

## Medical Savings Accounts and Healthcare Reform in Poland: A Critical Analysis\*

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\*Presented at the 47<sup>th</sup> IBIMA International Conference, 29-30 June 2026, Madrid, Spain

### Abstract

The healthcare system in Poland is controversial. Waiting times for tests, procedures, surgeries, or appointments with specialists are often last many months. From this perspective, the healthcare system in Poland is inefficient and underfunded. There is a widespread belief in Polish society that, thanks to the Christmas Charity Orchestra, among other initiatives, hospitals receive some funding. In reality, this translates into funding from individual household budgets. From an economic perspective, significant elements of the healthcare cost structure include: personnel costs for employees, primarily doctors and nurses; ongoing maintenance costs of healthcare infrastructure, including repairs to fixed assets; energy costs; pharmaceutical costs; investments; and so on. Healthcare spending is steadily rising, not least because of Poland's aging population.

The Polish healthcare system has evolved from a model reminiscent of Siemiaszko's centrally planned model to a blend of Bismarck's model based on social insurance, Beveridge's national healthcare system, and elements of a free-market model, where patient care has become a marketable commodity, with patients bearing the costs personally or through health insurance. Some countries have adopted financing for the healthcare system through so-called individual health accounts or medical savings accounts. This model is in effect in Singapore, China, South Africa, and, to some extent, the United States. In Poland, a similar solution was proposed in 1992 by a team of people represented by Zygmunt Hortmanowicz, himself a physician. The proposed solution was not adopted, and the idea of establishing a Health Protection Bank (BOZ) was also rejected. Many experts believe that a system involving individual health accounts cannot fully finance the growing needs of healthcare, especially with regard to the financing of chronic disease treatment and expensive surgical procedures.

**Keywords:** healthcare system, financing, patient, individual medical accounts

### Introduction

Healthcare in Poland has been periodically reformed since the beginning of the economic and social transformation. The primary goal of these reforms was to improve the quality of medical services and optimize

the costs of these services in the public sector. The effects of these changes were insufficient, and the set goals were not achieved, and the Polish public was dissatisfied with the adopted solutions. This dissatisfaction with the healthcare system is explained by the relatively long wait times for specialist appointments or scheduled medical procedures. Generally, it refers to the insufficient quality of services and the system's underfunding. The constitutional guarantee of providing public healthcare to our citizens results in a solution reminiscent of the communist era, primarily waiting in line for, for example, a hospital bed or a specialist appointment, etc. However, officially, in accordance with the Constitution, we as a country fulfill the requirement of guaranteed public healthcare, although the time and quality of this service are secondary.

Of course, in practice, it is possible to access healthcare in private medical practices and clinics for a relatively short period of time for a separate fee. As a rule, private healthcare facilities are staffed by the same medical staff employed in public medical centers. This suggests that the primary cause of the current state of affairs lies in the relatively poorly adapted financial model of healthcare in Poland.

According to an interview conducted by Gazeta Wyborcza with one of the directors of a public hospital, in practice, in his hospital "there are a dozen or so doctors who earn over PLN 100,000. He emphasizes that he does not agree with the calculations of the Agency for Health Technology Assessment and Tariff System, which show that doctors whose earnings exceed PLN 100,000 per month are 1% in Poland. Thirteen doctors earn over PLN 100,000, including one with a salary of almost PLN 200,000 – this is a specialist who agreed to work exclusively at the hospital. Three of them receive between PLN 80,000 and PLN 100,000 per month. 36 doctors receive between PLN 50,000 and PLN 80,000, and 31 between PLN 40,000 and PLN 50,000. The remaining doctors, i.e. over 100 people, earn less than PLN 40,000 under contracts. Of the 140 doctors who have employment contracts, two-thirds are residents, i.e. young doctors in the process of specializations, whose salaries are set and paid by the Ministry of Health. Of the remaining full-time physicians, seven earn between PLN 50,000 and PLN 80,000 per month, two between PLN 40,000 and PLN 50,000, and 18 between PLN 30,000 and PLN 40,000 1. According to other data, "General practitioners earn an average of PLN 5,000 to PLN 7,000 gross per month. Specialists – depending on the medical field – can expect a salary in the range of PLN 10,000 to PLN 20,000. Consultants and physicians working in leading clinics, especially in fields such as surgery, oncology, or orthopedics, can expect salaries exceeding PLN 25,000 per month 2. "

