press/press-releases/2022/06/17/recovery-fund-ministers-welcome-assessment-of-poland-s-national-plan/.

covering the scope of activities related to the provision of health services financed by the National Health Fund has also been programmed.
An additional investment objective is to accelerate the digital transformation of health care, not only through the development of existing services but also through the introduction of new digital health services, including patient health analysis tools, algorithmic decision support mechanisms for physicians, and a central repository of medical data integrated with other health service systems.
In terms of the human resources profile, the reform aims to boost medical studies by encouraging student loans and creating a second cycle of studies for emergency physicians, and the subsequent support for the practice of medicine in the Polish countryside through financial incentives. In general, it will be necessary to provide a legislative framework that will improve the attractiveness of entering the medical professions and the working conditions of medical professionals, as well as increasing the flexibility of postgraduate training. Therefore, a significant number of reforms and investments aimed at improving this aspect have been proposed, covering several aspects of the medical profession. These comprise specialized medicine, emergency units and nursing, while at the same time it is agreed that it is time to rethink the academic career and the profession, in order to make this study path attractive.
Among the measures planned for the modernization and adaptation of educational facilities with the aim of increasing admission limits to medical studies, investments will consist of incentives for entry and further study in selected medical courses, the development of new learning modalities based on digital technologies, and the improvement of teaching in central clinical hospitals, as well as the modernization of medical university libraries, student housing, and information systems.
The profile of Polish research and development in medical and health sciences is of particular importance in the economy of the plan. The reform will consist of direct action to encourage a transparent system for the management of clinical trials of medicinal products for human use by reducing administrative and legal barriers. Planned activities to improve research include competitions for funding with a focus on product innovations and medical device development, the increase of clinical research support centers, the creation of a research and analysis center with the specific task of monitoring risks to human health and the general health situation.

5.2. Reforms and investment for lending

One of the main goals is to ensure greater efficiency, availability, and quality of long-term care and geriatric centers in district hospitals in Poland through the modernization of the infrastructure of district-level medical facilities.
With regard to the drugs and medical devices sector, the reform aims to introduce a regulatory framework that facilitates the attraction and increase of the production of drugs and active ingredients in Poland through the identification of critical issues in the supply of active ingredients and support for entrepreneurs engaged in the production of drugs whose supply is lacking. With regard to the investment profiles of active ingredients, forms of

support for the development of active ingredients and related production lines are envisaged.

6. The National Recovery and Resilience Plan and prospects for reform of the Polish healthcare system: some preliminary thoughts

Having contextualized the establishment and development of the Polish healthcare system was particularly significant for the sake of this research. Indeed, outlining the framework made it possible to detect some of the system's long-term drawbacks. Specifically, in light of these problems, the necessity to investigate the main profiles of the Polish National Recovery and Resilience Plan has been laid bare, since its application is actually a part of a continuum that has a primary focus on the healthcare system and its issues. The plan provides a means to address a number of challenges that are inherent in the improvement of territorial and social cohesion, especially through a series of efforts directed at modernizing and expanding access to hospital care, while contemporaneously addressing labor market challenges through strategies for improving education and vocational training within the health professions. In addition, the plan also includes several measures that are expected to increase the resilience of the health and social care system, such as through reforms in hospital facilities and long-term care, digitization strategies, and investments in the development of drugs and active ingredients.

The reforms and the significant amount of investment in the healthcare sector are expected to be fundamental steps toward achieving the goals set. The measures contained in the plan also respond to the impact and risks of the Covid-19 pandemic in the area of healthcare, as well as the pre-existing challenges and critical issues that have beset the Polish health service over time.

In conclusion, these healthcare system reforms should contribute to increasing the effectiveness and efficiency of the health service while improving access to patient services, including from a perspective directed at mitigating social and territorial disparities. Thus, the measures on health and long-term care in the plan are also to be welcomed with respect to the contribution it can make to the implementation of the European Pillar of Social Rights.