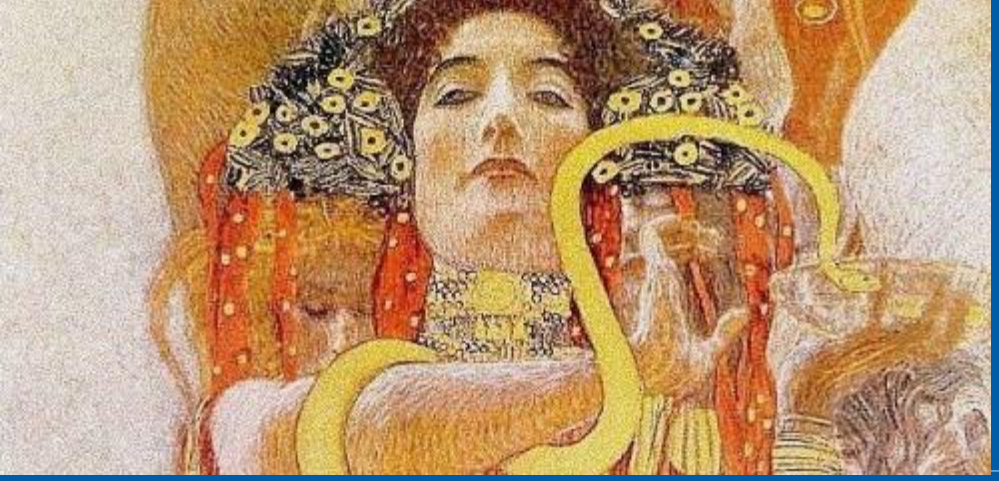

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POLISH HEALTHCARE SYSTEM EXPERIENCES WITH CRISIS MANAGEMENT AND REFORMS AND POST-COVID-19:

GOVERNANCE FOR SUSTAINABILITY AND RESILIENCE

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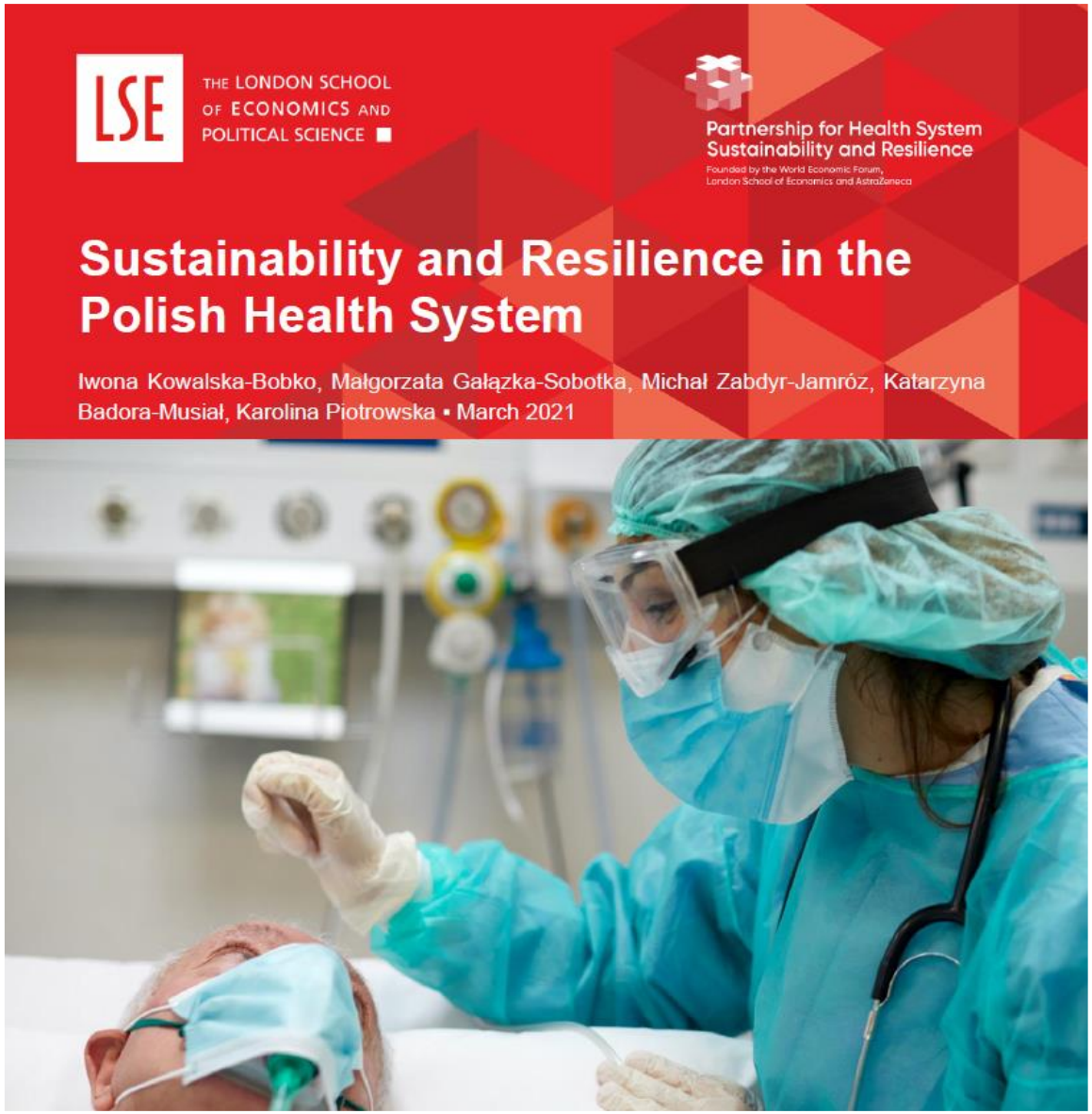
PREVIOUSLY ON *POLISH HEALTHCARE SYSTEM: EXPERIENCE IN REFORMS* – URGENT REFORMS IMPULSES:

- Still some problems with health needs-based contracting of services (based instead on available resources: infrastructure, hospitals, etc);
- Issues with public healthcare providers debt;
- Chronic underfunding;
- Excess of lean management;
- Medical personnel shortages;
- Silo policymaking;
- Structural egoism;
- Etc.



The Partnership for Health System Sustainability and Resilience (PHSSR). PHSSR was initiated by the London School of Economics and Political Science (LSE), the World Economic Forum (WEF) and AstraZeneca, motivated by a shared commitment to improving population health, through and beyond the COVID-19 pandemic. The initial phase of the partnership, of which this report is a product, was funded solely by AstraZeneca.

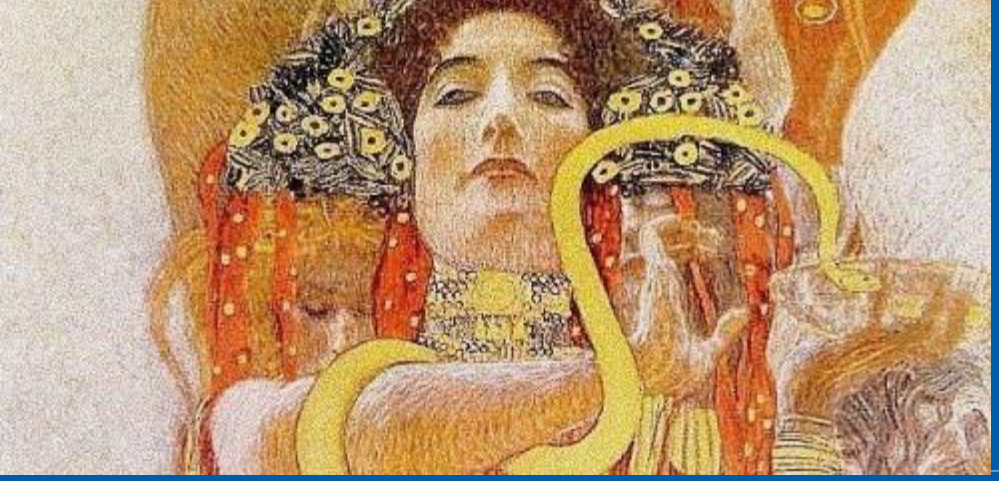
Spurce: https://www3.weforum.org/docs/WEF_PHSSR_Poland_Report.pdf

Resilience and Sustainability

Term	Definition
Health system sustainability	A health system's ability to continually deliver the key health system functions of providing services, generating resources, financing, and stewardship, incorporating principles of fair financing, equity in access, and efficiency of care, in pursuit of its goals of improving population health, and responsiveness to the needs of the populations it serves, and to learn and improve in doing so.
Heath system resilience	A health system's ability to absorb, adapt to, learn, and recover in the wake of crises born of short-term shocks and accumulated stresses, in order to minimise their negative impact on population health and disruption caused to health services.

ACROSS 5 DOMAINS (Health Systems'):

1. **GOVERNANCE**
2. Financing
3. Workforce
4. Medicines and Technology
5. Service Delivery



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GOVERNANCE

Analytical framework: governance for sustainability and resilience

ANALYTICAL FRAMEWORK: GOVERNANCE FOR SUSTAINABILITY AND RESILIENCE

framework was developed via literature review concerning governance, governance for health, good governance, deliberative and other, similar concepts such as pragmatic model of bureaucratic responsiveness – focusing on normative and prospective propositions related to the concept

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GOVERNANCE – a stage in a long history of public policy-making

Table 1. Stages of development of Public Administration.

Stages	Period	Description	Main characteristics	
Stage 1	1887-1926	Politics-administration dichotomy	1.Woodrow Wilson writing, 1887 2.Goodnow's *Politics and Administration*, 1900 3.Leonard White's *Introduction to the Study of Public Administration*, 1926	
Stage 2	1927-1937	Scientific Management (and Principles of administration)	1.Orthodoxy in Public Administration and a drive towards efficiency, 2.Gulick and Urwick importation of Fredrick N. Taylor's theories of 'scientific management' and Henri Fayol's 'theories of business administration' in the public sector-through the famous POSDCORB.	**OLD/ TRADITIONAL PUBLIC ADMINISTRATION**
Stage 3	1938-1950	Period of heterodoxy (or Conceptual challenge)	1.Challenge of both the politics-administration dichotomy and scientific management. 2.Hawthorne experiments (1920 to 1932) and 3.More emphasis on human relations	
Stage 4	1950s-1970s	The New Public Administration (NPA)	1.Identity Crisis 2.Rejection of both the principles of administration and the politics-administration dichotomy. 3.Simon's 'Administrative Behavior' and Robert Dahl's essay on 'The Science of Public Administration: three Problems', 1940s'. 4.Widening the scope of the Public Administration by relating it to other subjects such as psychology, sociology, economics and political science	
Stage 5	1970s – 1990s	The New Public Management (NPM)	1.Focus on "Managerialism", 2.Introduction of various forms of privatisation 3.Greater involvement of the private sector institutions in the management of public institutions and provision of public goods and services, 4.Structural Adjustment Programmes (SAPS) especially in Africa.	**NPM**
Stage 6	1990s to date (2014)	Governance period	1.Improvement of administrative and civil services 2.strengthening of parliamentary oversight 3.promotion of participatory decision-making 4.adoption of judicial reforms	**GOVERNANCE/ GOOD GOVERNANCE**

Table adapted by the authors on the basis of arguments presented by Coetzee, 2012; Basheka, 2012; Basu, 2009; Nasrullah, 2005.