The above examples demonstrate that the bottleneck to the quality of medical services provided is the relatively low wages, as perceived by medical personnel. However, as the aforementioned example demonstrates, varying estimates of medical personnel's income in Poland evoke strong emotions among patients, especially in the context of the national average wage in Poland, which is , with a median of ..... , which relatively distinguishes medical personnel's remuneration. A separate issue is the ongoing material costs of maintaining public medical facilities, the level of expenditure on replacement and modernization investments, and the belief among Polish society in its permanent support for financing investment needs in the public health service through collections from the Orchestra of Christmas Charity, for example, for the purchase of medical equipment for children's hospitals.

The aim of this article is, on the one hand, to assess the healthcare system in Poland, and, on the other, to return to the concept of Medical Savings Accounts (MKO), widely discussed in the literature, as a rationale for changing the financing model for this care in Poland. The authors once again return to the MKO model developed by Zygmunt Hortmanowicz and his team, critically examining it and proposing improvements to make healthcare more effective for citizens, who, as practice shows, cannot always afford truly timely public healthcare services unless they utilize private medical facilities.

The primary research method in this article is a literature review, primarily concerning the financing of healthcare systems through medical savings accounts. Critical professional observations are also included, highlighting the weaknesses of this solution, such as the increased costs of treatment, which are not covered by the version of medical savings accounts proposed by Dr. Z. Hortmanowicz and his team. Therefore, what could be proposed to ensure that the MKO model could function effectively in Poland?

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<sup>1</sup>K. Lurka, Shocking Doctors' Salaries, Health Manager, 2025, source: [Shocking Doctors' Salaries - Health Manager – Termedia](#)

<sup>2</sup>Doctors' salaries in Poland 2025 - how much do medics earn in healthcare?, Rocketspace.pl, October 1, 2025, source: [Doctors' salaries in Poland 2025 - how much do medics earn in healthcare? - RocketSpace.pl](#)

## Health expenditure by financing scheme

Generally, healthcare financing models are based on four pillars: the first is financing from the state budget in the form of government schemes or compulsory health insurance, the second is financial support through voluntary health insurance, and the third is medical savings accounts. The final pillar comprises privately provided services, for which the patient pays personally. These insurance plans more closely resemble budgetary solutions, with the difference that the account holders decide on the method and location of treatment.

Government financing schemes – on a national or sub-national basis or for specific population groups – entitle individuals to healthcare based on residency and form the principal mechanism to cover healthcare costs in close to half of OECD countries. The other main method of financing is some form of compulsory health insurance (managed through public or private entities). Direct spending by households (out-of-pocket spending) can constitute a significant part of overall health expenditure. Finally, voluntary health insurance, in its various forms, can also play an important funding role in some countries <sup>3</sup>. Table 1 presents the sources of financing health care in OECD countries in 2025.

