GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Retirement Series

Poland

Public Old-Age Health Insurance Plan Details

1992-2022

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Retirement Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Retirement Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Retirement Series* are country and time. We prioritize data collection for each country based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country and each broad category of policies covered in the *Gateway Policy Explorer: Retirement Series*.

Author and Contributor Disclaimers

† The opinions expressed here are those of authors and do not necessarily reflect the views of the OECD or of its member countries.

Poland

Old-Age Health Insurance
Plan details 1992-2022 * †

Poland has a universal health insurance system, regardless of age. Participation to the system is compulsory for all workers. Those who are not subject to compulsory participation can volutarily opt into the system. Everyone covered by health insurance is eligible for free healthcare benefits, although co-payments exists for the provision of drugs. The National Health Insurance Fund is responsible for the financing and provision of health care benefits.

In Poland's long-term care (LTC) system, the family is still identified as the main caregiver for elderly persons with limitations in the activities needed for daily living. There is no specific regulation that comprehensively covers the issues of care services for the elderly, the institutions providing these services, the rules of accessing, or the ways of financing them. Provision of LTC services is carried out in the health sector as well as in the social assistance sector, with limited coordination.

Although public health insurance covers most of the population in Poland, the share of private healthcare spending has remained stable around one-third of the total healthcare expenditure.

Key Dates
First law: 1945
Major changes since 1992: 1999, 2003, 2011

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* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1998

Overview

During this policy period, the Polish healthcare system was based on a highly-centralized universal healthcare system financed by state (i.e., national government) funds. Healthcare was provided by health care management units (ZOZ - Zakład opieki zdrowotnej) and local healthcare facilities. ZOZ are defined as public or private institutions (or groups thereof) - such as hospitals, outpatient clinics, primary and specialist health care providers, or any other facility intended for patients whose health condition requires all-day health services in a suitable permanent room - with the purpose of providing and promoting healthcare. Local healthcare facilities are described as district hospitals, polyclinics and outpatient clinics. While ZOZ can be administered by *voivodeships* (provinces), by *gminas* (local municipalities) or any other legal entity (both public and private), local healthcare facilities are exclusively public institutions administered by each *gmina* under their *voivodeship*'s commission.

Poland's long-term care (LTC) system is fragmented and characterized by a strong informal care component. The family of the individual in need of care is identified as the principal caregiver in the system. During this policy period, administration of formal long-term care services was divided between the Ministry of Health and the Ministry of Labor, Family and Social Policy. Long-term care services developed in two different government service sectors: the health sector and the social assistance sector. In the health sector, two kinds of care units are available: Care and Treatment Facilities (ZOL) and Nursing and Care Facilities (ZPO), which both provide continuous medical care for chronically ill patients, patients with disabilities or those after a serious illness or surgery, who do not require hospitalization. Long-term care services are also provided in hospital departments. In the social assistance sector, two kinds of care units are available: Residential Care Home (DPS) and Adult Day Care Home (DDPS). DPS provide continuous care, nursing and food services to the elderly, while DDPS provide the same services in a daycare setting. In the social assistance sector, cash and in-kind benefits are available for both individuals in need of care and caregivers. The administration and provision of these services, however, differ across each municipality (gmina). Long-term care for the elderly is also provided by private residential and care institutions.

Key health care reforms

The process of creating a universal healthcare system in Poland started in 1945 with the establishment of the Ministry of Health and the declaration of healthcare as a public responsibility. Article 70 of the Constitution of the Polish People's Republic (Journal of Laws, 1952) established the right of every Polish citizen to receive health protection and assistance in the event of illness or incapacity to work. In order to do so, the Polish People's Republic's government developed a state-organized health protection system, including free medical assistance for all working people and their families, the improvement of health and safety conditions, disease prevention and control, care for the disabled, creation of a health provider network including hospitals, outpatient clinics, health centers and other health facilities. The healthcare sector established by the Constitution was a predominantly public and centralized system: the healthcare principles established by the Constitution of the Polish People's Republic did not change after the fall of the Polish People's Republic and the transition towards to the Republic of Poland, which started in 1991. Healthcare services were provided free of charge to all state employees, which comprised most of the workforce. In 1972, healthcare coverage was extended to agricultural workers and health care management units (ZOZ) were created, which were responsible for the provision of all healthcare services. During the following decades, the Polish healthcare system's administration was decentralized from the state level to provincial (voivodeship) and municipal/commune (gmina) levels.

The Act of August 30, 1991 on Health Care Management Units (Journal of Laws, 1991) concluded the process of decentralization of the healthcare system, allowing different levels of ownership of ZOZs (including central, provincial, local and private ownership) and delegating their administration from the Ministry of Health to, primarily, local municipalities (gmina) and, secondarily, to provinces (voivodeship), with independent budgets funded by the Ministry of Finance. The reform also established the responsibility and obligation of ZOZs to provide immediate health services to all individuals presenting conditions posing risk to their life or health. Most healthcare services were provided free of charge, although informal payments to physicians and health care professionals were not uncommon.

Additional reforms during the policy period

- The Act of July 5, 1996 on the Nursing and Midwifery Professions (Journal of Laws, 1996) —effective from October 31, 1996 —allowed nurses to be independent contractors and providers of care, with the ability of signing private contracts with clients.

Eligibility

- **Qualifications**
  Healthcare
  Article 70 of the Constitution of the Polish People's Republic (Journal of Laws, 1952) guaranteed all Polish citizens the right to health protection and to assistance in the event of illness or incapacity to work. Article 7 of Journal of Laws (1991), furthermore, required that health care is provided to all individuals, regardless of citizenship status, in need of immediate health care services due to threats to their life of health.

  Long-Term Care
  For the residential care services provided within the health sector, the Ministry of Health defines, by way of an ordinance, the manner and procedure for referring people to ZOL and ZPO. For services provided within the social assistance sector, eligibility is determined by a formal assessment of the potential recipient's health conditions and their economic circumstances, a means-test, carried out through a subjective evaluation by a social worker at the local/municipal level (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits).

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

Coverage

Healthcare
Health care services are provided in public or private health care facilities and health care managerial units (ZOZ), which can be:

- Hospitals and other facilities for people who need 24-hour or all-day health services in an appropriate, permanent room
- Medical clinics and health centers for general and specialist care
- Emergency clinics
- Diagnostic laboratories
- Dental prosthetics and orthodontics laboratories
- Medical rehabilitation facilities
- Nurseries
- Other establishments meeting the conditions established by the Act of August 30, 1991 on Health Care Management Units (Journal of Laws, 1991)

Health care managerial units (ZOZ) and local health care centers provide different health services, depending on the individual unit, including basic and specialist health care, inpatient and outpatient care, and care to individuals within their geographic region in the fields of general medicine, family medicine, and pediatrics. The services provided, as established by Act of August 30, 1991 on Health Care Management Units (Journal of Laws, 1991), include:

- Medical prophylaxis, examination, diagnosis and advice
- Treatment of health conditions (both inpatient, outpatient, at home and emergency care)
- Supply of drugs and medical materials
- Psychological examination and therapy
- Medical rehabilitation
- Care for a pregnant woman and her fetus, childbirth, puerperium and the newborn
- Diagnostic examination, including medical analytics
- Nursing and care for the sick and disabled
- Palliative and hospice care
- Prosthetics and orthodontics dental care (basic dental care)
- Orthopedic care

Long-Term Care
In the health sector, care and treatment facilities (ZOL) and nursing and care facilities (ZPO) provide continuous health services, which include the care and rehabilitation of people who do not require hospitalization, and provide them with pharmaceuticals and medical materials, room and food appropriate to their health condition, as well as care during cultural and recreational activities. Persons entitled to free health services and who are residing in residential institutions (ZOL and ZPO) are provided with health care services, drugs, medicines and medical materials by the institution's doctor. In the social assistance sector, DPS are intended for the elderly, the chronically ill and individuals with specific medical, physical or mental conditions whose health requires constant care but does not

require hospital treatment. Each individual DPS is specialized in care for patients with specific conditions, but they are mostly populated by elderly individuals. DDPS provide daycare, nursing and food service for individuals in need of care, but whose family cannot provide care during the day.