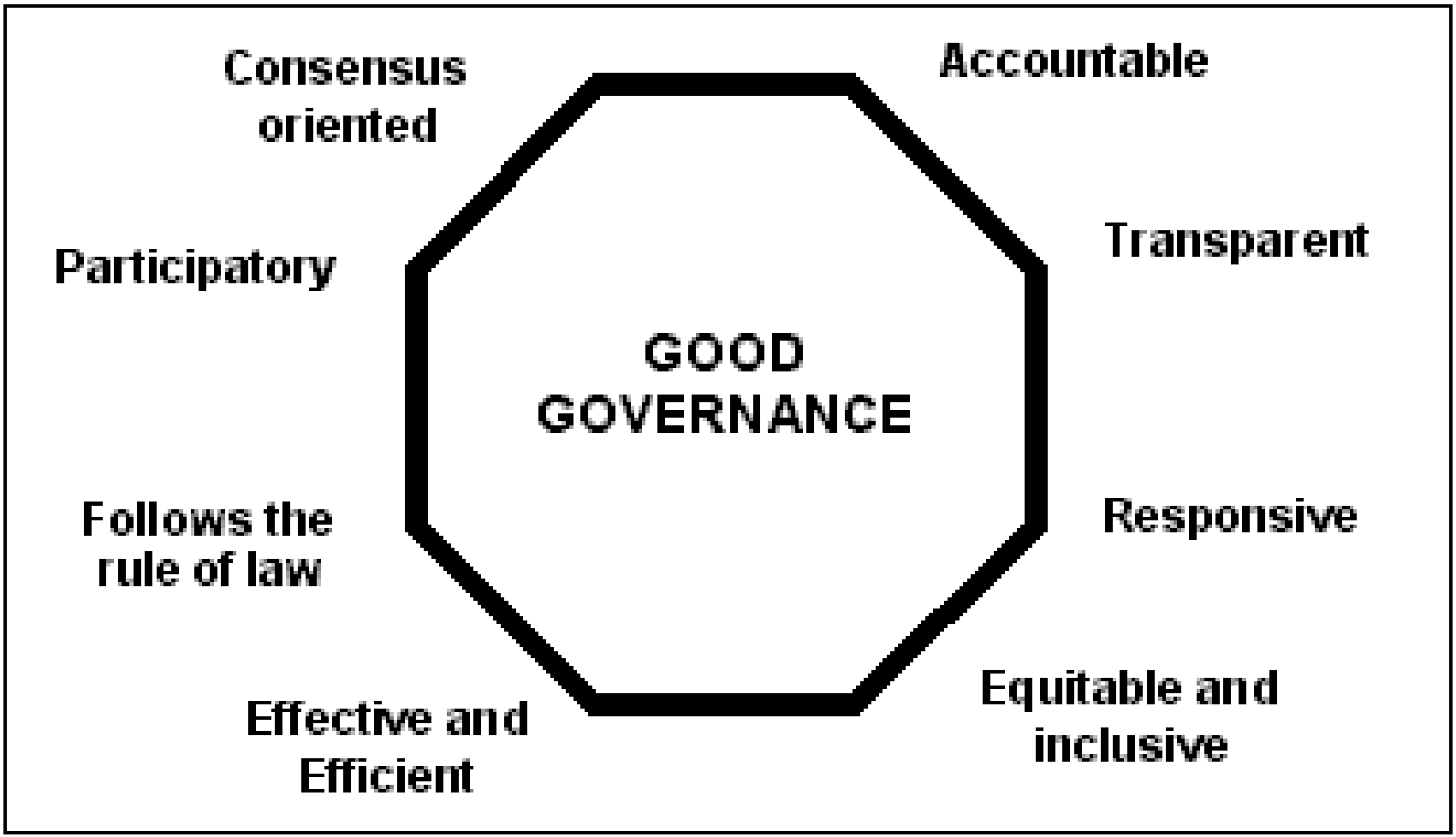
Traditional..., New... and Governance

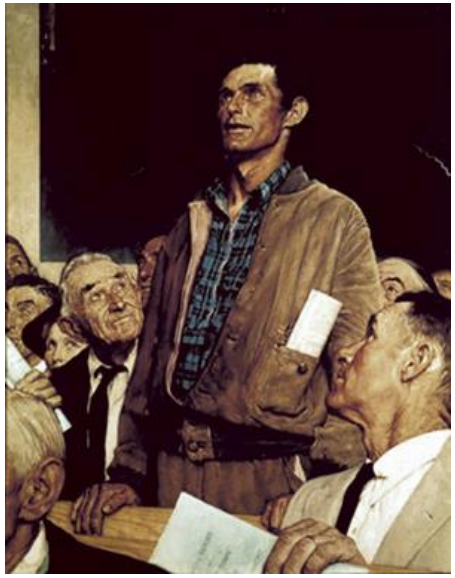
Traditional administration	New Public Management	Governance
• *Focus on structures* (legal framework or institutional set-up) *and inputs* (especially human and financial resources);	• *Focus on management systems* (performance or quality management) *and results*;	• *Focus on processes* (both performance and cooperation);
• *Legalistic approach*: administrative capacity building based on the application of legal rules;	• *Managerial approach*: capacity building through managerial instruments;	• *Mixed approach*: involvement of civil servants, researchers and experts, social partners, other stakeholders.
• *Internal approach*: civil servants are responsible for capacity building (by drafting procedures, participating in training events, etc.).	• *External approach*: private sector representatives are actively involved in capacity building through the provision of services and advice.	

Source: Public Policy and Management Institute (2011) Summary of the Evaluation of the Human Resources Development Operational Programme Priority 4. Vilnius, Lithuania.

United Nations ESCAP

The Economic and Social Commission for Asia and the Pacific



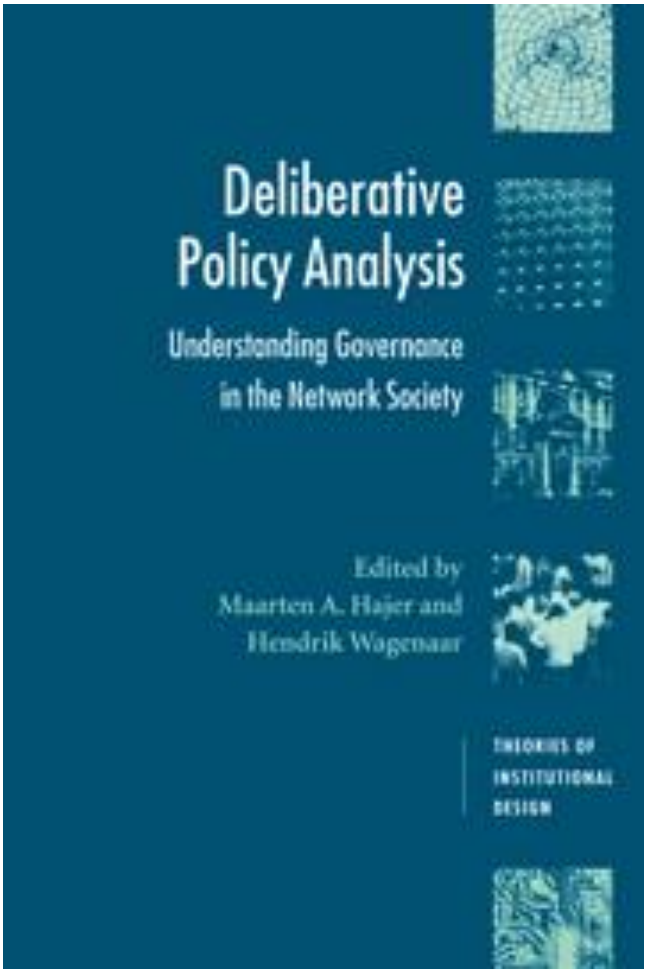


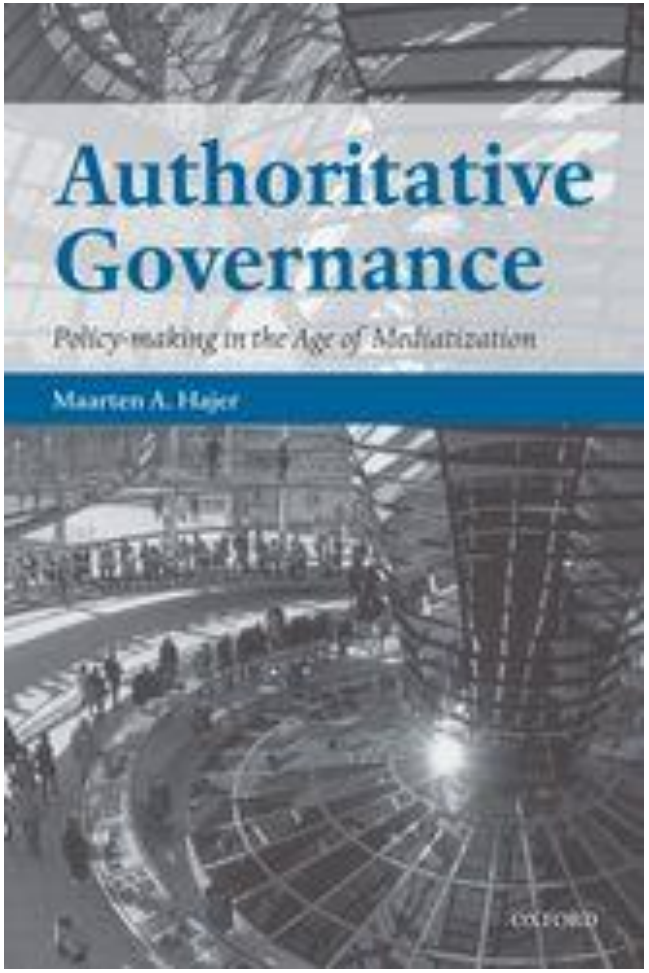
PARTICIPATION

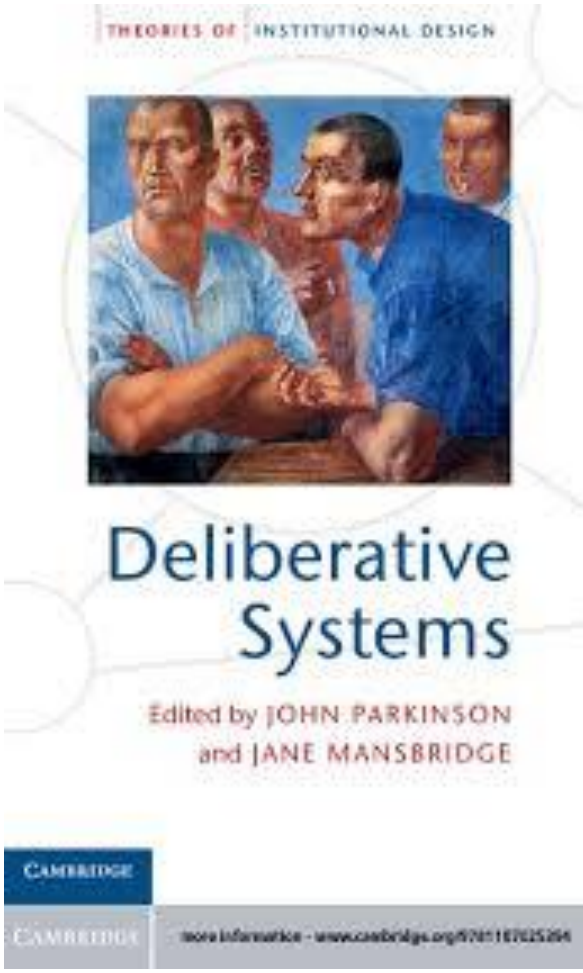
Dimensions of participation:

- **CLIENT'S PARTICIPATION**
  - Individual needs and interests
  - **MARKET** (*NPM* approach)
- **CITIZEN'S PARTICIPATION**
  - Common good, rights, law
  - **PARTICIPATORY DEMOCRACY** (*good governance* approach)

Deliberative governance in deliberative systems







DELIBERATIVE / AUTHORITATIVE / PRAGMATIC GOVERNANCE

Hendriks: „The central idea behind deliberative governance is that policy making requires spaces where different institutions, agencies, groups, activists and individual citizens can come together to deliberate on pressing social issues”

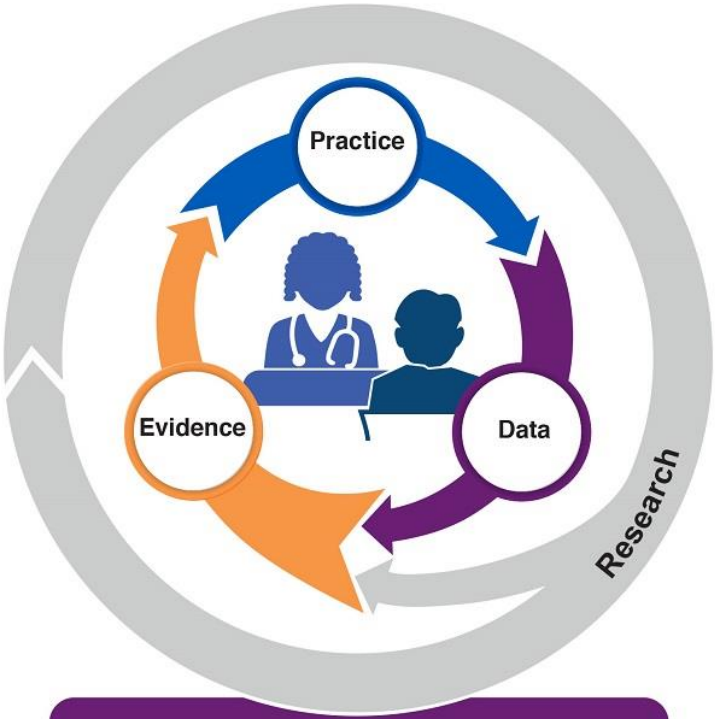
Hendriks, C. M. (2009). Deliberative Governance in the Context of Power. Policy and Society, 28(3), 173–184.

Table 1. Comparison of Three Models of Public Responsiveness.