**Table 1. Structure of health expenditure by type of financing, 2023 (or nearest year) in %**

| Country                    | Government schemes | Compulsory health insurance | Voluntary health insurance | Out-of-pocket | Other    |
|----------------------------|--------------------|-----------------------------|----------------------------|---------------|----------|
| Sweden                     | 86                 | 0                           | 1                          | 13            | 0        |
| Germany                    | 8                  | 78                          | 1                          | 11            | 2        |
| Norway <sup>2</sup>        | 86                 | 0                           | 0                          | 14            | 0        |
| Luxembourg                 | 7                  | 79                          | 3                          | 9             | 2        |
| Croatia *                  | 8                  | 77                          | 6                          | 9             | 0        |
| Japan                      | 8                  | 77                          | 2                          | 12            | 1        |
| Czechia                    | 12                 | 73                          | 0                          | 15            | 1        |
| France                     | 4                  | 80                          | 6                          | 9             | 1        |
| Iceland                    | 84                 | 0                           | 0                          | 15            | 2        |
| United States <sup>1</sup> | 28                 | 55                          | 1                          | 11            | 5        |
| Denmark                    | 83                 | 0                           | 3                          | 14            | 0        |
| Netherlands                | 8                  | 75                          | 4                          | 12            | 1        |
| United Kingdom             | 81                 | 0                           | 3                          | 15            | 2        |
| Finland                    | 69                 | 12                          | 2                          | 14            | 3        |
| New Zealand                | 72                 | 8                           | 5                          | 13            | 2        |
| Thailand *                 | 70                 | 10                          | 8                          | 10            | 2        |
| Slovak Republic            | 4                  | 75                          | 0                          | 20            | 1        |
| <b>Poland</b>              | <b>11</b>          | <b>67</b>                   | <b>5</b>                   | <b>16</b>     | <b>2</b> |
| Austria                    | 33                 | 44                          | 5                          | 16            | 2        |
| Colombia                   | 3                  | 73                          | 9                          | 15            | 0        |
| Ireland                    | 76                 | 1                           | 11                         | 11            | 2        |
| Romania *                  | 14                 | 62                          | 1                          | 23            | 0        |
| Türkiye                    | 30                 | 46                          | 3                          | 19            | 2        |

<sup>3</sup>Health at a Glance 2025, OECD Indicators, OECD (2025), OECD Publishing, Paris, <https://doi.org/10.1787/8f9e3f98-en>, p. 160.

|                             |           |           |          |           |          |
|-----------------------------|-----------|-----------|----------|-----------|----------|
| Estonia                     | 9         | 67        | 1        | 22        | 1        |
| <b>OECD38</b>               | <b>36</b> | <b>39</b> | <b>5</b> | <b>19</b> | <b>1</b> |
| Hungary                     | 12        | 62        | 2        | 23        | 1        |
| Belgium                     | 18        | 55        | 5        | 22        | 0        |
| Slovenia                    | 9         | 65        | 13       | 12        | 1        |
| Spain                       | 70        | 4         | 6        | 21        | 0        |
| Italy                       | 73        | 0         | 2        | 24        | 1        |
| Australia <sup>2</sup>      | 72        | 1         | 10       | 15        | 2        |
| Costa Rica                  | 3         | 68        | 4        | 24        | 1        |
| Canada                      | 69        | 1         | 13       | 15        | 2        |
| Switzerland                 | 23        | 45        | 7        | 22        | 4        |
| Lithuania                   | 7         | 60        | 2        | 31        | 0        |
| Israel                      | 15        | 51        | 12       | 20        | 2        |
| Peru *                      | 36        | 28        | 7        | 27        | 1        |
| Bulgaria *                  | 15        | 48        | 1        | 36        | 1        |
| Portugal                    | 59        | 3         | 8        | 29        | 1        |
| Greece                      | 29        | 32        | 4        | 34        | 0        |
| Korea                       | 11        | 49        | 8        | 31        | 0        |
| Latvia                      | 60        | 0         | 5        | 35        | 0        |
| Chile                       | 2         | 57        | 6        | 35        | 0        |
| China * <sup>2</sup>        | 18        | 37        | 9        | 34        | 3        |
| Indonesia *                 | 24        | 29        | 5        | 31        | 10       |
| Mexico <sup>2</sup>         | 24        | 28        | 7        | 39        | 2        |
| South Africa * <sup>2</sup> | 46        | 0         | 45       | 7         | 2        |
| Brazil * <sup>2</sup>       | 45        | 1         | 27       | 27        | 0        |
| India * <sup>2</sup>        | 34        | 6         | 9        | 46        | 6        |

Note: 1. All spending by private health insurance companies reported under compulsory health insurance. 2. 2022 date.

\*Accession/country partner.