Costs

Healthcare

There is no cost-sharing for primary care and referred outpatient specialist care, emergency medical care and inpatient care, although cost-sharing may be applied to outpatient medicines, medical transport of patients, and inpatient long-term care. With the exception of medicines, medicinal products and auxiliary medical devices, as well as health resort treatments and certain dental procedures and materials, services are fully covered. All individuals have the right to free outpatient emergency care.

Outpatient specialist health services provided to the patient without referral of a physician are paid by the patient. Referral is not required for the following specialists:

- Gynecologist and obstetrician
- Dentist
- Dermatologist
- Venereologist
- Oncologist
- Ophthalmologist
- Psychiatrist
- Specialists in tuberculosis or HIV

Referral is also not required for circumstances posing imminent threat to life and childbirth.

Out-of-pocket costs include:

- Rehabilitation services
  Although rehabilitation services are provided free of charge, the cost of food and accommodation might be fully paid by the patient, or covered on terms provided by separate regulations.
- Diagnostic tests
  The Ministry of Health and Social Welfare define, by means of an ordinance, the list of diagnostic tests for which the patient should pay a flat-fee copayment, and the maximum amount of these fees.
- Drugs and medicines
  Drugs, medicines and medical materials are provided free of charge to the patient if they are admitted to hospitals or other health care facilities for inpatient treatment, if they are receiving emergency assistance, when receiving therapeutic, diagnostic and rehabilitation treatments in outpatient facilities, or if they suffer from certain chronic, congenital or acquired diseases. In all other cases, individuals might incur copayments depending on the classification of the drugs prescribed:
  - Basic drugs: Life-saving drugs, or drugs necessary in therapy and to maintain health
  - Complementary drugs: Drugs supporting or supplementing the action of basic drugs, as well as drugs of the latest generation with similar therapeutic properties and higher price

  Basic drugs are issued after the patient pays a lump-sum fee (if lower than the price of the drug), and the lump-sum fee paid may not exceed 0.5% of the minimum wage. Complementary drugs are issued after the patient pays a fee equal to 30% of the price of the drug. The Minister of Health and Social Welfare, after consulting the Supreme Medical Council and the Supreme Pharmaceutical Council, determines, by a way of an ordinance, the list of basic and complementary drugs, the amount of the lump-sum fees paid by the patient for the provision of basic drugs, the amount of payment for complementary drugs, and the reference dosages for which these copayments apply. Prices of drugs included in the Ministry of Health's ordinances are considered reference prices, and individual pharmacies can sell them at lower retail prices. Prices of generic drugs are not regulated. Exemptions on copayments for drugs exist for specific cases defined by law.
- Orthopedic items, auxiliary and technical equipment
  A patient may be require to pay part or all of the cost for orthopedic items, auxiliary and technical equipment. The Ministry of Health and Social Welfare, by means of an ordinance, provides a list of items defined as orthopedic items, auxiliary and technical equipment, as well as the amount of the patient's share in their purchase price.
- Medical transport
  Medical transport is provided free of charge on the basis of a doctor's or a medical assistant's order if:
  - The patient requires immediate treatment in a healthcare institution
  - The patient requires transportation in order to maintain continuity of treatment in the event of health- or life-threatening conditions

Long-Term Care

In the health sector, a person staying in ZOL or ZPO care institutions shall bear the costs of food and accommodation. The monthly fee is equal to the amount corresponding to 250% of the minimum old-age pension (see Table 1 for yearly values), but the fee may not be higher than the amount corresponding to 70% of the individual's monthly income. All medical services and drugs are provided free of charge. In the social assistance sector, individuals are responsible for paying the cost for stays in DPS, and the monthly fee is equal to 200% of the minimum old-age pension (see Table 1 for yearly values), but the fee cannot be higher than 70% of the individual's monthly income. The fee for stays in DDPS is equal to the cost of food provided. These costs are applicable to all DPS and DDPS facilities, except those run by municipalities (gminas) and their associations, which are free to set different prices and copayments.

Chapter 2: Policy enacted 1999-2002

Policy change in 1999

With the Four Reform Program (Program czterech reform), the Polish government introduced a major reform on four key sectors: retirement, education, public administration, and healthcare. The healthcare reform (Reforma służby zdrowia) consisting of Act of February 6, 1997 on Universal Health Insurance —effective from January 1, 1999 —introduced the following substantial reforms to the healthcare system:

- Changed the financing structure of the healthcare system into a system based on a compulsory public health insurance system, financed by contributions paid by the insured and, for some services, the state budget
- Created 16 regional health insurance funds, one for each of the 16 regions (voivodeship), plus one additional separate health insurance fund reserved for uniformed public employees (such as the army and railroad workers), aimed at managing health insurance contributions with the task of financing health services for insured individuals and contracting health services with public and private care providers
- Established the institutions of family doctors, family doctor centers and independent healthcare facilities
- Transformed the public health care management units (ZOZ) that were funded from the state budget from state budgetary units to independent contractors with an independent budget (defined as SPZOZ), which establish contracts with health insurance funds to provide healthcare services
- Changed the administrative structure of the system by establishing a three-tier system based on territorial divisions, separating responsibilities as follows:
  - Ministry of Health and Social Welfare: Tertiary hospital care
  - Region (Voivodeship): Primary and secondary care through voivodeship-owned health care management units (ZOZ), with different degrees of specialization
  - Local government (Gmina): Primary and secondary care through gmina-owned health care management units (ZOZ)
- Separated sickness insurance from health insurance. Sickness insurance is administered by ZUS and provides cash benefits in the event of sickness and maternity. Sickness insurance contributions and participation are compulsory for all employees, and voluntary for the self-employed and homeworkers.

Overview

During this policy period, the Polish healthcare system was based on a decentralized universal system, financed by mandatory public health insurance contributions and state (i.e., national government) funds. Healthcare is provided by health care management units (ZOZ - Zakład opieki zdrowotnej) and local healthcare facilities. ZOZ are defined as public or private institutions (or groups thereof) - such as hospitals, outpatient clinics, primary and specialist health care providers, or any other facility intended for patients whose health condition requires all-day health services in a suitable permanent room - with the purpose of providing and promoting healthcare. Local healthcare facilities are described as district hospitals, polyclinics and outpatient clinics, and are only public institutions. While ZOZ can be administered by *voivodeships* (provinces), by *gminas* (local municipalities) or any other legal entity (both public and private), local healthcare facilities are administered by each *gmina* under their *voivodeship*'s commission. Both ZOZ and local healthcare facilities must operate exclusively as independent budgetary units.

Almost the entire population is covered by public mandatory public health insurance. All employees, self-employed individuals, unemployed individuals and pensioners, among others, are subject to mandatory health insurance contributions and are covered by the system. Individuals subject to mandatory healthcare contributions must enroll in a health insurance fund to receive health care. Individuals not subject to mandatory healthcare contributions may voluntarily enroll in a health insurance fund and pay healthcare contributions in order to receive health care. Insured individuals must declare family members that would not be covered by the system otherwise, and they acquire the same healthcare coverage as the insured.

The healthcare system is decentralized at the administrative and territorial levels. Different levels of territorial administration are responsible for the provision of services:

- Ministry of Health and Social Welfare: Tertiary hospital care
- Provinces (Voivodeship): Primary and secondary care through voivodeship-managed health care management units (ZOZ), with different degrees of specialization
- District and municipal government (Powiat and Gmina): Primary and secondary care through powiat- and gmina-managed health care management units (ZOZ) and hospitals

Services are contracted by 16 regional health insurance funds, plus an additional health insurance fund reserved for uniformed public employees (such as the army and railroad workers). Contributions are collected from ZUS (Poland's Social Insurance Institution - Zakład

Ubezpieczeń Społecznych) and paid to each health insurance fund.

The insured has the right to receive healthcare services on the basis of a referral from a health insurance fund's doctor. Healthcare services are provided free of charge for all insured and their family members, although copayments may be required depending on the beneficiary's income.

Some specialized services (such as organ transplants) and also public health programs (such as the National Health Program, National Heart Protection Program and the Cancer Control Program) remain financed from the state budget.