	The role of administrators	The behavioral norm	The goal
The citizen-driven model	Subordinate	Follow citizen demands and political directives	A congruence between citizens' stated preferences and bureaucratic behavior
The expertise-driven model	Expert	Professional expertise	The "objective" measure of citizen wishes
The pragmatic model	Community spokesperson	Openness and public deliberation	"Discover" public interest through public discussion and deliberation; Balance competing demands under the guidance of public interest

Liao, Y. (2018). Toward a Pragmatic Model of Public Responsiveness: Implications for Enhancing Public Administrators' Responsiveness to Citizen Demands. International Journal of Public Administration, 41(2), 159–169.

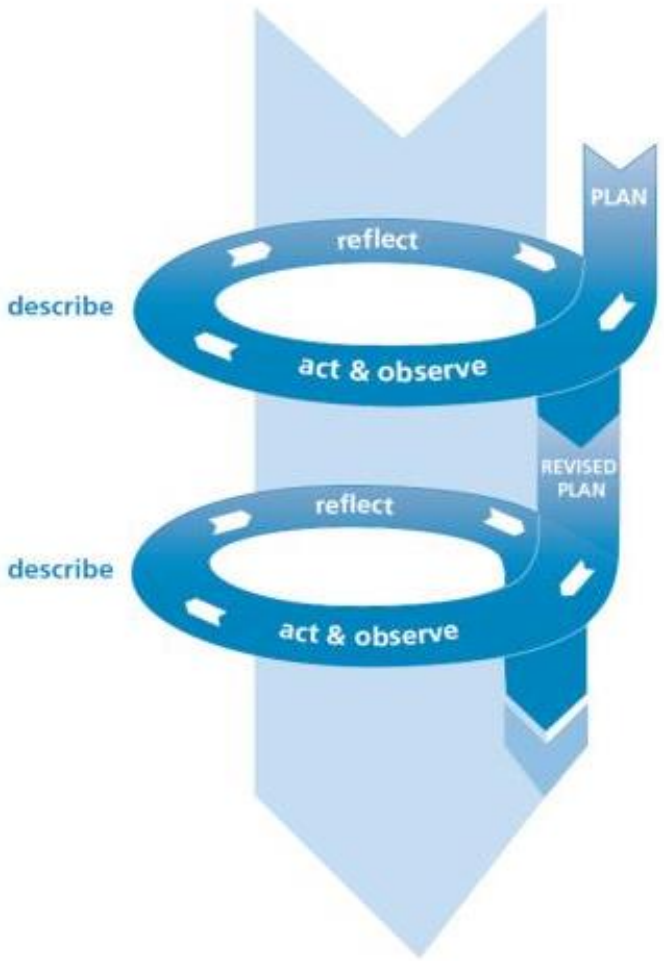
Learning Health Systems

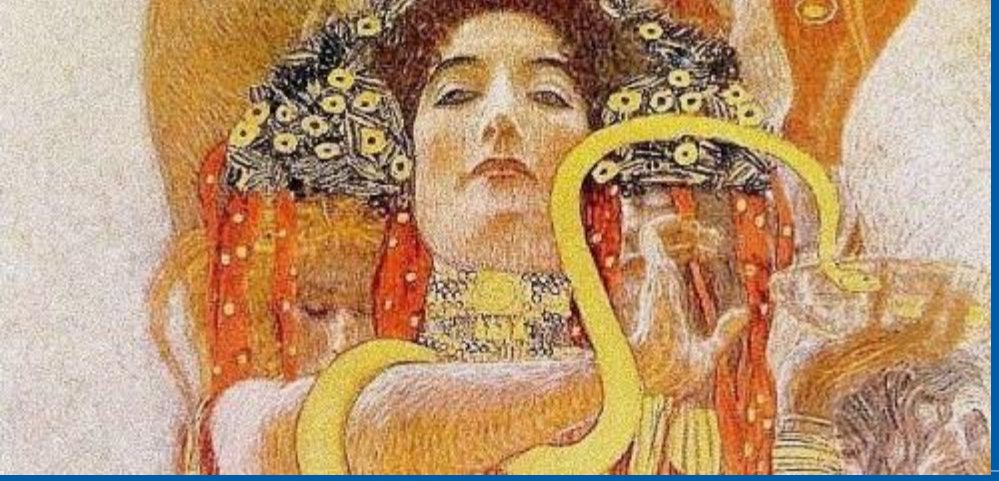


Systematically gather and create evidence.

Apply the most promising evidence to improve care.

Action Learning Spiral





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RESULTS

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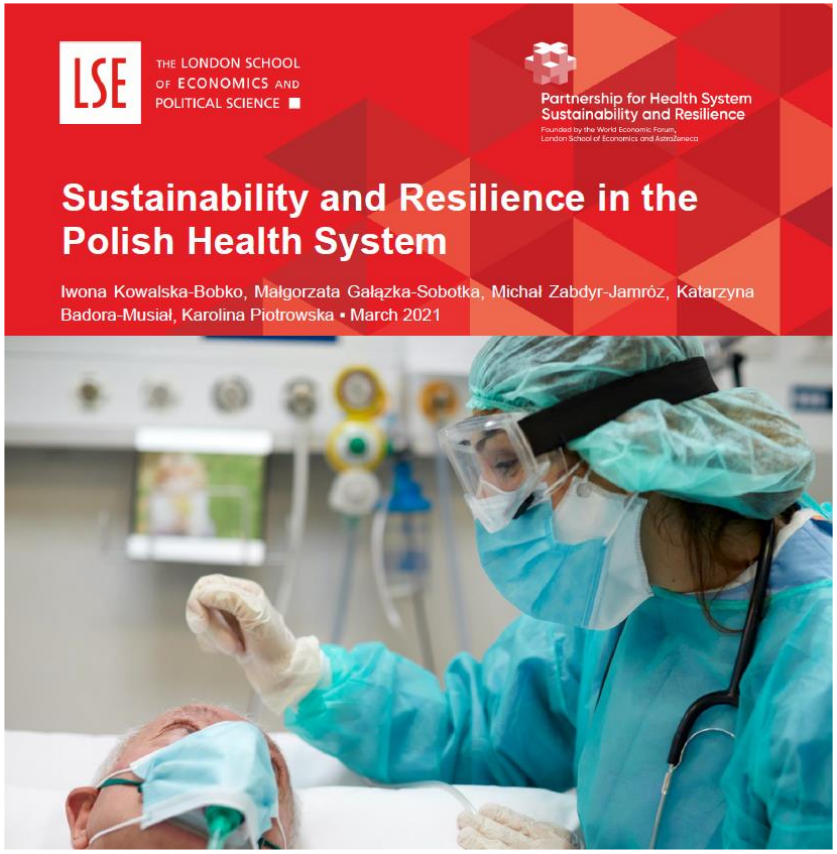
RESULTS:



Domain		Strengths and opportunities	Weaknesses and threats	Impacted areas	Recommendations
Health System Governance	1a	Existing structures of public health institutions (on paper).	Underappreciation and neglect of public health institutions.	Sustainability and resilience	Improvement of the public health system (reform of the State Sanitary Inspection).
	1b	*Relatively quick pandemic response.*	Current underappreciation of healthcare issues other than COVID-19.	Resilience at the cost of sustainability	Institutional reorganisation that reactivates capacity to tackle health issues other than COVID-19.
	1c	Some existing standards concerning legislation impact assessment.	Lack of institutionalised health impact assessment and underdevelopment of other assessment methods.	Sustainability	Institutionalisation of HIA in all policies for decision-making.
	1d	Robust structure of expert institutions for assessment and evaluation (compartmentalised).	"Policy based evidence" – primacy of politics (political will) over evidence-based policy-making.	Sustainability and resilience	Deliberative authority in evidence informed as well as inclusive policy-making.
	1e	Existing institutions of intersectoral coordination and stakeholders' involvement (on paper). Introduction of mechanisms for more coordinated, rational and responsive resource allocation. Attempts at coalition building in strategic planning.	Scattered, fragmented and ad hoc implementation of coordination and consultation institutions. Lack of deliberative know-how for coalition building and consensus strategic planning. Decision-makers irresponsive to feedback. 'Autopoietic' legislative process. Ad hoc conflict resolution. Structural misalignment between healthcare system and policymaking (end-of-pipe-deadlocks)	Sustainability	[1e-1] Integration of various councils on central and voivodship level. [1e-2] Greater feedback from 'frontline' workers (e.g. action learning and learning healthcare systems methods). [1e-3] Introduction of deliberative governance methods + minipublics. [1e-4] Consistent public communication and education strategy.
	1f	Existing system for quality control and patients' safety (on paper)	"Blame-game" and shifting responsibility to others for adverse events.	Sustainability and resilience	No-fault system for quality control and patients' safety [see also: 1e-2].
	1g	Decentralisation, competition, partnership model of public services	Uncoordinated complexity. "Silo-policymaking" and compartmentalisation – lack of common strategic vision. Structural egoism – susceptibility to conflicts and suboptimal resource allocation based on hard bargaining (hypertrophy of lean management) – damaging emergency redundancies of the system.	Sustainability (short and mid-term) at the cost of resilience and long-term sustainability	[1g-1] Consolidation of ownership of healthcare providers: hospitals at voivodship level and open basic care (primary and ambulatory) at county level. [1g-2] Deliberative negotiation between providers and payer and enhancement of mediation in conflict resolution.

Results for governance: Pt. 1/3

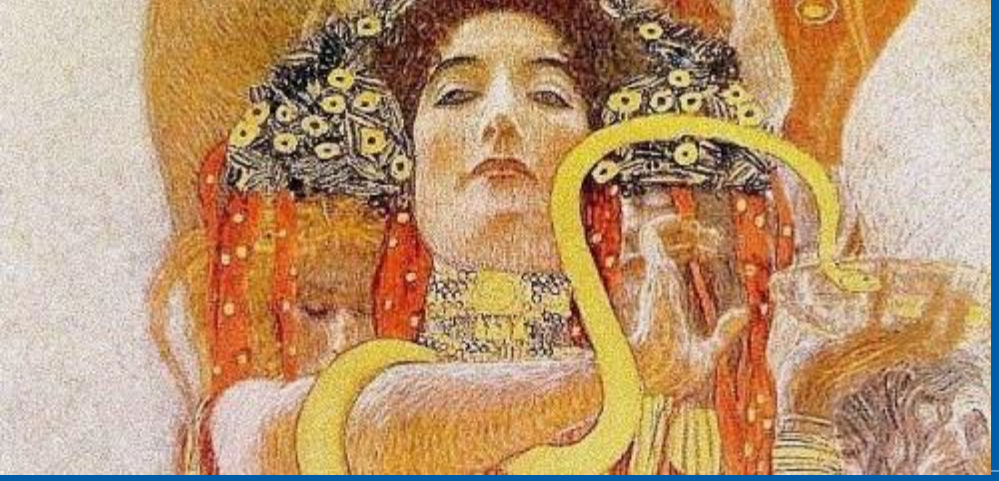
Domain		Strengths and opportunities	Weaknesses and threats	Impacted areas	Recommendations
Governance	1a	Existing structures of public health institutions (on paper).	Underappreciation and neglect of public health institutions.	Sustainability and resilience	Improvement of the public health system (reform of the State Sanitary Inspection).
	1b	*Relatively quick pandemic response.*	Current underappreciation of healthcare issues other than COVID-19.	Resilience at the cost of sustainability	Institutional reorganisation that reactivates capacity to tackle health issues other than COVID-19.
	1c	Some existing standards concerning legislation impact assessment.	Lack of institutionalised health impact assessment and underdevelopment of other assessment methods.	Sustainability	Institutionalisation of HIA in all policies for decision-making.
	1d	Robust structure of expert institutions for assessment and evaluation (compartmentalised).	"Policy based evidence" – primacy of politics (political will) over evidence-based policy-making.	Sustainability and resilience	Deliberative authority in evidence informed as well as inclusive policy-making.

Results for governance: Pt. 2/3

Health System (	1e	Existing institutions of intersectoral coordination and stakeholders' involvement (on paper). Introduction of mechanisms for more coordinated, rational and responsive resource allocation. Attempts at coalition building in strategic planning.	Scattered, fragmented and ad hoc implementation of coordination and consultation institutions. Lack of deliberative know-how for coalition building and consensus strategic planning. Decision-makers irresponsive to feedback. 'Autopoietic' legislative process. Ad hoc conflict resolution. Structural misalignment between healthcare system and policymaking (end-of-pipe-deadlocks)	Sustainability	[1e-1] Integration of various councils on central and voivodship level. [1e-2] Greater feedback from 'frontline' workers (e.g. action learning and learning healthcare systems methods). [1e-3] Introduction of deliberative governance methods + minipublics. [1e-4] Consistent public communication and education strategy.