Source: OECD Health Statistics 202

Compulsory or automatic coverage, through government schemes or health insurance, forms the bulk of healthcare financing in OECD countries. Taken together, three-quarters of all healthcare spending in 2023 was covered through these types of mandatory financing schemes. Central, regional or local government schemes in Sweden, Norway, Iceland, Denmark and the United Kingdom accounted for 80% or more of national health spending. In France, Germany, Luxembourg and Japan, more than three-quarters of spending was covered through a type of compulsory health insurance scheme. In the United States, federal and state programs covered around 28% of total health spending in 2023, while another 55% of expenditure was classified under compulsory insurance schemes, covering a mix of public arrangements and private health insurance considered compulsory under the Affordable Care Act 4.

Some countries effectively have dual financing sources, such as government schemes and out-of-pocket financing. Such countries include Sweden, Norway, Iceland, Denmark, and Latvia. This may also translate into relatively lower transaction costs incurred by these countries in operating their healthcare systems. Questions arise: does a greater number of financing sources also mean greater competition in the healthcare market, which should translate into better quality of medical services and/or lower costs? Or perhaps each financing source is simultaneously accompanied by transaction costs related to, among other things, administrative support for that source, which ultimately increases the costs of the entire healthcare system in a given country, and the benefits of the existing market are smaller than the scale of these costs?

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<sup>4</sup> There

Out-of-pocket payments financed just under one-fifth of all health spending in 2023 in OECD countries, with this share broadly increasing as GDP decreases. Households had to bear more than one-third of all healthcare costs directly in Mexico, Chile, Latvia and Greece. In partner country India, nearly half of all health spending is made out-of-pocket. By contrast, in France and Luxembourg, out-of-pocket spending accounted for less than 10% of total health expenditure. Voluntary health insurance only covered 5% of all healthcare costs across the OECD but financed more than one-tenth of all total health budget in Slovenia, Canada, Ireland, Israel, although Slovenia abolished complementary voluntary health insurance in 2024. In accession/partner countries Brazil (27%) and South Africa (45%), voluntary health insurance accounted for much larger shares of total health expenditure 5.

Poland is one of the countries with relatively multipolar healthcare financing sources, although public financing dominates. However, out-of-pocket financing is becoming increasingly popular. In a country like Poland, this stems from the numerous bottlenecks in public healthcare, which manifest themselves in the aforementioned long waits for specialists and even primary care physicians.

While financing schemes purchase healthcare on behalf of individuals and the population, the revenues to fund this expenditure can originate from different sources. Most funding for government schemes comes from general government revenues (such as taxation), which are channeled through the budget process. However, governments might also contribute to social health insurance by covering the contributions of specific population groups or providing general budget support to insurance funds. Individuals may purchase private health insurance, but part of their premium may be paid by the employer, or it may be subsidized by the government. Individuals also finance care directly, using household income to pay for services in their entirety or as part of a cost-sharing arrangement. Other health financing schemes (such as non-profit or enterprise schemes) can receive donations or generate income from investments or other commercial operations. Finally, revenues can also come from non-domestic sources 6. Table 2 shows the structure of public health care expenditure in 2023.

**Table 2 Health expenditure from public sources as share of total health expenditure, 2023 (or nearest year)**

| Specification            | Public (no breakdown) | Government transfers | Social insurance contributions |
|--------------------------|-----------------------|----------------------|--------------------------------|
| Luxembourg               |                       | 39                   | 47                             |
| Sweden                   |                       | 86                   |                                |
| Japan <sup>2</sup>       |                       | 42                   | 44                             |
| Norway <sup>2</sup>      |                       | 86                   |                                |
| Czechia                  |                       | 34                   | 50                             |
| Croatia*                 |                       | 21                   | 63                             |
| Iceland                  |                       | 84                   |                                |
| Denmark                  |                       | 83                   |                                |
| United Kingdom           |                       | 82                   |                                |
| Finland                  |                       | 76                   | 5                              |
| New Zealand <sup>1</sup> | 81                    |                      |                                |
| Germany                  |                       | 14                   | 65                             |
| Slovak Republic          |                       | 27                   | 52                             |
| France <sup>1</sup>      | 78                    |                      |                                |
| Thailand*                |                       | 73                   | 5                              |
| <b>Poland</b>            |                       | <b>11</b>            | <b>66</b>                      |
| Austria <sup>1</sup>     | 77                    |                      |                                |
| Ireland                  |                       | 76                   | 1                              |
| Romania* <sup>1</sup>    | 76                    |                      |                                |
| Türkiye                  |                       | 41                   | 35                             |
| Estonia                  |                       | 22                   | 53                             |