Poland's long-term care (LTC) system is fragmented and characterized by a strong informal care component. The family of the individual in need of care is identified as the principal caregiver in the system. During this policy period, administration of formal long-term care services was divided between the Ministry of Health and the Ministry of Labor, Family and Social Policy. Long-term care services developed in two different sectors: the health sector and the social assistance sector. In the health sector, two kinds of care units are available: Care and Treatment Facilities (ZOL) and Nursing and Care Facilities (ZPO), which both provide continuous medical care for chronically ill patients, patients with disabilities or those after a serious illness or surgery, who do not require hospitalization. Long-term care services are also provided in hospital departments. In the social assistance sector, two kinds of care units are available: Residential Care Home (DPS) and Adult Day Care Home (DDPS). DPS provide continuous care, nursing and food services to the elderly, while DDPS provide the same services in a daycare setting. In the social assistance sector, cash and in-kind benefits are available for both individuals in need of care and caregivers. The administration and provision of this services, however, differs across each individual municipality (gmina). Long-term care for the elderly is also provided by private residential and care institutions.

Eligibility

- **Qualifications**
  Healthcare
  All individuals having Polish citizenship and residing in the Republic of Poland, and all foreign individuals residing in the Republic of Poland with a permanent or temporary residence permit, are insured by the healthcare system if they are subject to compulsory health insurance contributions or if they voluntarily contribute to the health insurance system. Individuals subject to compulsory healthcare contributions are:
  - Employees (including farmers and homeworkers)
  - Civil servants and public employees
  - Armed forces, policemen, firefighters and other public safety employees
  - Unemployed
  - Pensioners (recipients of old-age and disability pensions, as well as social assistance benefits, both temporary and permanent)
  - Students

  Declared family members of the insured are also deemed insured by the healthcare system. Family members eligible to be covered by the healthcare system through the insured's coverage are:
  - The insured's own, foster or adopted child
    - Until age 18
    - Until age 26, if they continue their education
    - No age limit, if severely disabled
  - The insured's spouse
  - Other ascendants who reside in the same household and who are not covered by the insurance obligation

  Long-Term Care
  For the residential care services provided within the health sector, the Ministry of Health defines, by way of an ordinance, the manner and procedure for referring people to ZOL and ZPO. For services provided within the social assistance sector, eligibility is determined by a formal assessment of the potential recipient's health conditions and their economic circumstances, a means-test, carried out through a subjective evaluation by a social worker at the local/municipal level (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits).

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

Coverage

Healthcare

Health care services are provided in public or private health care facilities and health care managerial units (ZOZ), which can be:

- Hospitals and other facilities for people who need 24-hour or all-day health services in an appropriate, permanent room
- Medical clinics and health centers for general and specialist care
- Emergency clinics
- Diagnostic laboratories
- Dental prosthetics and orthodontics laboratories
- Medical rehabilitation facilities
- Nurseries
- Other establishments meeting the conditions established by the Act of August 30, 1991 on Health Care Management Units (Journal of Laws, 1991)

Health care facilities and health care managerial units (ZOZ) provide different health services, depending on the individual unit, including basic and specialist health care, inpatient and outpatient care, and care to individuals within their geographic region in the fields of general medicine, family medicine, and pediatrics. The services provided, as established by Act of February 6, 1997 on Universal Health Insurance (Journal of Laws, 1997), include:

- Medical prophylaxis, examination, diagnosis and advice
- Treatment of health conditions (both inpatient, outpatient, at home and emergency care)
- Supply of drugs and medical materials
- Medical rehabilitation
- Care for a pregnant woman and her fetus, childbirth, puerperium and the newborn
- Diagnostic examination, including medical analytics
- Nursing and care for the sick and disabled
- Palliative and hospice care
- Prosthetics and orthodontics dental care (basic dental care)
- Orthopedic care

The insured has the right to hospital treatment on the basis of a referral from a health insurance doctor, if the purpose of the treatment cannot be achieved through outpatient treatment. The insured has the right to choose a hospital among the network of hospitals that have an agreement with the health insurance fund in which the individual is insured. The insured can also choose a facility outside of their health insurance fund's network. However, their health insurance fund would cover only costs up to their reference cost calculated within their own network.

Long-Term Care

In the health sector, care and treatment facilities (ZOL) and nursing and care facilities (ZPO) provide continuous health services, which include the care and rehabilitation of people who do not require hospitalization, and provide them with pharmaceuticals and medical materials, room and food appropriate to their health condition, as well as care during cultural and recreational activities. Insured persons entitled to free health services and who are residing in residential institutions (ZOL and ZPO) are provided with health care services, drugs, medicines and medical materials by the institution's doctor. In the social assistance sector, DPS are intended for the elderly, the chronically ill and individuals with specific medical, physical or mental conditions whose health requires constant care but does not require hospital treatment. Each individual DPS is specialized in care for patients with specific conditions, but they are mostly populated by elderly individuals. DDPS provide daycare, nursing and food service for individuals in need of care, but whose family cannot provide care during the day.

Costs

Healthcare

For the insured, there is no cost-sharing for primary care and referred outpatient specialist care, emergency medical care and inpatient care, although cost-sharing may be applied to outpatient medicines, medical transport of patients, and inpatient long-term care. With the exception of medicines, medicinal products and auxiliary medical devices, as well as health resort treatments and certain dental procedures and materials, services are fully covered. Uninsured individuals have the right to free outpatient emergency care.

Outpatient specialist health services provided to the insured without referral of a health insurance physician are paid by the insured. Referral is not required for the following specialists:

- Gynecologist and obstetrician
- Dentist
- Dermatologist
- Venereologist
- Oncologist
- Ophthalmologist
- Psychiatrist
- Specialists in tuberculosis or HIV

Referral is also not required for circumstances posing imminent threat to life and childbirth. Reimbursement is also provided if the insured individual chooses to use an out-of-network healthcare provider that has not contracted healthcare services with the insured's health insurance fund, to the extent of the reference cost of the service. The reference cost is calculated as the average cost over the preceding calendar year of treating a patient in hospitals providing a given specialty within the territorial responsibility of each health insurance fund.

Out-of-pocket costs include:

- Hospital services
  If the insured, after a referral from their insurance health fund's doctor, chooses to receive hospital treatment from an out-of-network hospital, they are responsible for paying the difference between the final cost paid and the reference cost calculated within each health insurance fund.
- Rehabilitation services
  Although rehabilitation services are provided free of charge, the cost of food and accommodation might be fully paid by the patient, or covered on terms provided by separate regulations.
- Diagnostic tests
  The Ministry of Health and Social Welfare define, by means of an ordinance, the list of diagnostic tests for which the patient should pay a flat-fee copayment, and the maximum amount of these fees.
- Drugs and medicines
  Drugs, medicines and medical materials are provided free of charge to the insured if they are admitted to hospitals or other health care facilities for inpatient treatment, if they are receiving emergency assistance, when receiving therapeutic, diagnostic and rehabilitation treatments in outpatient facilities, or if they suffer from certain chronic, congenital or acquired diseases. In all other cases, insured individuals might incur in copayments depending on the classification of the drugs prescribed:
  - Basic drugs: Life-saving drugs, or drugs necessary in therapy and to maintain health
  - Prescription drugs: Drugs prepared in a pharmacy on the basis of a prescription
  - Complementary drugs: Drugs supporting or supplementing the action of basic drugs, as well as drugs of the latest generation with similar therapeutic properties and higher price

  Basic and prescription drugs are issued after the insured pays a lump-sum fee (if lower than the price of the drug), and the lump-sum fee paid may not exceed 0.5% of the minimum wage for basic drugs and 1.5% of the minimum wage for prescription drugs. Complementary drugs are issued after the insured pays a fee equal to 30% or 50% of the price of the drug. The Minister of Health and Social Welfare, after consulting the Supreme Medical Council and the Supreme Pharmaceutical Council, determines, by a way of an ordinance, the list of basic and complementary drugs, the amount of the lump-sum fees paid by the insured for the provision of basic and prescription drugs, the amount of payment for complementary drugs, and the reference dosages for which these copayments apply. Prices of drugs included in the Ministry of Health's ordinances are considered reference prices, and individual pharmacies can sell them at lower retail prices. Prices of generic drugs are not regulated. Exemptions on copayments for drugs exist for specific cases defined by law.
- Orthopedic items, auxiliary and technical equipment
  The insured might bear part or the entirety of the cost of orthopedic items, auxiliary and technical equipment. The Ministry of Health and Social Welfare, by means of an ordinance, provides a list of items defined as orthopedic items, auxiliary and technical equipment, as well as the amount of the insured's share in their purchase price.
- Medical transport
  Medical transport is provided free of charge on the basis of a doctor's or a medical assistant's order if:
  - The insured requires immediate treatment in a healthcare institution
  - The insured requires transportation in order to maintain continuity of treatment in the event of health- or life-threatening conditions