Results for governance: Pt. 3/3

	1f	Existing system for quality control and patients' safety (on paper)	"Blame-game" and shifting responsibility to others for adverse events.	Sustainability and resilience	No-fault system for quality control and patients' safety [see also: 1e-2].
	1g	Decentralisation, competition, partnership model of public services	Uncoordinated complexity. "Silo-policymaking" and compartmentalisation – lack of common strategic vision. Structural egoism – susceptibility to conflicts and suboptimal resource allocation based on hard bargaining (hypertrophy of lean management) – damaging emergency redundancies of the system.	Sustainability (short and mid-term) at the cost of resilience and long-term sustainability	[1g-1] Consolidation of ownership of healthcare providers: hospitals at voivodship level and open basic care (primary and ambulatory) at county level. [1g-2] Deliberative negotiation between providers and payer and enhancement of mediation in conflict resolution.



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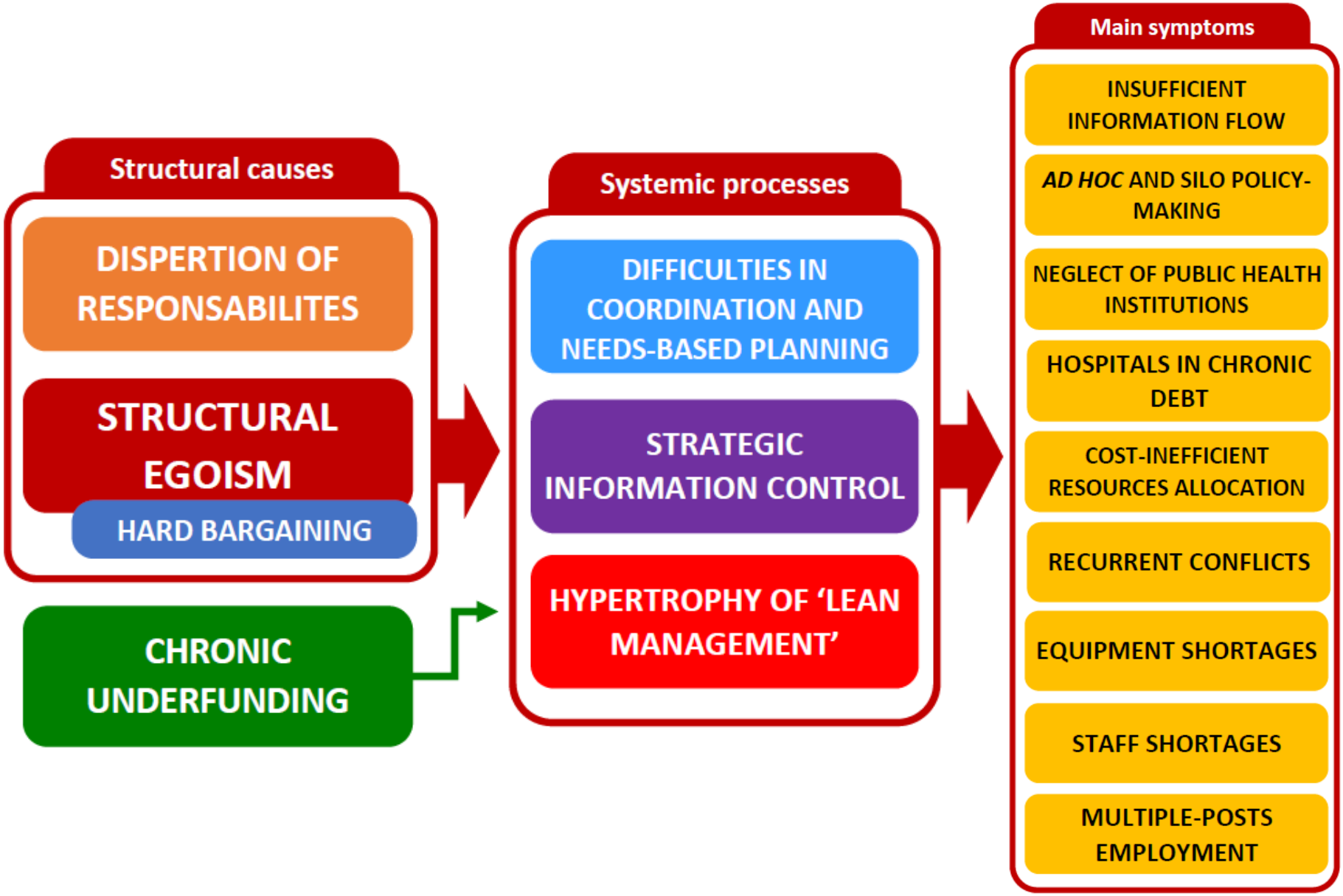
SOME CONCLUSIONS

DESCRIPTIVE IMPLICATIONS OF NORMATIVE THEORY


Structural causes
DISPERTION OF RESPONSABILITES
STRUCTURAL EGOISM
HARD BARGAINING
CHRONIC UNDERFUNDING
Systemic processes
DIFFICULTIES IN COORDINATION AND NEEDS-BASED PLANNING
STRATEGIC INFORMATION CONTROL
HYPERTROPHY OF 'LEAN MANAGEMENT'
Main symptoms
INSUFFICIENT INFORMATION FLOW
AD HOC AND SILO POLICY-MAKING
NEGLECT OF PUBLIC HEALTH INSTITUTIONS
HOSPITALS IN CHRONIC DEBT
COST-INEFFICIENT RESOURCES ALLOCATION
RECURRENT CONFLICTS
EQUIPMENT SHORTAGES
STAFF SHORTAGES
MULTIPLE-POSTS EMPLOYMENT

PROCESSES OF DECISION-MAKING ARE CHARACTERIZED BY THE FOLLOWING PHENOMENA

1. Silo policymaking
2. Sequenced compartmentalization
3. Misalignment between policymaking practices (top-down decision-making) and organization of healthcare system
4. Structural egoism

1. SILO POLICYMAKING

Coordination is either insufficient or *ad hoc* leading to 'silo policymaking' and myopic or narrow policy motivation (tunnel-vision). This issue is somewhat recognized by the Ministry of Health, particularly in the search for health impact assessment tools.

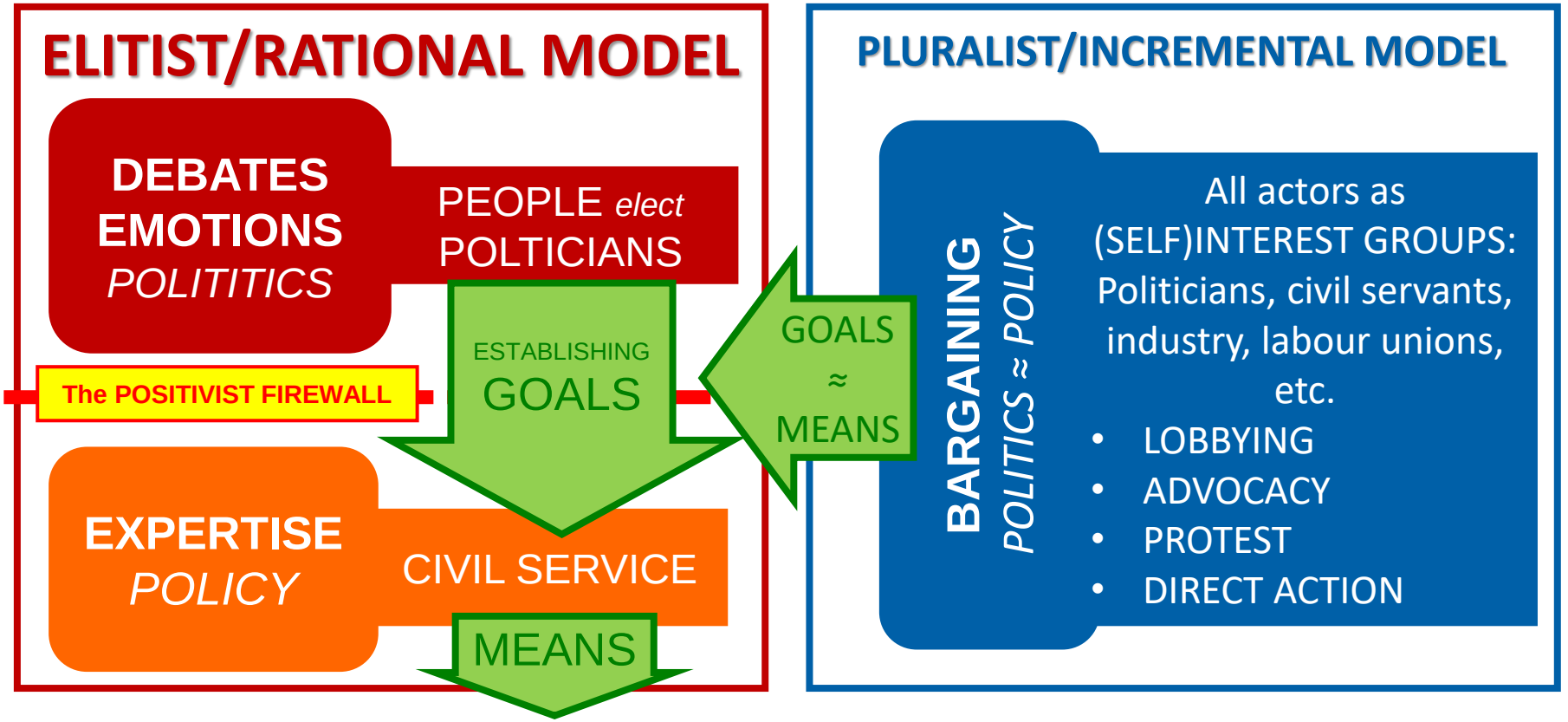
2. SEQUENCED COMPARTMENTALISATION

– is a predominant mode of processing complex issues, resulting in inconsistent decision-making. It comprises of systemic rules to deconstruct wider policy problems into smaller aspects (or inputs), to compartmentalize processing of those aspects in dedicated institutions and to sequence those processing stages in a specific order.

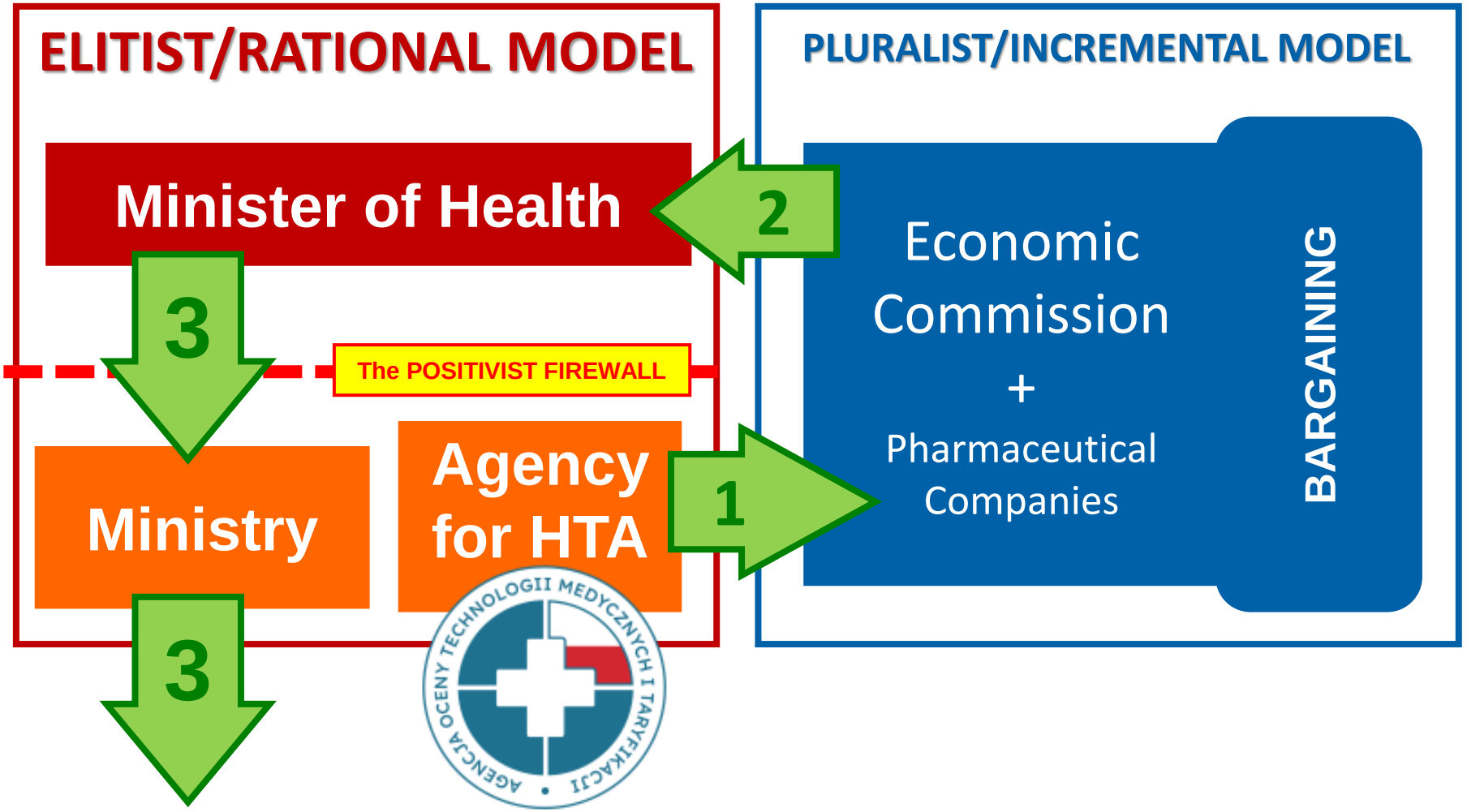
For instance, pharmaceutical reimbursement decisions are sequenced in a following way:

1. AOTMiT (Agency for Health Technology Assessment and Tariffs System) provides expertise;
2. this is followed by Economic Commission bargaining with producers;
3. and this is followed by MoH's final political decision.