<sup>5</sup>There

<sup>6</sup>Ibid., p. 162

|                            |    |    |    |
|----------------------------|----|----|----|
| Australia <sup>2</sup>     |    | 74 |    |
| Belgium                    |    | 38 | 36 |
| Hungary                    |    | 46 | 28 |
| Slovenia                   |    | 14 | 59 |
| Spain                      |    | 70 | 3  |
| Italy <sup>1</sup>         | 73 |    |    |
| OECD38                     | 72 |    |    |
| Colombia                   |    | 39 | 31 |
| Canada                     |    | 69 | 1  |
| Netherlands                |    | 31 | 38 |
| Costa Rica                 |    | 4  | 64 |
| Lithuania                  |    | 25 | 40 |
| Israel                     |    | 42 | 24 |
| Peru*                      |    | 36 | 27 |
| Bulgaria* <sup>1</sup>     | 63 | 0  | 0  |
| South Africa* <sup>2</sup> |    | 62 |    |
| Portugal <sup>1</sup>      | 62 |    |    |
| Greece <sup>1</sup>        | 61 |    |    |
| Latvia                     |    | 60 |    |
| Korea                      |    | 19 | 40 |
| China* <sup>2</sup>        |    | 28 | 27 |
| United States              |    | 42 | 12 |
| Indonesia*                 |    | 37 | 17 |
| Mexico <sup>2</sup>        |    | 28 | 24 |
| Chile                      |    | 41 | 11 |
| Brazil <sup>1 2</sup>      | 45 |    |    |
| India* <sup>2</sup>        |    | 38 | 2  |
| Switzerland                |    | 32 | 1  |

*Note: 1. All spending by private health insurance companies reported under compulsory health insurance. 2. 2022 date.  
\*Accession/country partner.*

*Source: OECD Health Statistics 2025*

Public funding can be defined as the sum of government transfers and all social contributions. In 2023, public sources financed on average 72% of healthcare spending in OECD. Where government financing schemes are the principal financing mechanism, as in Norway and Sweden, government transfers fund 85% or more of healthcare expenditure. In other countries such as Costa Rica, Poland and Germany, the majority of public funding refers to social insurance contributions – payable by employers and employees – which financed close to two-thirds of all healthcare spending in 2023. In some countries, a disconnect between public funding on the one hand and government and compulsory insurance spending on the other hand can be observed. While government and compulsory spending accounted for 83% of all health spending in the United States and 68% in Switzerland, the corresponding shares of public funding were only 54% and 33%. This discrepancy is due to the important role of compulsory private insurance which is not part of public expenditure in these countries.

The predominance of public funding for healthcare expenditures demonstrates that healthcare services are treated as a public responsibility in most societies, with personal responsibility for each individual's health somewhat relegated to the background. In other words, healthcare is understood, particularly in European countries, as a social achievement of societies. Table 3 presents the share of public healthcare expenditures in individual countries' total expenditures in 2013 and 2014.

**Table 3 Health expenditure from public sources as a share of total government expenditure, 2013 and 2023 (or nearest year)**

| Specification | 2013 | 2023 |
|---------------|------|------|
| United States | 20   | 23   |