Long-Term Care

In the health sector, a person staying in ZOL or ZPO care institutions shall bear the costs of food and accommodation. The monthly fee is equal to the amount corresponding to 250% of the minimum old-age pension (see Table 1 for yearly values), but the fee may not be

higher than the amount corresponding to 70% of the individual's monthly income. All medical services and drugs are provided free of charge. In the social assistance sector, individuals are responsible for paying the cost for stays in DPS, and the monthly fee is equal to 200% of the minimum old-age pension (see Table 1 for yearly values), but the fee cannot be higher than 70% of the individual's monthly income. The fee for stays in DDPS is equal to the cost of food provided. These costs are applicable to all DPS and DDPS facilities, except those run by municipalities (gminas) and their associations, which are free to set different prices and copayments.

Chapter 3: Policy enacted 2003-2010

Policy change in 2003

The Act of January 23, 2003 on Universal Health Insurance in the National Health Fund (Journal of Laws, 2013) —effective from April 1, 2003 —introduced the following substantial reforms to the healthcare system:

- Created the National Health Insurance Fund (NFZ) consisting of a centralized fund with 16 regional branches, replacing the previous system based on multiple regional funds
- Unified procedures and standards for certain procedures
- Increased the role of the Ministry of Health as policymaker in the system
- Gave financial management of NFZ to the Ministry of Finance
- Imposed a symbolic cap on basic drugs (defined as life-saving drugs and drugs necessary in therapy to maintain health) for insured individuals aged 65 or more, equal to 1 zł
- Established rules for introducing the provision of long-term care services at the patient's home by nurses and nursing units that have contracted services with NFZ

The 2003 Act did not meet the Constitutional Tribunal's requirements concerning the list of health care services financed by the National Health Insurance Fund (NFZ). Therefore, the Act of August 27, 2004 on Health Care Services Financed from Public Funds —effective from January 1, 2005 —provided a list of services whose financing should be excluded from public state funds. This act satisfied the constitutional requirements breached by the previous legislation, but it did not change eligibility, coverage and out-of-pocket provisions included in the 2003 Act.

Additional reforms during this period include:

- Regulation of the Minister of Health of August 30, 2009 on Guaranteed Benefits in the Field of Nursing and Care Benefits as Part of Long-Term Care (Journal of Laws, 2009) —effective from August 31, 2009 —introduced additional eligibility requirements for patients seeking admission into residence homes within the health sector (ZOL and ZPO). Eligible patients must have received a score below 40 points on the Barthel test during a medical evaluation. The Barthel test is used to assess a person's level of independence in 10 Activities of Daily Living (ADL). This reform significantly restricted access to LTC services financed by NFZ.

Overview

During this policy period, the Polish healthcare system was based on a centralized universal system, financed by mandatory public health insurance contributions and state (i.e., national government) funds. Healthcare is provided by health care management units (ZOZ - Zakład opieki zdrowotnej) and local healthcare facilities. ZOZ are defined as public or private institutions (or groups thereof) - such as hospitals, outpatient clinics, primary and specialist health care providers, or any other facility intended for patients whose health condition requires all-day health services in a suitable permanent room - with the purpose of providing and promoting healthcare. Local healthcare facilities are described as district hospitals, polyclinics and outpatient clinics, and are only public institutions. While ZOZ can be administered by *voivodeships* (provinces), by *gminas* (local municipalities) or any other legal entity (both public and private), local healthcare facilities are administered by each *gmina* under their *voivodeship*'s commission.

Almost the entire population is covered by public mandatory public health insurance. All employees, self-employed individuals, unemployed individuals and pensioners, among others, are subject to mandatory health insurance contributions and are covered by the system. Individuals subject to mandatory healthcare contributions must enroll in the National Health Insurance Fund (Narodowy Fundusz Zdrowia - NFZ) to receive health care. Individuals not subject to mandatory healthcare contributions may voluntarily enroll in NFZ and pay healthcare contributions in order to receive health care. Insured individuals must declare family members that would not be covered by the system otherwise, and they acquire the same healthcare coverage as the insured.

The administration of the healthcare system is centralized at the national level, and the provision of services is decentralized to territorial units. Different levels of territorial administration are responsible for the provision of services:

- Ministry of Health and Social Welfare: Tertiary hospital care
- Provinces (Voivodeship): Primary and secondary care through voivodeship-managed health care management units (ZOZ), with different degrees of specialization
- District and municipal government (Powiat and Gmina): Primary and secondary care through powiat- and gmina-managed health care management units (ZOZ) and hospitals

Services are contracted by the National Health Insurance Fund (NFZ). Contributions are collected from ZUS (Poland's Social Insurance Institution - Zakład Ubezpieczeń Społecznych) and paid to NFZ.

The insured has the right to receive healthcare services on the basis of a referral from a NFZ doctor. Healthcare services are provided free of charge for all insured and their family members, although copayments may be required depending on the beneficiary's income.

Some specialized services (such as organ transplants) and also public health programs (such as the National Health Program, National Heart Protection Program and the Cancer Control Program) remain financed from the state budget.

Poland's long-term care (LTC) system is fragmented and characterized by a strong informal care component. The family of the individual in need of care is identified as the principal caregiver in the system. During this policy period, administration of formal long-term care services was divided between the Ministry of Health and the Ministry of Labor, Family and Social Policy. Long-term care services developed in two different sectors: the health sector and the social assistance sector. In the health sector, two kinds of care units are available: Care and Treatment Facilities (ZOL) and Nursing and Care Facilities (ZPO), which both provide continuous medical care for chronically ill patients, patients with disabilities or those after a serious illness or surgery, who do not require hospitalization. Eligibility for admission into ZOL and ZPO requires a medical evaluation of activities of daily living (ADLs) that the patient is unable to carry out by themself. Long-term care services are also provided in hospital departments. In the social assistance sector, two kinds of care units are available: Residential Care Home (DPS) and Adult Day Care Home (DDPS). DPS provide continuous care, nursing and food services to the elderly, while DDPS provide the same services in a daycare setting. In the social assistance sector, cash and in-kind benefits are available for both individuals in need of care and caregivers. From 2004, all benefits provided within the social assistance sector are subject to a national mean-test (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits), although services provided differ by each municipality (gmina). Long-term care for the elderly is also provided by private residential and care institutions.

Eligibility

- **Qualifications**
  Healthcare
  All individuals having Polish citizenship and residing in the Republic of Poland, and all foreign individuals residing in the Republic of Poland with a permanent or temporary residence permit, are insured by the healthcare system if they are subject to compulsory health insurance contributions or if they voluntarily contribute to the health insurance system. Individuals subject to compulsory healthcare contributions are:
  - Employees (including farmers and homeworkers)
  - Civil servants and public employees
  - Armed forces, policemen, firefighters and other public safety employees
  - Unemployed
  - Pensioners (recipients of old-age and disability pensions, as well as social assistance benefits, both temporary and permanent)
  - Students

  Declared family members of the insured are also deemed insured by the healthcare system. Family members eligible to be covered by the healthcare system through the insured's coverage are:
  - The insured's own, foster or adopted child
    - Until age 18
    - Until age 26, if they continue their education
    - No age limit, if severely disabled
  - The insured's spouse
  - Other ascendants who reside in the same household and who are not covered by the insurance obligation

  Long-Term Care
  For the residential care services provided within the health sector, until 2009, the Ministry of Health defines, by way of an ordinance, the manner and procedure for referring people to ZOL and ZPO. From 2009, patients must receive a score below 40 points on the Barthel test, carried out during a medical evaluation. The Barthel test is used to assess a person's level of independence in 10 Activities of Daily Living (ADLs). For services provided within the social assistance sector, eligibility is determined by a formal assessment of the potential recipient's health conditions and their economic circumstances, a means-test, carried out by a social worker at the local/municipal level following nationwide eligibility criteria (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits).