TRADITIONAL MODELS OF POLICY-MAKING: COMPARTMENTALISATION

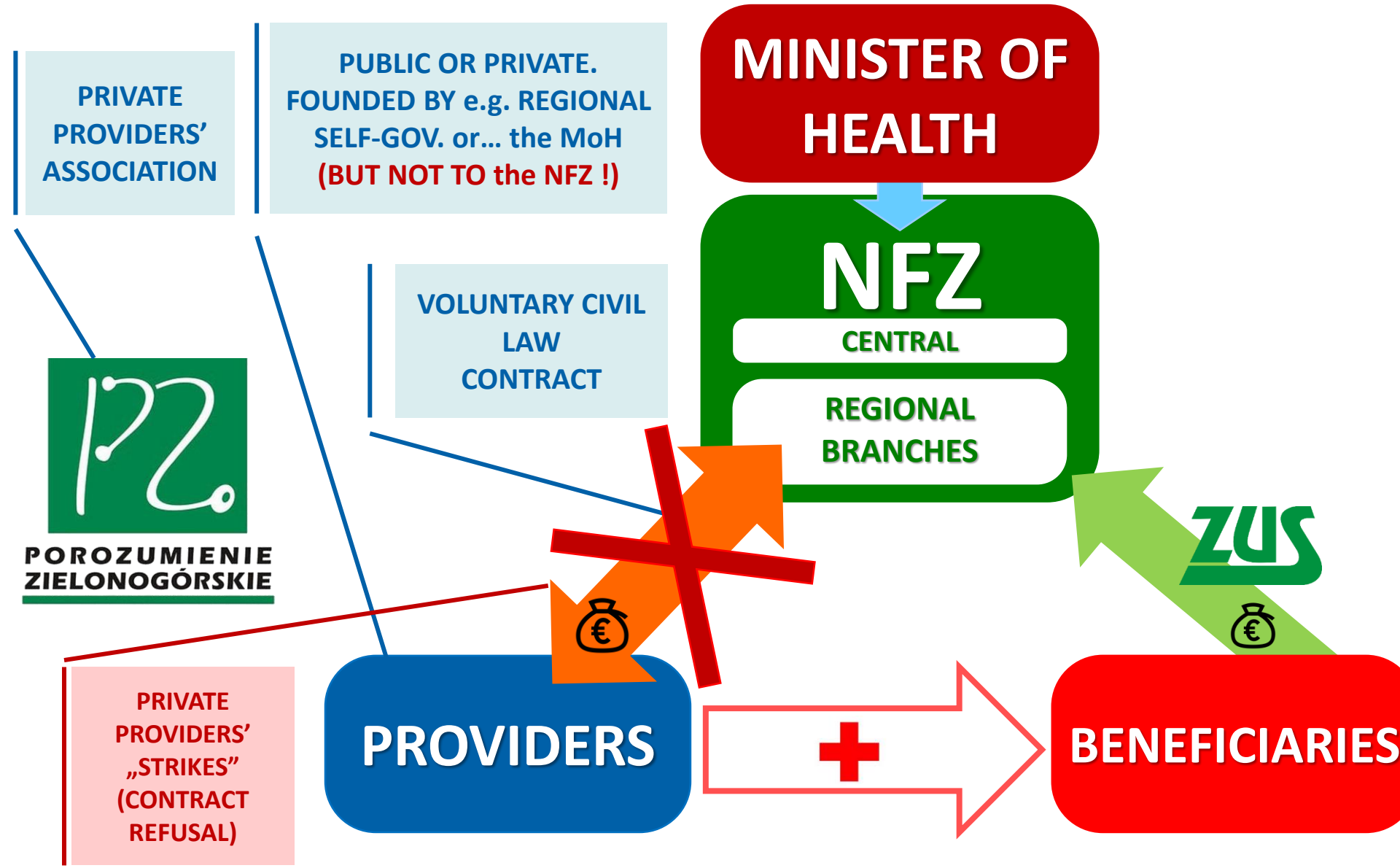


TRADITIONAL MODELS OF POLICY-MAKING: COMPARTMENTALISATION



3. MISALIGNMENT BETWEEN POLICYMAKING PRACTICES AND ORGANISATION OF HEALTHCARE SYSTEM

Misalignment between policymaking practices (top-down decision-making) and organization of healthcare system (contracting of services requiring consensus between principal stakeholders) results in end-of-pipe deadlocks (e.g. “strikes” of providers refusing to accept contracts under new imposed conditions and reforms).


PRIVATE PROVIDERS' ASSOCIATION
PUBLIC OR PRIVATE. FOUNDED BY e.g. REGIONAL SELF-GOV. or… the MoH (BUT NOT TO the NFZ !)
MINISTER OF HEALTH
NFZ
CENTRAL
REGIONAL BRANCHES
VOLUNTARY CIVIL LAW CONTRACT
POROZUMIENIE ZIELONOGÓRSKIE
ZUS
PRIVATE PROVIDERS' „STRIKES" (CONTRACT REFUSAL)
PROVIDERS
BENEFICIARIES

4. STRUCTURAL EGOISM

– rules of the system force actors to behave egoistically – not the result of bad will or human nature but a survival strategy…

(As informants observe:) This results in disjointed actions of actors (between NHF and providers) where particularistic motivations dominate over policy objectives.

Structural egoism causes or leads to:

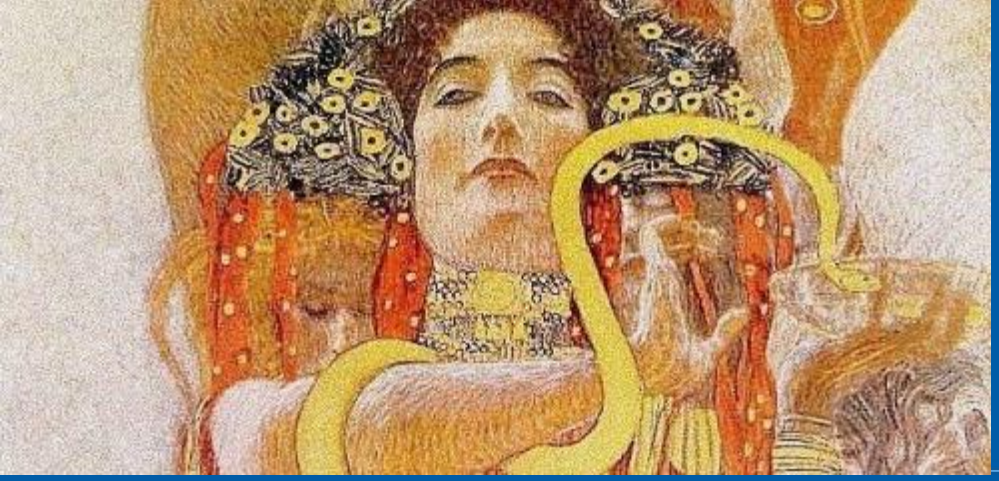
- **breakdown of cooperation** between actors (negotiator's dilemma);
- **breakdown of communication** between actors (strategic control of information);
- **opportunistic behaviors** of healthcare providers that strive to exploit overpricing of certain services, eventually leading to unfair competition practices and **wasteful resources allocation**;
- (in the context of serious system underfunding) excessive **austerity practices** and **lean management**, bringing with them the overburdening of personnel and **lack of emergency redundancies** due to practices of employing only the minimum necessary Staff.

4. STRUCTURAL EGOISM

- All processes and decisions are to take place via **quasi-market bargaining** between cooperating but rival antagonists.
- An integral feature of the Polish health-care system since the 1999 reforms: **civil law contracts** between the National Health Fund and service providers.
- Provider competition for system's resources – encourages the search for **cream skimming** opportunities and hampers coordination.
- **The negotiator's dilemma** – assuming the selfishness of the other side provokes exaggerated claims at the start and withholding information (strategic info control).
- Shifting responsibility and costs onto others or saving on emergency reserves.
- It forces drastic savings on staff and supplies…

4. STRUCTURAL EGOISM

- Disjointed governance – dispersion of responsibilities
- Chronic underfunding
- **SUSTAINABILITY DEFICIT**: inefficient resources allocation
- **RESILIENCY DEFICIT**: lack of crisis redundancies
- Difficulties in coordination and needs-based planning
- Strategic information control
- Hypertrophy of 'lean management'



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FAILED HOSPITAL SYSTEM REFORM: HOSPITAL DEVELOPMENT AGENCY

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Health policy

journal homepage: www.elsevier.com/locate/healthpol

Health Reform Monitor

The 2021 plan for hospital care centralization in Poland – When politics overwhelms the policy process

Katarzyna Dubas-Jakóbczyk [a,*], Alicja Domagała [b], Michał Zabdyr-Jamróz [b], Iwona Kowalska-Bobko [b], Christoph Sowada [a]

[a] Health Economics and Social Security Department, Institute of Public Health, Faculty of Health Sciences, Jagiellonian University Medical College, 066 Krakow, Poland

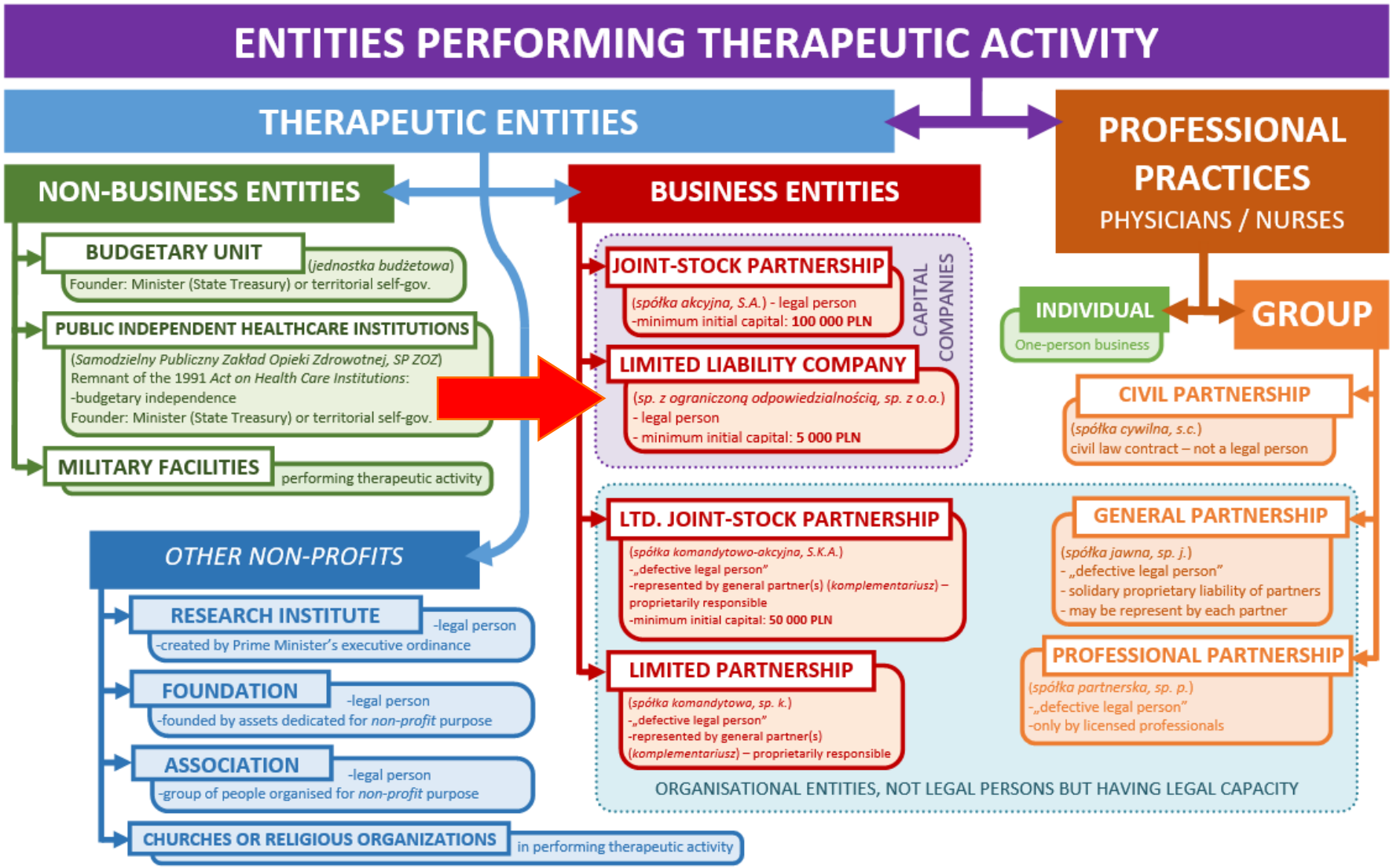
[b] Health Policy and Management Department, Institute of Public Health, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

Hospitals system reform impulse

- System's chronic underfunding (healthcare insurance contribution lower than planned) → public hospitals' chronic debt.
- Constant need to exceed contractual limits, for which the National Health Fund did not always return the money (sometimes also overestimating some benefits provoking unnecessary treatments, e.g. invasive cardiology).
- Hospital debt was blamed overwhelmingly on poor management or the lack of bankruptcy capacity of dominant legal form of public hospitals, i.e., Independent Public Healthcare Institutions (SPZOZ).
- Proposed solution: transforming SPZOZs into capital companies (LLC, JSC)
  - For example, the Act on Medical Activity of 2011 was intended to, among other things, force local governments to transform SPZOZ into capital companies.