|                              |           |           |
|------------------------------|-----------|-----------|
| Japan <sup>1</sup>           | 22        | 22        |
| Ireland                      | 18        | 22        |
| Australia <sup>2</sup>       | 16        | 20        |
| Sweden                       | 18        | 19        |
| Germany                      | 18        | 19        |
| United Kingdom               | 18        | 19        |
| Chile                        | 15        | 19        |
| New Zealand <sup>1</sup>     | 18        | 19        |
| Canada                       | 18        | 18        |
| Norway <sup>1 2</sup>        | 17        | 18        |
| Denmark                      | 16        | 17        |
| Austria <sup>1</sup>         | 15        | 16        |
| Czechia                      | 15        | 16        |
| Iceland                      | 14        | 16        |
| France <sup>1</sup>          | 15        | 16        |
| Netherlands                  | 15        | 16        |
| Finland                      | 14        | 15        |
| OECD38                       | 14        | 15        |
| Belgium                      | 14        | 15        |
| Spain                        | 14        | 15        |
| Slovenia <sup>1</sup>        | 11        | 15        |
| Portugal <sup>1</sup>        | 12        | 15        |
| Korea                        | 12        | 14        |
| Lithuania <sup>1</sup>       | 11        | 13        |
| Croatia* <sup>1</sup>        | 11        | 13        |
| Estonia                      | 12        | 13        |
| Bulgaria* <sup>1</sup>       | 11        | 13        |
| Slovak Republic <sup>1</sup> | 14        | 12        |
| <b>Poland</b>                | <b>11</b> | <b>12</b> |
| Colombia                     | 12        | 12        |
| Switzerland                  | 11        | 12        |
| Israel                       | 11        | 12        |
| Italy <sup>1</sup>           | 13        | 11        |
| Costa Rica                   | 18        | 11        |
| Mexico <sup>2</sup>          | 11        | 11        |
| Romania* <sup>1</sup>        | 12        | 11        |
| Luxembourg                   | 11        | 10        |

|                         |    |    |
|-------------------------|----|----|
| Greece <sup>1</sup>     | 8  | 10 |
| Türkiye <sup>1 2</sup>  | 11 | 10 |
| Latvia <sup>1</sup>     | 8  | 10 |
| Hungary                 | 10 | 10 |
| Brazil* <sup>1 2</sup>  | 6  | 7  |
| Indonesia* <sup>2</sup> | 3  | 6  |

Note: 1. Public funding is estimated by summing up spending by government schemes and social health insurance. 2. Latest data from 2020-22. \* Accession/country partner.

Source: OECD Health Statistics 2025

Governments fund a range of public services, and healthcare is competing for resources with many other sectors including education, defense, and housing. The level of public funding on health is determined by factors such as the type of health system in place, the demographic of the population, shifting budget priorities, and economic conditions. Health spending accounted for an average of 15.1% of total government expenditure across OECD countries in 2023, an increase of 1 percentage points (pp) compared to 2013. During the initial phase of the pandemic, many OECD countries were able to increase the public resources available to healthcare substantially. As a result, the share of government expenditure dedicated to health increased, peaking at 15.6% in 2021. However, 2022 saw new economic and geopolitical challenges. Russia's war on Ukraine disrupted global energy markets and fueled inflationary pressures, while many countries dealt with growing fiscal deficits. These constraints limited their ability to expand or even maintain healthcare spending, with the share of government expenditure dedicated to health declining in 2022 and 2023 on average across OECD countries 7.

In addition to the phenomena mentioned above, the increase in public spending on healthcare is due to an aging population and the specific lifestyles of the majority of the world's population. Less is being invested in prevention and more in disease control.

## Financial Models of Healthcare and Transaction Costs.

Every institution that provides medical services, regardless of whether it is in the public or private sector, generates so-called transaction costs. "R. Coase is considered to be the forerunner of the transaction cost theory. Among the first works in which the author took this issue into account is the article entitled *The Nature of the Firm* (first published in *"Economica"*, no. 4 of 1937, it was later reprinted, among others, in the work R. Coase: *The Firm, the Market and the Law* from 1988). Initially, the author used the terms costs of using the price mechanism and marketing costs 8. In his considerations, R. Coase formulated the theorem according to which the basis for determining the boundaries of an enterprise, and thus the scope of tasks performed independently, should not be technological conditions, but the amount of costs that must be incurred in connection with conducting transactions hierarchically (within an organization) or between enterprises on the market. Such costs were later referred to by O. Williamson as transaction costs and defined as: "comparative costs of planning, adaptation and supervision over the fulfillment of tasks in different management structures . " "The author 9He noted that narrowly specialized units typically benefit from economies of scale and are able to ensure lower production costs for their products compared to enterprises that perform most of the necessary tasks to produce specific goods and services independently. A drawback of collaborating with specialized service providers on the market, however, is the higher costs of planning, coordinating, and supervising operations compared to the solution of independently performing the tasks offered by such units 10.