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

Coverage

Healthcare

Health care services are provided in public or private health care facilities and health care managerial units (ZOZ), which can be:

- Hospitals and other facilities for people who need 24-hour or all-day health services in an appropriate, permanent room
- Medical clinics and health centers for general and specialist care
- Emergency clinics
- Diagnostic laboratories
- Dental prosthetics and orthodontics laboratories
- Medical rehabilitation facilities
- Nurseries
- Other establishments meeting the conditions established by the Act of January 23, 2003 on Universal Health Insurance in the National Health Fund (Journal of Laws, 2003)

Health care facilities and health care managerial units (ZOZ) provide different health services, depending on the individual unit, including basic and specialist health care, inpatient and outpatient care, and care to individuals in need in their residence in the field of general medicine, family medicine, and pediatrics. The services provided, as established by Act of January 23, 2003 on Universal Health Insurance in the National Health Fund (Journal of Laws, 2003), include:

- Medical prophylaxis, examination, diagnosis and advice
- Treatment of health conditions (both inpatient, outpatient, at home and emergency care)
- Supply of drugs and medical materials
- Medical rehabilitation
- Care for a pregnant woman and her fetus, childbirth, puerperium and the newborn
- Diagnostic examination, including medical analytics
- Nursing and care for the sick and disabled
- Palliative and hospice care
- Prosthetics and orthodontics dental care (basic dental care)
- Orthopedic care

The insured has the right to hospital treatment on the basis of a referral from a health insurance doctor, if the purpose of the treatment cannot be achieved through outpatient treatment. The insured has the right to choose a hospital among the network of hospitals that have an agreement with the National Health Insurance Fund (NFZ). The insured can also choose a facility outside of NFZ's network. However, the NFZ would cover only costs up to their reference cost calculated within comparable in-network healthcare service providers in the NFZ's branch's area.

Long-Term Care

In the health sector, care and treatment facilities (ZOL) and nursing and care facilities (ZPO) provide continuous health services, which include the care and rehabilitation of people who do not require hospitalization, and provide them with pharmaceuticals and medical materials, room and food appropriate to their health condition, as well as care during cultural and recreational activities. Insured persons entitled to free health services and who are residing in residential institutions (ZOL and ZPO) are provided with health care services, drugs, medicines and medical materials by the institution's doctor. In the social assistance sector, DPS are intended for the elderly, the chronically ill and individuals with specific medical, physical or mental conditions whose health requires constant care but does not require hospital treatment. Each individual DPS is specialized in care for patients with specific conditions, but they are mostly populated by elderly individuals. DDPS provide daycare, nursing and food service for individuals in need of care, but whose family cannot provide care during the day.

Costs

Healthcare

For the insured, there is no cost-sharing for primary care and referred outpatient specialist care, emergency medical care and inpatient care, although cost-sharing may be applied to outpatient medicines, medical transport of patients, and inpatient long-term care. With the exception of medicines, medicinal products and auxiliary medical devices, as well as health resort treatments and certain dental procedures and materials, services are fully covered. Uninsured individuals have the right to free outpatient emergency care.

Outpatient specialist health services provided to the insured without referral of a health insurance physician are paid by the insured. Referral is not required for the following specialists:

- Gynecologist and obstetrician
- Dentist
- Dermatologist
- Venereologist
- Oncologist
- Ophthalmologist
- Psychiatrist
- Specialists in tuberculosis or HIV

Referral is also not required for circumstances posing imminent threat to life and childbirth. Reimbursement is also provided if the insured individual chooses to use an out-of-network healthcare provider that has not contracted healthcare services with the National Health Insurance Fund (NFZ), to the extent of the reference cost of the service. The reference cost is calculated as the average cost over the preceding calendar year of treating a patient in hospitals providing a given specialty within the territorial responsibility of each branch of NFZ.

Out-of-pocket costs include:

- Hospital services
  If the insured, after a referral from their insurance health fund's doctor, chooses to receive hospital treatment from an out-of-network hospital, they are responsible for paying the difference between the final cost paid and the reference cost calculated within each health insurance fund.
- Rehabilitation services
  Although rehabilitation services are provided free of charge, the cost of food and accommodation might be fully paid by the insured, or covered on terms provided by separate regulations.
- Diagnostic tests
  The Ministry of Health and Social Welfare define, by means of an ordinance, the list of diagnostic tests for which the insured person should pay a flat-fee copayment, and the maximum amount of these fees.
- Drugs and medicines
  Drugs, medicines and medical materials are provided free of charge to the insured if they are admitted to hospitals or other health care facilities for inpatient treatment, if they are receiving emergency assistance, when receiving therapeutic, diagnostic and rehabilitation treatments in outpatient facilities, or if they suffer from certain chronic, congenital or acquired diseases. In all other cases, insured individuals might incur in copayments depending on the classification of the drugs prescribed:
  - Basic drugs: Life-saving drugs, or drugs necessary in therapy and to maintain health
  - Prescription drugs: Drugs prepared in a pharmacy on the basis of a prescription
  - Complementary drugs: Drugs supporting or supplementing the action of basic drugs, as well as drugs of the latest generation with similar therapeutic properties and higher price

  Basic and prescription drugs are issued after the insured pays a lump-sum fee (if lower than the price of the drug), and the lump-sum fee paid may not exceed 0.5% of the minimum wage for basic drugs and 1.5% of the minimum wage for prescription drugs. Insured persons aged over 65 are issued basic drugs, on the basis of a prescription issued by a doctor, after paying a symbolic copayment of PLN 1 for a unit package. Complementary drugs are issued after the insured pays a fee equal to 30% or 50% of the price of the drug. The Minister of Health and Social Welfare, after consulting the Supreme Medical Council and the Supreme Pharmaceutical Council, determines, by a way of an ordinance, the list of basic and complementary drugs, the amount of the lump-sum fees paid by the insured for the provision of basic and prescription drugs, the amount of payment for complementary drugs, and the reference dosages for which these copayments apply. Prices of drugs included in the Ministry of Health's ordinances are considered reference prices, and individual pharmacies can sell them at lower retail prices. Prices of generic drugs are not regulated. Exemptions on copayments for drugs exist for specific cases defined by law.
- Orthopedic items, auxiliary and technical equipment
  The insured might bear part or the entirety of the cost of orthopedic items, auxiliary and technical equipment. The Ministry of Health and Social Welfare, by means of an ordinance, provides a list of items defined as orthopedic items, auxiliary and technical equipment, as well as the amount of the insured's share in their purchase price.
- Medical transport
  Medical transport is provided free of charge on the basis of a doctor's or a medical assistant's order if:
  - The insured requires immediate treatment in a healthcare institution
  - The insured requires transportation in order to maintain continuity of treatment in the event of health- or life-threatening conditions

Long-Term Care

In the health sector, a person staying in ZOL or ZPO care institutions shall bear the costs of food and accommodation. The monthly fee

is equal to the amount corresponding to 250% of the minimum old-age pension (see Table 1 for yearly values), but the fee may not be higher than the amount corresponding to 70% of the individual's monthly income. All medical services and drugs are provided free of charge. In the social assistance sector, individuals are responsible for paying the cost for stays in DPS, and the monthly fee is equal to 200% of the minimum old-age pension (see Table 1 for yearly values), but the fee cannot be higher than 70% of the individual's monthly income. The fee for stays in DDPS is equal to the cost of food provided. These costs are applicable to all DPS and DDPS facilities, except those run by municipalities (gminas) and their associations, which are free to set different prices and copayments.