Since 2011 – a new legal systematization of healthcare providers

+ FORCED COMERCIALIZATION OF PUBLIC HOSPITALS IN DEBT



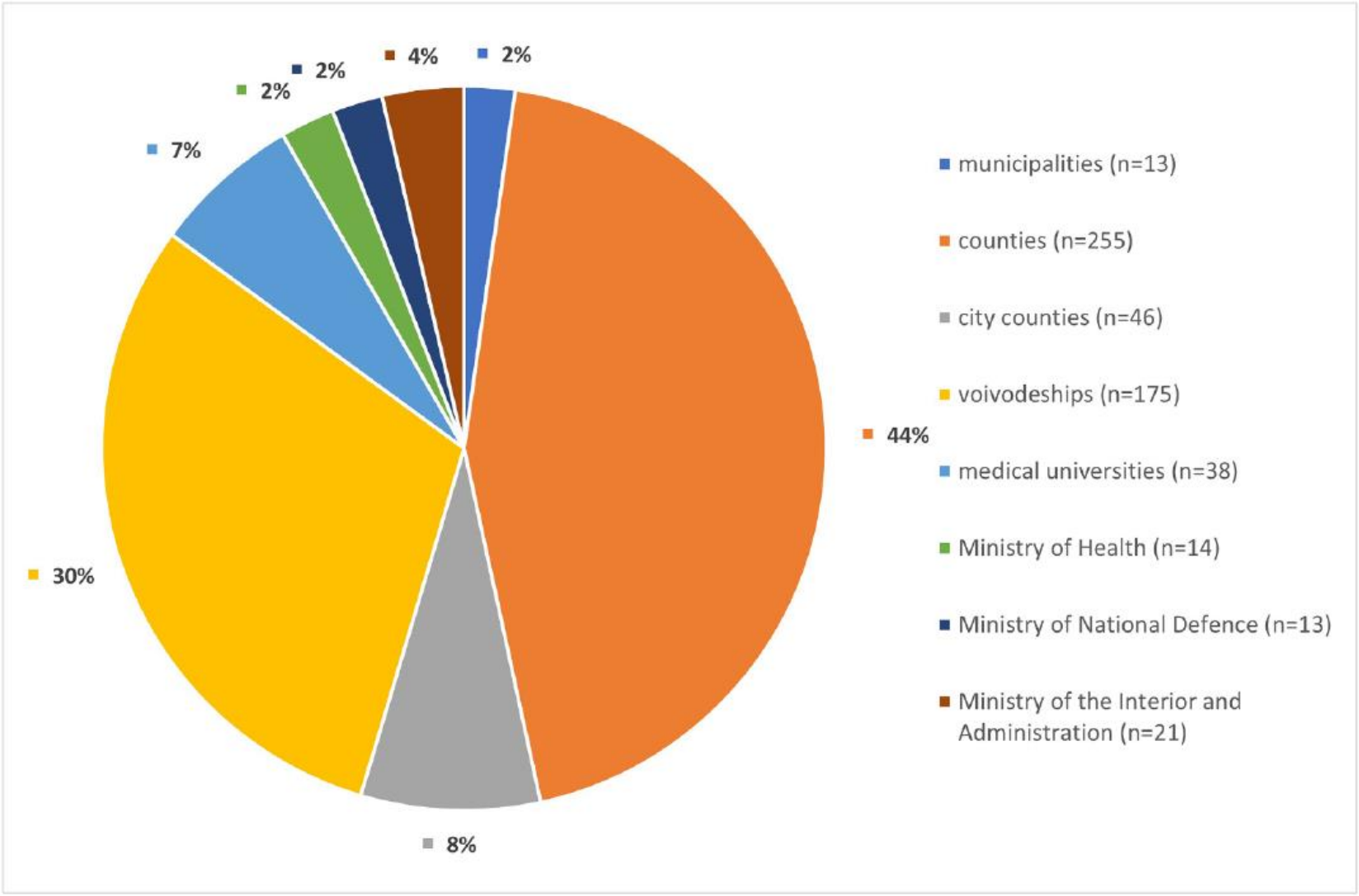


Fig. 1. Ownership structure of public hospitals in Poland in 2020 ($n = 575$).

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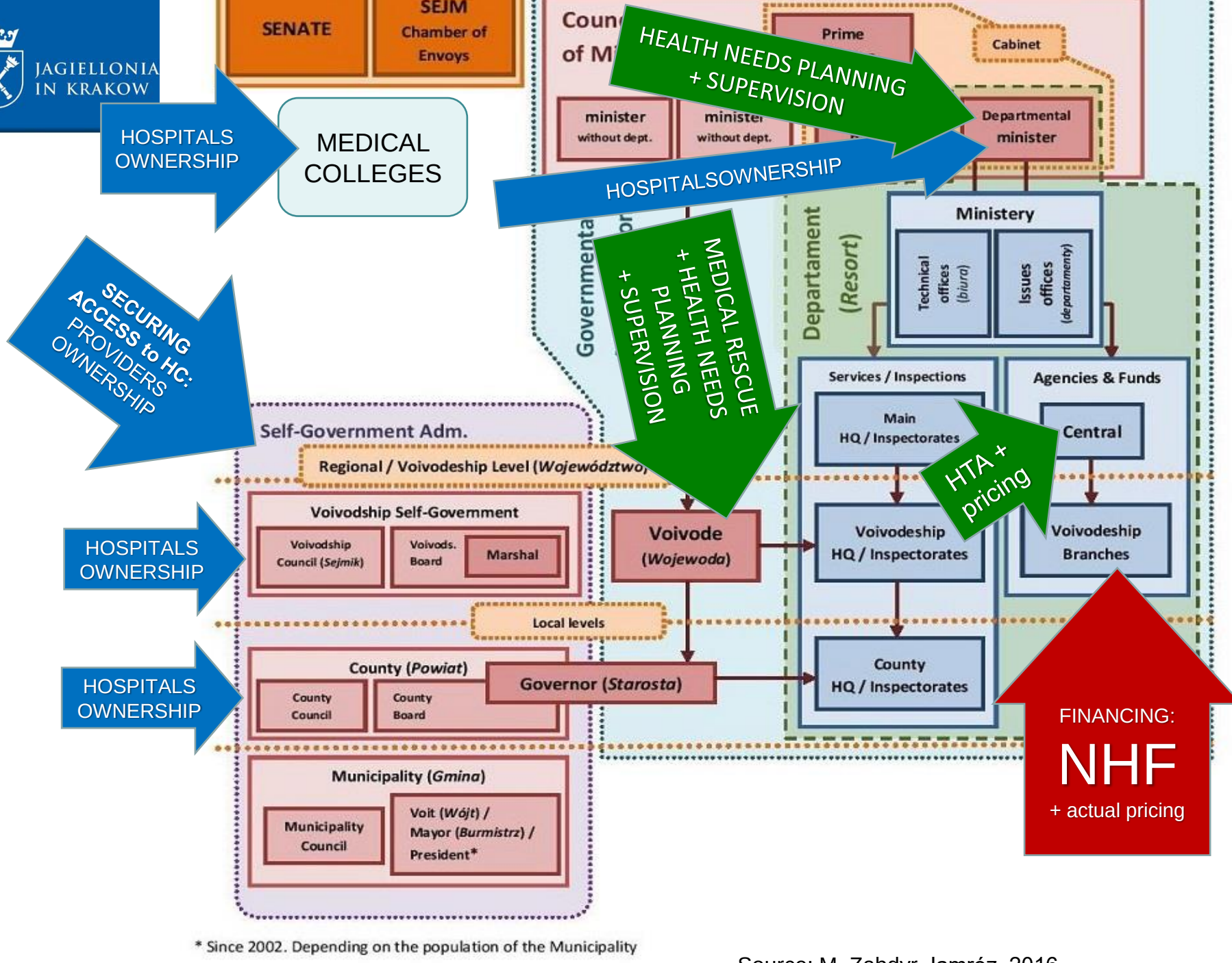
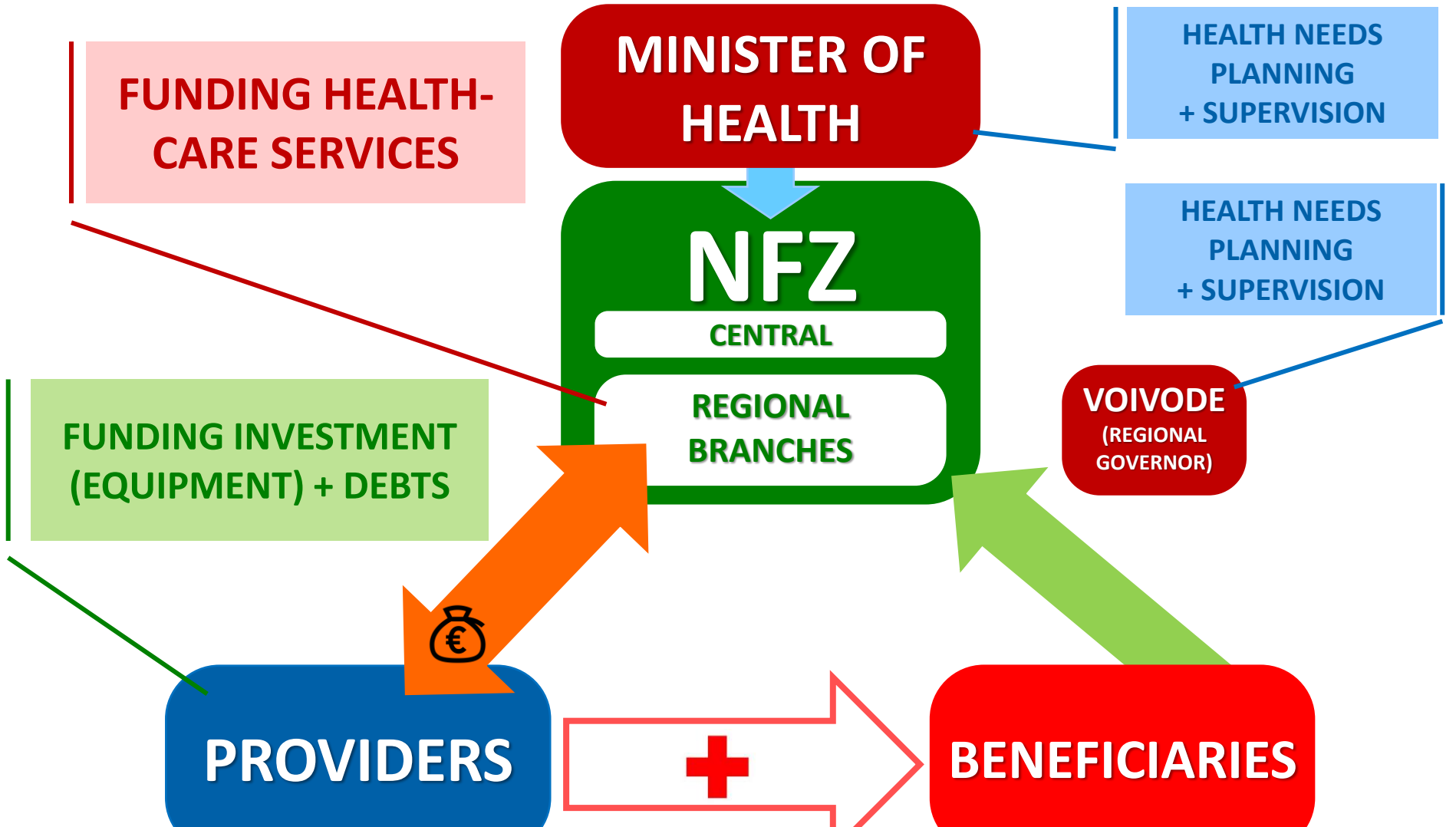
Public Aadministration System