Chapter 4: Policy enacted 2011-2022

Policy change in 2011

The Act of April 15, 2011 on Therapeutic Activity (Journal of Laws, 2011a) —effective from July 1, 2011 —introduced the following substantial reforms to the healthcare system:

- Replaced the concept of health care management units (ZOZ) and local health care facilities with the concept of therapeutic entities, a broader definition that includes any entity performing tasks in healthcare provision, promotion and research
- Increased the financial responsibility of the therapeutic entities owned by the public sector (i.e., national government, voivodeships, powiats, and gminas), by requiring that the public owners of these entities to cover the net loss of their own hospitals and healthcare facilities within 3 months of having approved their financial statements

Additional reforms during this period include:

- Act of May 12, 2011 on Reimbursement of Drugs, Foodstuffs for Particular Nutritional Uses and Medical Devices (Journal of Laws, 2011b) —effective from January 1, 2012 —introduced the following reforms to the reimbursement criteria applied to drugs:
  - Fixed statutory prices of drugs, including price limits for generic drugs (equal to 75% of the price of the original drugs) and fixed wholesale and retail margins
  - Established a fixed percentage of funds collected by the National Health Insurance Fund (NFZ) that can be used for drug reimbursements to pharmaceutical companies holding the market authorization to produce and distribute a drug, equal to 17% of the funds collected through healthcare contributions and public funds. Pharmaceutical companies holding market authorization to distribute a drug are responsible to cover extra expenditures if such threshold is exceeded
  - Established the Economic Committee within the Ministry of Health, responsible for publishing bimonthly a list of authorized drugs available in the market, their level of reimbursement, and market prices
- Act of March 18, 2016 amending the Act on Health Care Services Financed from Public Funds and Certain Other Acts (Journal of Laws, 2016) —effective from January 1, 2017 —introduced the program known as "Leki 75+", which provides free access to drugs for individuals aged 75 or older
- Act of March 23, 2017 amending the Act on Health Care Services Financed from Public Funds (Journal of Laws, 2017) —effective from May 5, 2017 —introduced a hospital network system, for which hospital are divided into seven levels of healthcare services' provision, depending on the services provided (see Box 1 for a summary of the classification criteria included in Act of March 23, 2017). Hospitals satisfying the criteria of inclusion within the hospital network would receive public funds to finance healthcare services. These hospitals were also required to coordinate outpatient care within the local territory, to ensure continuous patient assistance throughout the whole care cycle. Hospital wards providing services not receiving public funds and out-of-network hospitals still negotiate prices with the National Health Insurance Fund (NFZ).

Overview

During this policy period, the Polish healthcare system is based on a centralized universal system, financed by mandatory public health insurance contributions and state (i.e., national government) funds. Healthcare is provided by therapeutic entities (podmiot leczniczy). Therapeutic entities are defined as a public or private legal entity with the purpose of providing and promoting healthcare. Therapeutic entities can be independent public health care institutions, state-financed health care institutions, private healthcare providers, research institutes, and foundations or associations who perform tasks in the field of health protection and provision. Therapeutic entities include hospitals, outpatient clinics, primary and specialist health care providers, or any other facility intended for patients whose health condition requires all-day health services in a suitable permanent room.

Almost the entire population is covered by public mandatory public health insurance. All employees, self-employed individuals, unemployed individuals and pensioners, among others, are subject to mandatory health insurance contributions and are covered by the system. Individuals subject to mandatory healthcare contributions must enroll in the National Health Insurance Fund (Narodowy Fundusz Zdrowia - NFZ) to receive health care. Individuals not subject to mandatory healthcare contributions may voluntarily enroll in NFZ and pay healthcare contributions in order to receive health care. Insured individuals must declare family members that would not be covered by the system otherwise, and they acquire the same healthcare coverage as the insured.

The administration of the healthcare system is centralized at the national level, and the provision of services is decentralized to territorial units. Different levels of territorial administration are responsible for the provision of services:

- Ministry of Health and Social Welfare: Tertiary hospital care

- Provinces (Voivodeship): Primary and secondary care through voivodeship-managed therapeutic entities, with different degrees of specialization
- District and municipal government (Powiat and Gmina): Primary and secondary care through powiat- and gmina-managed health care therapeutic entities

Services are contracted by the National Health Insurance Fund (NFZ). Contributions are collected from ZUS (Poland's Social Insurance Institution - *Zakład Ubezpieczeń Społecznych*) and paid to NFZ.

The insured has the right to receive healthcare services on the basis of a referral from a NFZ doctor. Healthcare services are provided free of charge for all insured and their family members, although copayments may be required depending on the beneficiary's income.

Some specialized services (such as organ transplants) and also public health programs (such as the National Health Program, National Heart Protection Program and the Cancer Control Program) remain financed from the state budget.

Poland's long-term care (LTC) system is fragmented and characterized by a strong informal care component. The family of the individual in need of care is identified as the principal caregiver in the system. During this policy period, administration of formal long-term care services was divided between the Ministry of Health and the Ministry of Labor, Family and Social Policy. Long-term care services developed in two different sectors: the health sector and the social assistance sector. In the health sector, two kinds of care units are available: Care and Treatment Facilities (ZOL) and Nursing and Care Facilities (ZPO), which both provide continuous medical care for chronically ill patients, patients with disabilities or those after a serious illness or surgery, who do not require hospitalization. Eligibility for admission into ZOL and ZPO requires a medical evaluation of activities of daily living (ADLs) that the patient is unable to carry out by themself. Long-term care services are also provided in hospital departments. In the social assistance sector, two kinds of care units are available: Residential Care Home (DPS) and Adult Day Care Home (DDPS). DPS provide continuous care, nursing and food services to the elderly, while DDPS provide the same services in a daycare setting. In the social assistance sector, cash and in-kind benefits are available for both individuals in need of care and caregivers. All benefits provided within the social assistance sector are subject to a national mean-test (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits), although services provided differ by each municipality (gmina). Long-term care for the elderly is also provided by private residential and care institutions.

Eligibility

- **Qualifications**

  Healthcare

  All individuals having Polish citizenship and residing in the Republic of Poland, and all foreign individuals residing in the Republic of Poland with a permanent or temporary residence permit, are insured by the healthcare system if they are subject to compulsory health insurance contributions or if they voluntarily contribute to the health insurance system. Individuals subject to compulsory healthcare contributions are:
  - Employees (including farmers and homeworkers)
  - Civil servants and public employees
  - Armed forces, policemen, firefighters and other public safety employees
  - Unemployed
  - Pensioners (recipients of old-age and disability pensions, as well as social assistance benefits, both temporary and permanent)
  - Students

  Declared family members of the insured are also deemed insured by the healthcare system. Family members eligible to be covered by the healthcare system through the insured's coverage are:
  - The insured's own, foster or adopted child
    - Until age 18
    - Until age 26, if they continue their education
    - No age limit, if severely disabled
  - The insured's spouse
  - Other ascendants who reside in the same household and who are not covered by the insurance obligation

  Long-Term Care

  For the residential care services provided within the health sector, patients must receive a score below 40 points on the Barthel test, carried out during a medical evaluation. The Barthel test is used to assess a person's level of independence in 10 Activities of Daily Living (ADLs). For services provided within the social assistance sector, eligibility is determined by a formal assessment of

the potential recipient's health conditions and their economic circumstances, a means-test, carried out by a social worker at the local/municipal level following nationwide eligibility criteria (See *Poland Social Assistance Benefit Plan Details* for further details on eligibility for social assistance benefits).

- **To receive health benefits, does an individual have to claim them?** Answer: Yes
- **To continue to receive health benefits, does an individual have to remain qualified?** Answer: No

Coverage

Healthcare

Health care services are provided in public or private therapeutic entities, which can be:

- Hospitals and other facilities for people who need 24-hour or all-day health services in an appropriate, permanent room
- Medical clinics and health centers for general and specialist care
- Emergency clinics
- Diagnostic laboratories
- Dental prosthetics and orthodontics laboratories
- Medical rehabilitation facilities
- Nurseries
- Other establishments meeting the conditions established by the Act of April 15, 2011 on Therapeutic Activity (Journal of Laws, 2011)

Therapeutic entities provide different health services, depending on the individual entity, including basic and specialist health care, inpatient and outpatient care, and care to individuals in need in their residence in the field of general medicine, family medicine, and pediatrics. The services provided, as established by Act of January 23, 2003 on Universal Health Insurance in the National Health Fund (Journal of Laws, 2003) include:

- Medical prophylaxis, examination, diagnosis and advice
- Treatment of health conditions (both inpatient, outpatient, at home and emergency care)
- Supply of drugs and medical materials
- Medical rehabilitation
- Care for a pregnant woman and her fetus, childbirth, puerperium and the newborn
- Diagnostic examination, including medical analytics
- Nursing and care for the sick and disabled
- Palliative and hospice care
- Prosthetics and orthodontics dental care (basic dental care)
- Orthopedic care

The insured has the right to hospital treatment on the basis of a referral from a health insurance doctor, if the purpose of the treatment cannot be achieved through outpatient treatment. The insured has the right to choose a hospital among the network of hospitals that have concluded an agreement with the National Health Insurance Fund (NFZ). The insured can also choose a facility outside of NFZ's network. However, the NFZ would cover only costs up to their reference cost calculated within comparable in-network healthcare service providers in the NFZ's branch's area.

Long-Term Care

In the health sector, care and treatment facilities (ZOL) and nursing and care facilities (ZPO) provide continuous health services, which include the care and rehabilitation of people who do not require hospitalization, and provide them with pharmaceuticals and medical materials, room and food appropriate to their health condition, as well as care during cultural and recreational activities. Insured persons entitled to free health services and who are residing in residential institutions (ZOL and ZPO) are provided with health care services, drugs, medicines and medical materials by the institution's doctor. In the social assistance sector, DPS are intended for the elderly, the chronically ill and individuals with specific medical, physical or mental conditions whose health requires constant care but does not require hospital treatment. Each individual DPS is specialized in care for patients with specific conditions, but they are mostly populated by elderly individuals. DDPS provide daycare, nursing and food service for individuals in need of care, but whose family cannot provide care during the day.

Costs

Healthcare

For the insured, there is no cost-sharing for primary care and referred outpatient specialist care, emergency medical care and inpatient care, although cost-sharing may be applied to outpatient medicines, medical transport of patients, and inpatient long-term care. With the exception of medicines, medicinal products and auxiliary medical devices, as well as health resort treatments and certain dental procedures and materials, services are fully covered. Uninsured individuals have the right to free outpatient emergency care.

Outpatient specialist health services provided to the insured without referral of a health insurance physician are paid by the insured. Referral is not required for the following specialists:

- Gynecologist and obstetrician
- Dentist
- Dermatologist
- Venereologist
- Oncologist
- Ophthalmologist
- Psychiatrist
- Specialists in tuberculosis or HIV

Referral is also not required for circumstances posing imminent threat to life and childbirth. Reimbursement is also provided if the insured individual chooses to use an out-of-network healthcare provider that has not contracted healthcare services with the National Health Insurance Fund (NFZ), to the extent of the reference cost of the service. The reference cost is calculated as the average cost over the preceding calendar year of treating a patient in hospitals providing a given specialty within the territorial responsibility of each branch of NFZ.

Out-of-pocket costs include:

- Hospital services
  If the insured, after a referral from their insurance health fund's doctor, chooses to receive hospital treatment from an out-of-network hospital, they are responsible for paying the difference between the final cost paid and the reference cost calculated within each health insurance fund.
- Rehabilitation services
  Although rehabilitation services are provided free of charge, the cost of food and accommodation might be fully paid by the insured, or covered on terms provided by separate regulations.
- Diagnostic tests
  The Ministry of Health and Social Welfare define, by means of an ordinance, the list of diagnostic tests for which the insured person should pay a flat-fee copayment, and the maximum amount of these fees.
- Drugs and medicines
  Drugs and medicines are provided free of charge to the insured if they are admitted to hospitals or other health care facilities for inpatient treatment, if they are receiving emergency assistance, when receiving therapeutic, diagnostic and rehabilitation treatments in outpatient facilities, or if they suffer from certain chronic, congenital or acquired diseases. In all other cases, insured individuals might incur in copayments depending on the classification of drugs available for reimbursement, published bimonthly as Announcements by the Ministry of Health (see Ministry of Health, 2018 for the announcements published by the Ministry of Health from 2011 to 2018 and Ministry of Health, 2022 for announcements published from 2019 onwards). Each announcement includes information on:
  - Name of the drug, its active substance and its scope
  - Wholesale and retail fixed market prices
  - Financing limit (the maximum amount reimbursed by NFZ)
  - Type of copayment (lump-sum, percentage of retail price, free of charge) and amount paid by insured, which can be:
    * A lump-sum fee
    * 50% of the financing limit of the drug, for therapies shorter than 30 days, plus the difference between the price of the drug and its financing limit
    * 30% of the financing limit of the drug, plus the difference between the price of the drug and its financing limit
    * Provided free of charge

  The price of generic drugs is also regulated, as described in Figure 1: the first registered generic drug's price must be equal to 75% of the original drug price, while the following registered generic drugs have their price set to the price of the cheapest drug with the same active substance. Exemptions on copayments for drugs exist for specific cases defined by law. Since January 1, 2017, insured individuals aged 75 and older are exempt from copayments on a list of drugs and medicines (see Ministry of Health, 2018

and Ministry of Health, 2022 for a detailed list of drugs and copayments available in Poland).

- Orthopedic items, auxiliary and technical equipment
  The insured might bear part or the entirety of the cost of orthopedic items, auxiliary and technical equipment. The Ministry of Health and Social Welfare, by means of an ordinance, provides a list of items defined as orthopedic items, auxiliary and technical equipment, as well as the amount of the insured's share in their purchase price.
- Medical transport
  Medical transport is provided free of charge on the basis of a doctor's or a medical assistant's order if:
  - The insured requires immediate treatment in a healthcare institution
  - The insured requires transportation in order to maintain continuity of treatment in the event of health- or life-threatening conditions

Long-Term Care

In the health sector, a person staying in ZOL or ZPO care institutions shall bear the costs of food and accommodation. The monthly fee is equal to the amount corresponding to 250% of the minimum old-age pension (see Table 1 for yearly values), but the fee may not be higher than the amount corresponding to 70% of the individual's monthly income. All medical services are provided free of charge, while drugs can be provided free of charge, or after a copayment, following the rules established in the *Healthcare - Out-of-pocket costs* subsection. From 2017, all individuals aged 75 and more are provided drugs free of charge. In the social assistance sector, individuals are responsible for paying the cost for stays in DPS, and the monthly fee is equal to 200% of the minimum old-age pension (see Table 1 for yearly values), but the fee cannot be higher than 70% of the individual's monthly income. The fee for stays in DDPS is equal to the cost of food provided. These costs are applicable to all DPS and DDPS facilities, except those run by municipalities (gminas) and their associations, which are free to set different prices and copayments.