* Since 2002. Depending on the population of the Municipality

Source: M. Zabdyr-Jamróz, 2016

DISJOINTED GOVERNANCE

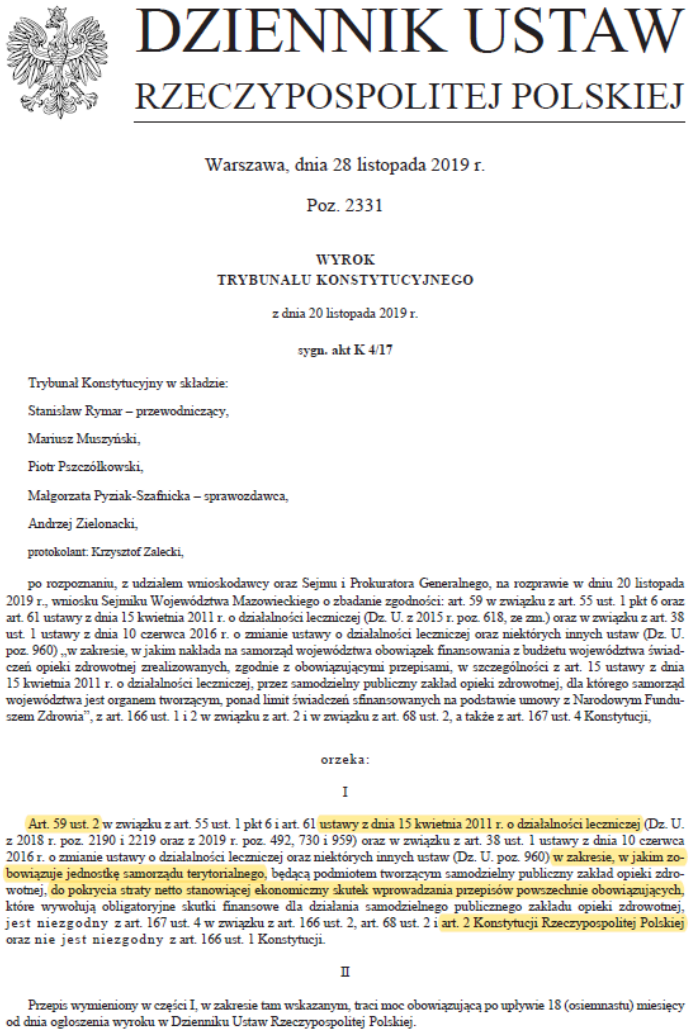


STRUCTURAL EGOISM → INEFFICIENT RESOURCES ALLOCATION

- Disjointed governance – dispersion of responsibilities.
- Difficulties in coordination and needs-based planning.
- Strategic information control.
- **Cream skimming attempts** – uncoordinated investments on an internal market – **by local hospitals in the same area lead to waste** of resources: NHF does not have enough money to contract same specialist wards in the same area.
- Attempted solution: **Electronic tool for coordinating investments in local healtcare providers IOWISZ** *(Instrument Oceny Wniosków Inwestycyjnych w Sektorze Zdrowia)* – Evaluation Instrument of Investment Motions in Health Care, EIIM.

Hospitals' system reform impulse

- **Legal consensus till 2019:** the founding entities, primarily territorial self-governments, should be responsible for hospitals' debts.
- **2019 Constitutional Tribunal ruling:** territorial self-governments cannot be held responsible for the debts of their hospitals. Those debts were the result of the implementation of their statutory and constitutional tasks – i.e. providing healthcare according to MoH established guaranteed benefits basket – which the National Health Fund often refused to reimburse, because of the contractual limits had been exhausted.



DZIENNIK USTAW
RZECZYPOSPOLITEJ POLSKIEJ

Warszawa, dnia 28 listopada 2019 r.

Poz. 2331

WYROK
TRYBUNAŁU KONSTYTUCYJNEGO

z dnia 20 listopada 2019 r.

sygn. akt K 4/17

Trybunał Konstytucyjny w składzie:

Stanisław Rymar – przewodniczący,

Mariusz Muszyński,

Piotr Pszczółkowski,

Małgorzata Pyziak-Szafnicka – sprawozdawca,

Andrzej Zielonacki,

protokolant: Krzysztof Zalecki,

po rozpoznaniu, z udziałem wnioskodawcy oraz Sejmu i Prokuratora Generalnego, na rozprawie w dniu 20 listopada 2019 r., wniosku Sejmiku Województwa Mazowieckiego o zbadanie zgodności: art. 59 w związku z art. 55 ust. 1 pkt 6 oraz art. 61 ustawy z dnia 15 kwietnia 2011 r. o działalności leczniczej (Dz. U. z 2015 r. poz. 618, ze zm.) oraz w związku z art. 38 ust. 1 ustawy z dnia 10 czerwca 2016 r. o zmianie ustawy o działalności leczniczej oraz niektórych innych ustaw (Dz. U. poz. 960) „w zakresie, w jakim nakłada na samorząd województwa obowiązek finansowania z budżetu województwa świadczeń opieki zdrowotnej zrealizowanych, zgodnie z obowiązującymi przepisami, w szczególności z art. 15 ustawy z dnia 15 kwietnia 2011 r. o działalności leczniczej, przez samodzielny publiczny zakład opieki zdrowotnej, dla którego samorząd województwa jest organem tworzącym, ponad limit świadczeń sfinansowanych na podstawie umowy z Narodowym Funduszem Zdrowia", z art. 166 ust. 1 i 2 w związku z art. 2 i w związku z art. 68 ust. 2, a także z art. 167 ust. 4 Konstytucji,

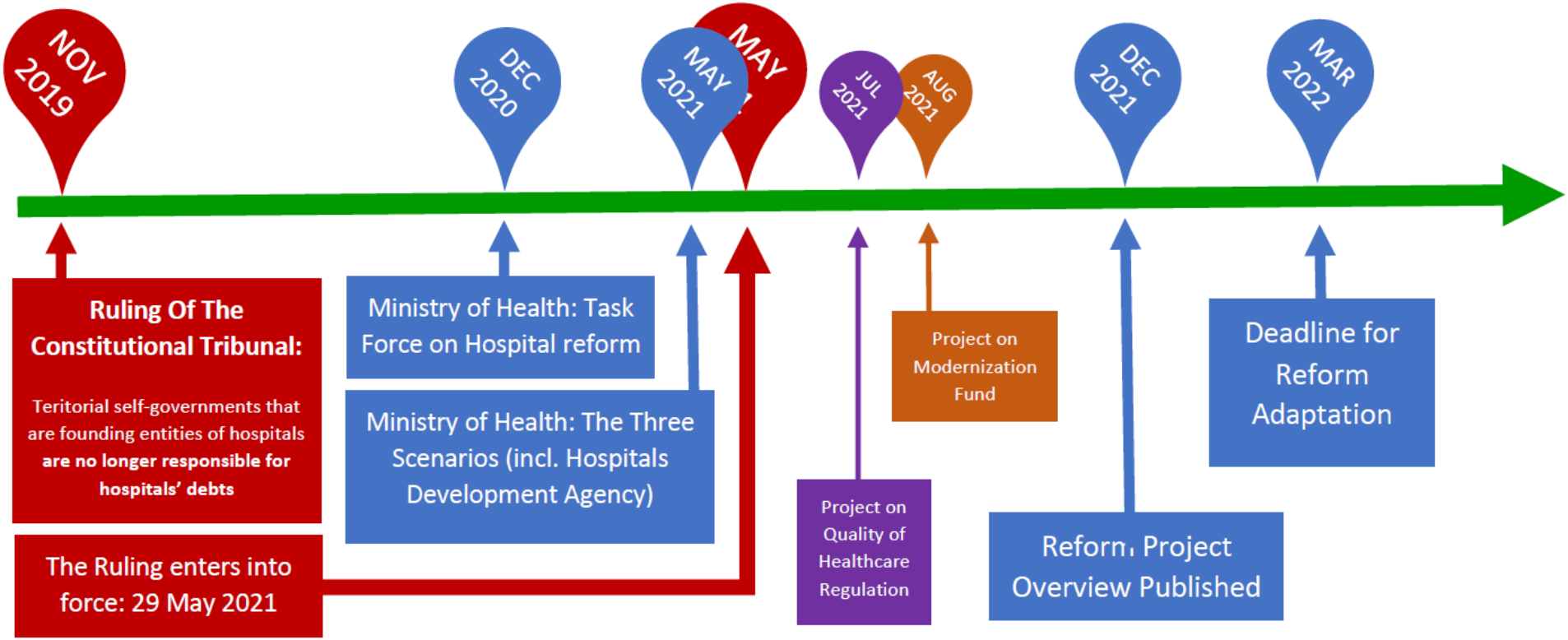
orzeka:

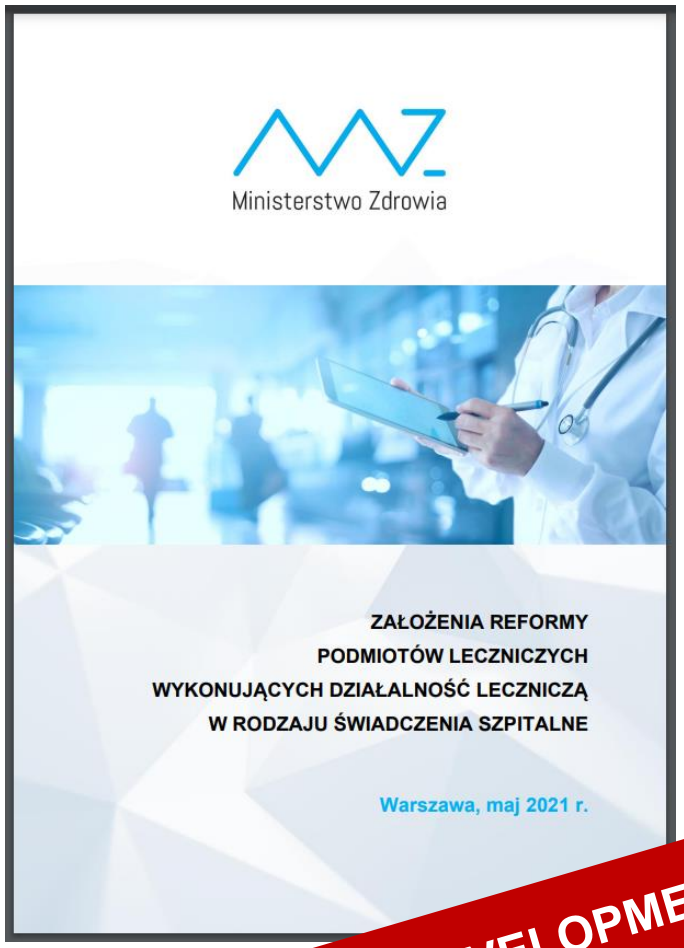
I

Art. 59 ust. 2 w związku z art. 55 ust. 1 pkt 6 i art. 61 ustawy z dnia 15 kwietnia 2011 r. o działalności leczniczej (Dz. U. z 2018 r. poz. 2190 i 2219 oraz z 2019 r. poz. 492, 730 i 959) oraz w związku z art. 38 ust. 1 ustawy z dnia 10 czerwca 2016 r. o zmianie ustawy o działalności leczniczej oraz niektórych innych ustaw (Dz. U. poz. 960) w zakresie, w jakim zobowiązuje jednostkę samorządu terytorialnego, będącą podmiotem tworzącym samodzielny publiczny zakład opieki zdrowotnej, do pokrycia straty netto stanowiącej ekonomiczny skutek wprowadzania przepisów powszechnie obowiązujących, które wywołują obligatoryjne skutki finansowe dla działania samodzielnego publicznego zakładu opieki zdrowotnej, jest niezgodny z art. 167 ust. 4 w związku z art. 166 ust. 2, art. 68 ust. 2 i art. 2 Konstytucji Rzeczypospolitej Polskiej oraz nie jest niezgodny z art. 166 ust. 1 Konstytucji.

II

Przepis wymieniony w części I, w zakresie tam wskazanym, traci moc obowiązującą po upływie 18 (osiemnastu) miesięcy od dnia ogłoszenia wyroku w Dzienniku Ustaw Rzeczypospolitej Polskiej.


NOV 2019
DEC 2020
MAY 2021
MAY
JUL 2021
AUG 2021
DEC 2021
MAR 2022
Ruling Of The Constitutional Tribunal:
Teritorial self-governments that are founding entities of hospitals are no longer responsible for hospitals' debts
The Ruling enters into force: 29 May 2021
Ministry of Health: Task Force on Hospital reform
Ministry of Health: The Three Scenarios (incl. Hospitals Development Agency)
Project on Quality of Healthcare Regulation
Project on Modernization Fund
Reform Project Overview Published
Deadline for Reform Adaptation



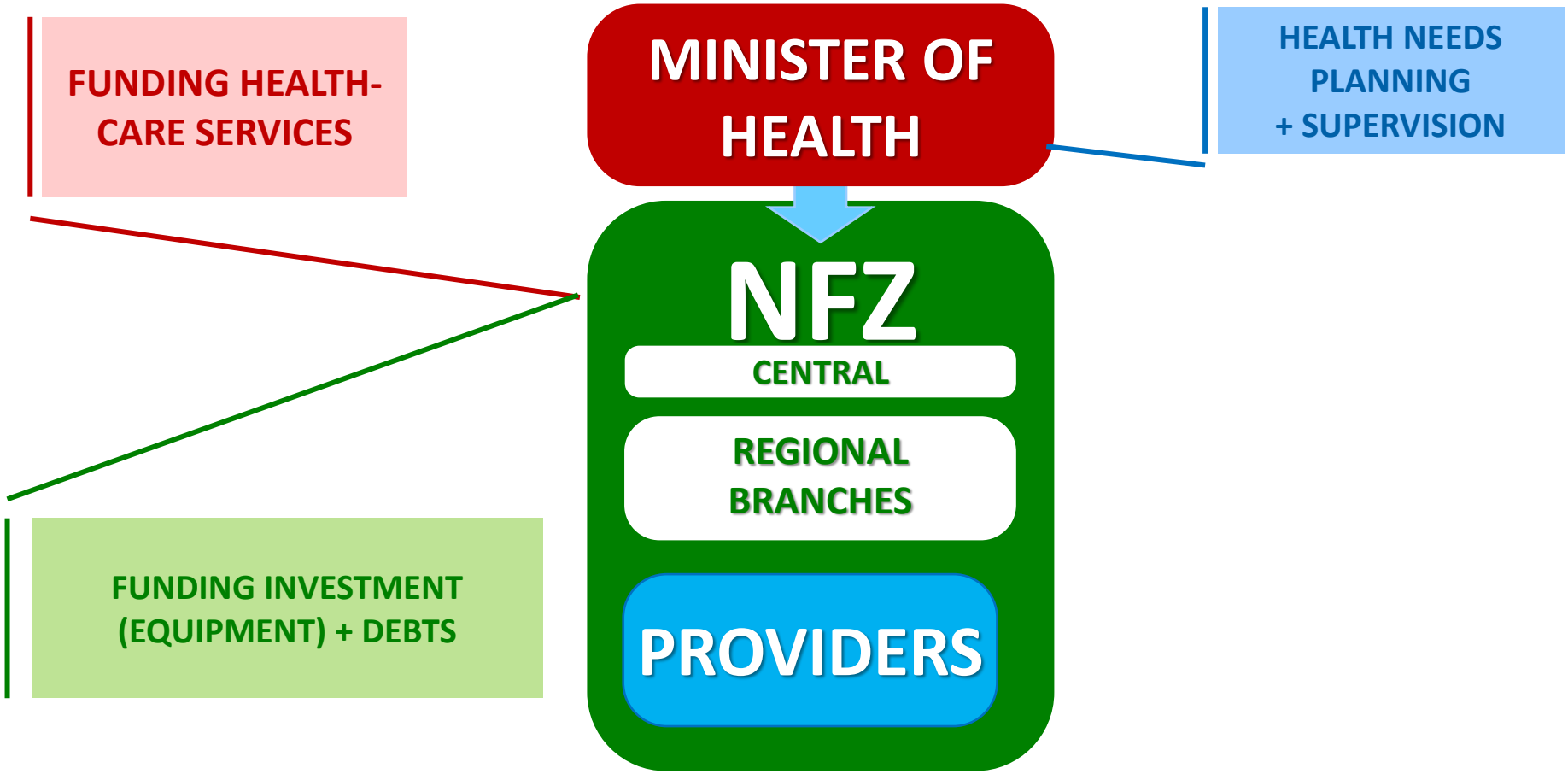
HOSPITALS DEVELOPMENT AGENCY

Table 1
The three scenarios of the hospital reform.

Scenario	Content
1 - **Ownership centralization**	• The ownership of all public hospitals is to be taken over by a central administration body (e.g. the MoH, the National Health Fund, etc.). • Limiting the number of owners should improve the operational and strategic management capacities of the hospital sector (including i.a. hospital emergency management, restructuration, adapting to the population's health needs).
2 - **Management centralization**	• The management and control of all public hospitals is to be taken over by a central administration body (but without taking over asset ownership and application instead of long-term asset lease agreements). • Similarly as with scenario no 1, the centralized management should improve the operational and strategic management capacities of the hospital sector.
3 – **Supervision centralization**	• A central agency will be launched, responsible for supervising the financial situation of hospitals and supporting their restructuration processes. • Hospitals are to be classified into categories, depending on their financial situation, while the agency will finance investment, support restructuration or take control over the restructuration process (in the case of the hospitals in the worst financial situation). • Formal certification of hospital managers will be introduced (confirmation of management competencies).

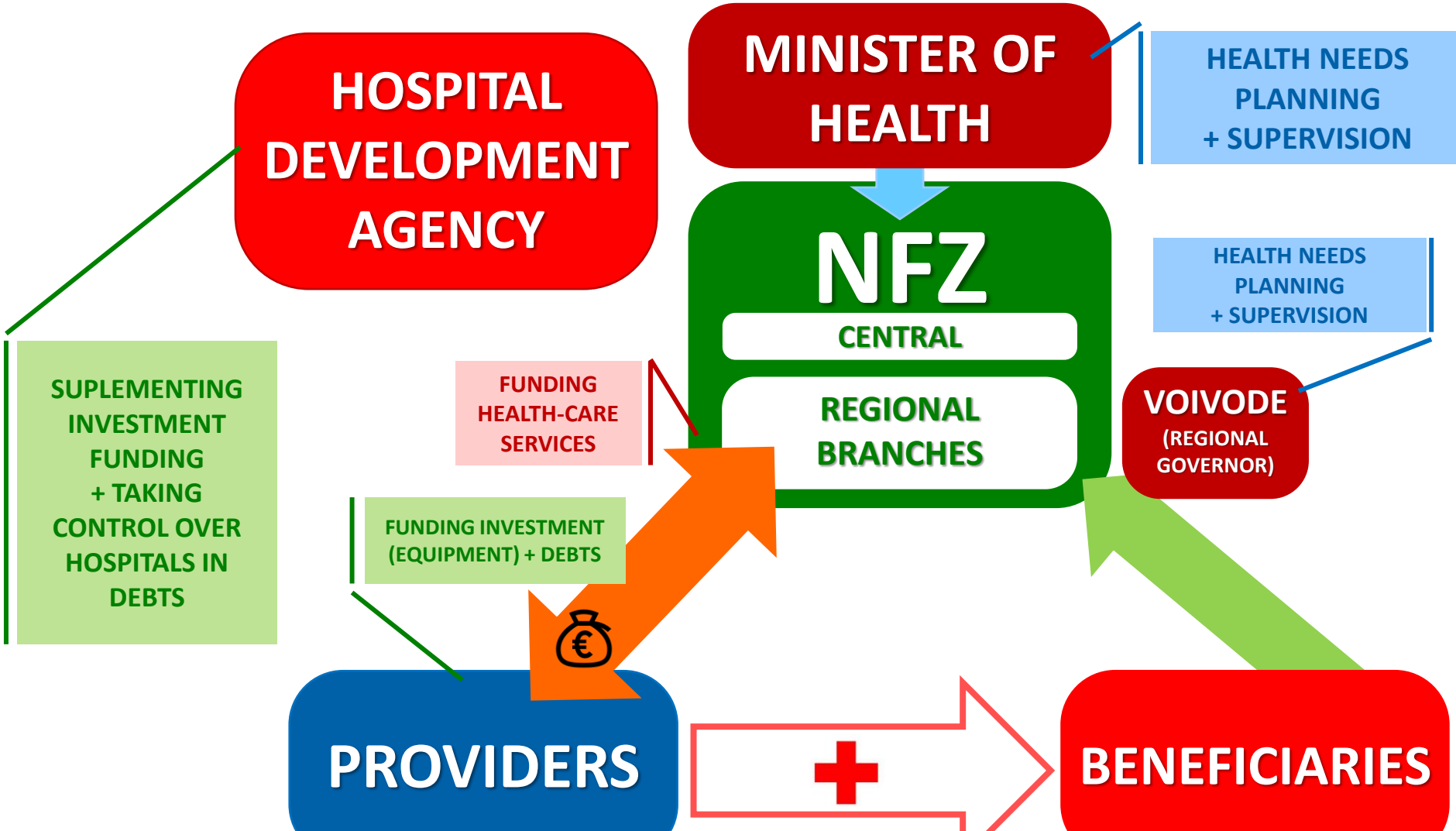
Source: based on MoH 2021 [9].

SCENARIO 1: towards integrated model, E.g.:



SCENARIO 3: MOST FAVOURED

EVEN MORE DISJOINTED GOVERNANCE…?



REFORM FAILURE

PULS Medycyny Najnowsze Podcasty Puls Farmacji Oblicza Medycyny Konsylium24 Wideo

Niedzielski: to nie jest dobry czas na powoływanie Agencji Rozwoju Szpitali

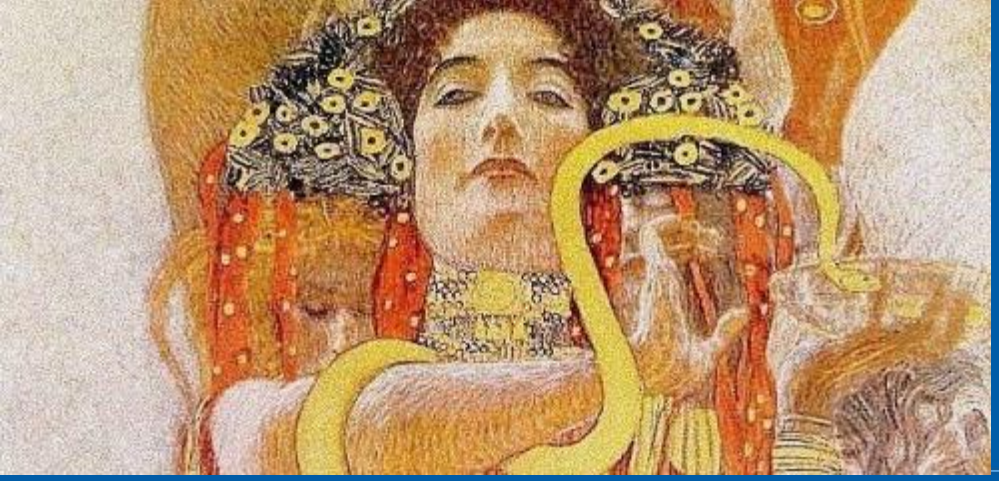
EMILIA GRZELA email opublikowano: 12-08-2022, 13:33

Czy losy ustawy o modernizacji szpitali są już przesądzone? - Podzielamy pogląd, że kryzys finansowy dotyczący wszystkich Polaków oraz instytucji państwowych i administracji to nie jest dobry czas na powoływanie nowej instytucji, która kosztowałaby miliony złotych rocznie - powiedział Adam Niedzielski.

- MoH, August 2022: „Not a good time for creating Hospital Development Agency
- Rampant inflation…
- Military investments announced…

Results for governance: Pt. 3/3

	1f	Existing system for quality control and patients' safety (on paper)	"Blame-game" and shifting responsibility to others for adverse events.	Sustainability and resilience	No-fault system for quality control and patients' safety [see also: 1e-2].
	1g	Decentralisation, competition, partnership model of public services	Uncoordinated complexity. "Silo-policymaking" and compartmentalisation – lack of common strategic vision. Structural egoism – susceptibility to conflicts and suboptimal resource allocation based on hard bargaining (hypertrophy of lean management) – damaging emergency redundancies of the system.	Sustainability (short and mid-term) at the cost of resilience and long-term sustainability	[1g-1] Consolidation of ownership of healthcare providers: hospitals at voivodship level and open basic care (primary and ambulatory) at county level. [1g-2] Deliberative negotiation between providers and payer and enhancement of mediation in conflict resolution.



JAGIELLONIAN UNIVERSITY
MEDICAL COLLEGE

Thank you for your attention

MICHAŁ ZABDYR-JAMRÓZ

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