Tables and Formulas

Table 1: Monthly Minimum Pension

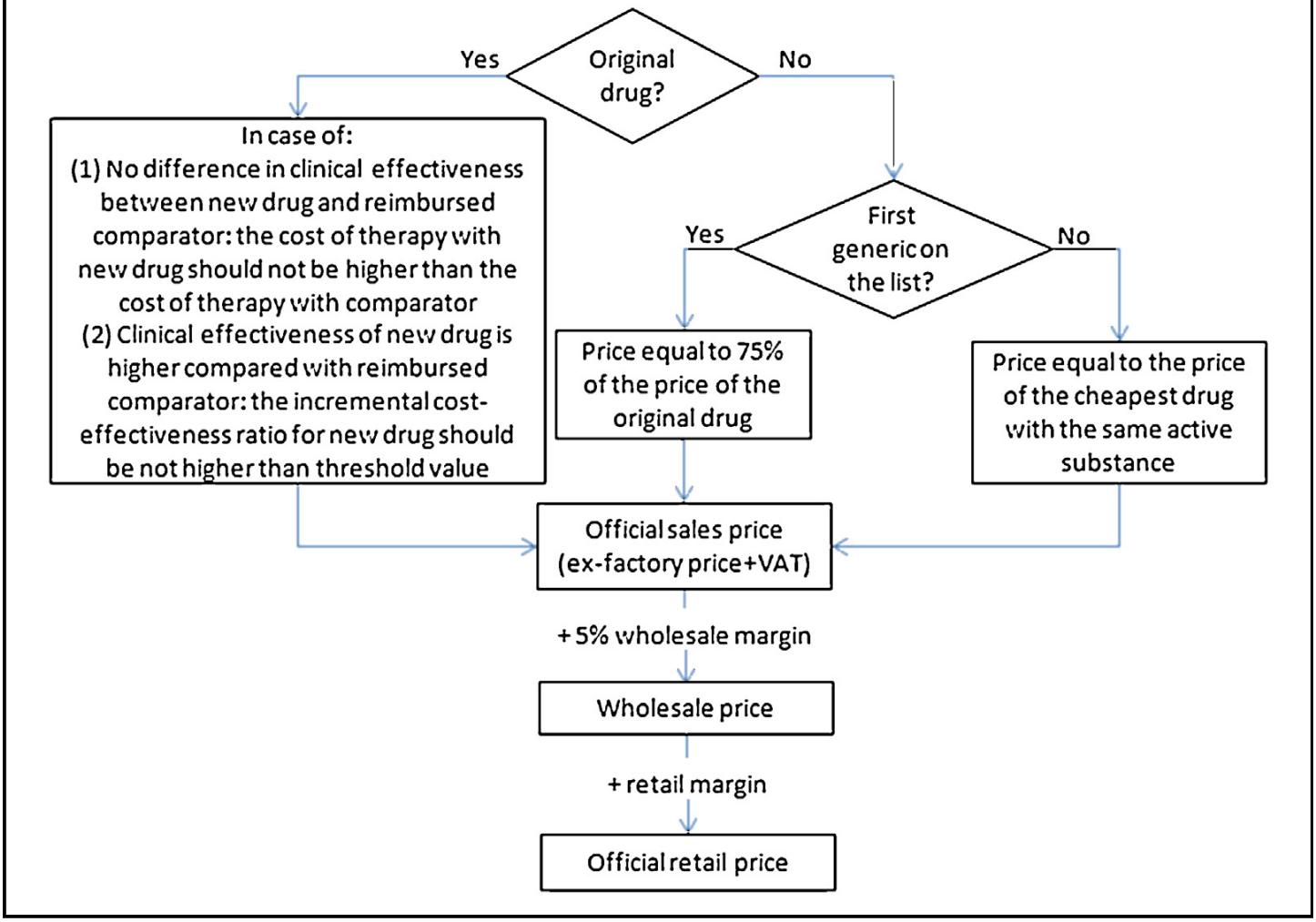
Period	Value
April 1, 1992 - August 30, 1992	84.91 PLN
September 1, 1992 - November 30, 1992	92.75
December 1, 1992 - February 29, 1992	108.15
March 1, 1993 - November 30, 1993	123.13
December 1, 1993 - May 31, 1994	140.00
June 1, 1994 - November 30, 1994	176.01
December 1, 1994 - February 28, 1995	213.96
March 1, 1995 - November 30, 1995	243.40
December 1, 1995 - August 30, 1996	279.69
September 1, 1996 - February 28, 1997	322.20
March 1, 1997 - August 30, 1997	346.41
September 1, 1997 - February 28, 1998	374.63
March 1, 1998 - August 30, 1998	394.30
September 1, 1998 - May 31, 1999	415.00
June 1, 1999 - May 31, 2000	451.11
June 1, 2000 - May 31, 2001	470.51
June 1, 2001 - May 31, 2002	530.26
June 1, 2002 - February 28, 2003	532.91
March 1, 2003 - February 29, 2004	552.63
March 1, 2004 - February 28, 2005	562.58
March 1, 2005 - February 28, 2006	562.58
March 1, 2006 - February 28, 2007	597.46
March 1, 2007 - February 29, 2008	597.46
March 1, 2008 - February 28, 2009	636.29
March 1, 2009 - February 28, 2010	675.10
March 1, 2010 - February 28, 2011	706.29
March 1, 2011 - February 29, 2012	728.18
March 1, 2012 - February 28, 2013	799.18
March 1, 2013 - February 28, 2014	831.15
March 1, 2014 - February 28, 2015	844.45
March 1, 2015 - February 29, 2016	880.45
March 1, 2016 - February 28, 2017	882.56
March 1, 2017 - February 28, 2018	1,000.00
March 1, 2018 - February 28, 2019	1,029.80
March 1, 2019 - February 29, 2020	1,100.00
March 1, 2020 - February 28, 2021	1,200.00
March 1, 2021 - February 28, 2022	1,250.88

Notes:

- PLN represents the ISO code for Polish złoty, the official currency of Poland

Source: Authors' collection of data deriving from publications of Announcements of the President of the Social Insurance Institution, published yearly in Monitor Polski by ZUS [Zakład Ubezpieczeń Społecznych - Social Insurance Institution], 1992-2022.

Figure 1: Pricing of reimbursed drugs and medicines in Poland after the 2011 Reimbursement Act



Source: Kawalec et al. (2016)

Box 1: Hospital Network Classification

The levels of the hospital network are determined by the types of healthcare services provided:

- Level 1 hospitals
  - General surgery
  - Internal diseases
  - Obstetrics and gynecology
  - Neonatology
  - Pediatrics
- Level 2 hospitals
  - Pediatric surgery
  - Plastic surgery (within provisions of the Act)
  - Cardiology
  - Neurology
  - Ophthalmology
  - Orthopedics and traumatology of the musculoskeletal system
  - Otorhinolaryngology
  - Rheumatology (within provisions of the Act)
  - Urology
- Level 3 hospitals
  - Thoracic, vascular, cardiac, and neuro surgery
  - Lung and infectious diseases
  - Clinical toxicology
  - Clinical transplantology
- Specialist Level 1
  - Oncology and pulmonary hospitals providing highly specialized care
- Specialist Level 2
  - Pediatric hospitals providing highly specialized care
- Nationwide Level
  - Research institutes
  - Clinical hospitals

Sources: Act of March 23, 2017 (Journal of Laws, 2017)

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADL): ADLs (Activities of Daily Living) are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Adult Day Care Home (Dzienny Dom Pomocy Społecznej - DDPS): In the social assistance sector, Adult Day Care Homes are institutions that provide living, caring, supportive and educational services to people who require daycare due to age, illness or disability.

Care and Treatment Facility (Zakład opiekuńczo-leczniczy - ZOL): In the healthcare sector, Care and Treatment Facilities (along with Nursing and Care Facilities - ZPO) are institutions providing stationary and 24-hour medical services including long-term medical care and care for patients who do not require hospitalization.

Claimable Benefit: A benefit where the beneficiary must actively file a claim for benefits with the government's administering authority.

Health Care Management Unit (Zakład Opieki Zdrowotnej - ZOZ): Public or private institutions (or groups thereof) - such as hospitals, outpatient clinics, primary and specialist health care providers, or any other facility intended for patients whose health condition requires all-day health services in a suitable permanent room - with the purpose of providing and promoting healthcare.

National Health Fund (Narodowy Fundusz Zdrowia - NFZ): Founded in 2003, NFZ is Poland's National Health Fund, consisting in a centralized fund with 16 regional branches. The fund is responsible for contracting healthcare services with individual healthcare provider and for providing such services to those insured. Most of Poland's population is insured with NFZ.

Nursing and Care Facility (zakład Pielęgnacyjno-Opiekuńczy - ZPO): In the healthcare sector, Nursing and Care Facilities (along with Care and Treatment Facilities - ZOL) are institutions providing stationary and 24-hour medical services including long-term medical care and care for patients who do not require hospitalization.

Qualified Benefit: A benefit is qualified if an individual must continue to meet certain standards, such as a means test, to continue receipt of benefits.

Residential Care Home (Domy Pomocy Społecznej - DPS): In the social assistance sector, Residential Care Homes are institutions that provide living, caring, supportive and educational services to people who require 24-hour care due to age, illness or disability.

Social Insurance Institution (Zakład Ubezpieczeń Społecznych - ZUS): Polish state social insurance agency

Therapeuting Entity: Broad definition, introduced in 2001, representing any entity performing tasks in healthcare provision, promotion and research in Poland.

Version information

Current Version: 2.1 (August 2023)

Version History

- 1.0 (March 2021): First version
- 2.0 (Nov. 2022): Substantial revision of all content
- 2.1 (August 2023): Updated formatting