Therefore, healthcare systems can be assessed based on transaction cost theory. On the one hand, assuming the redistribution of healthcare services from the central level represented by the public sector to specialized facilities, both public and private, one can assume that these costs will be lower if the costs of planning,

<sup>7</sup> Health at a Glance 2025, OECD Indicators, OECD (2025), OECD Publishing, Paris, <https://doi.org/10.1787/8f9e3f98-en>, p. 162.

<sup>8</sup>R. Coase, *The Firm, the Market and the Law*, The University of Chicago Press , Chicago and London 1988; Transaction Cost Theory, source: [Transaction Cost Theory – Encyclopedia of Management](#)

<sup>9</sup>O. Williamson, *Economic institutions of capitalism* , PWN Scientific Publishers, Warsaw, 1998, p. 15.

<sup>10</sup>Transaction Cost Theory, source: [Transaction Cost Theory – Encyclopedia of Management](#)

coordinating medical services, etc., do not predominate. Of course, such a center for managing healthcare services should be a single center. This model is practiced, among others, in the Scandinavian countries discussed. It is worthwhile to expand research to precisely determine all the operating costs of individual solutions, and perhaps thus prove the thesis that with a single dominant financing source, transaction costs will be lowest. It seems that the more separate financing sources there are, for example, in the form of additional mandatory health insurance, or even voluntary insurance, and private medical facilities with their own separate administration responsible for generating transaction costs, the entire healthcare system will cost more, as the individual transaction costs of the separate financing sources will increase the overall cost of the system compared to a solution with a single dominant financing source.

A separate issue that could also be included as a contribution to the development of transaction cost theory is the very process of collecting funds for public healthcare from taxpayers and then redistributing them. One of the authors of this article conducted a personal interview with the former Minister of Finance of the Polish government in 2006-2007, who stated that the costs of collecting and distributing funds in the form of taxes and fees intended for public purposes amount to/cost twice as much as the value of the funds transferred for these purposes, and sometimes even more, given poorly organized or overdeveloped administration in a given country. Therefore, from this perspective, administrative systems can also be subsumed under the category of transaction costs. Optimizing administrative management would reduce these costs. Perhaps the use of digital tools, including the use of artificial intelligence, would be useful. By optimizing transaction costs and understanding them more broadly, more funds could be allocated to the provision of medical services and preventive healthcare, reducing or even eliminating out-of-pocket financing.

## Healthcare systems in Poland

In Poland, the model in place is one in which the public sector plays a leading role. The entity providing public medical services is The National Health Fund (NFZ), which finances treatment from mandatory health contributions paid into it, i.e., with the help of the public administration. These contributions, transferred to the Social Insurance Institution (ZUS), constitute 9% of the employee's salary and are collected by ZUS. The NFZ officially provides access to public services such as family doctors, specialists with referrals from primary care physicians (outpatient specialist care – AOS), and access to public hospitals, including emergency medical services. An additional fee applies to certain services, such as dental services for adults. The NFZ also finances medical services provided by the private sector. This typically applies to specialized services, such as urology. The state budget also funds services for social groups such as students, the unemployed, and farmers. Patients have the right to personally choose a primary care physician (PHC) without the need for a regional registration. PHC also includes preventive care for children and adolescents, provided by a nurse/hygienist at school or preschool. Within the PHC, you choose:

- doctor
- a nurse
- midwife.

You make your choice by submitting a written declaration to the clinic of your choice. You can do this via the Online Patient <sup>11</sup>[Account](#).

Both your primary care physician and a specialist can refer you to a hospital. You have the right to choose any hospital in Poland, provided it has a contract with the National Health Fund. If necessary due to your health condition, a doctor who does not have a contract with the National Health Fund (i.e., one with whom you are treated privately) can also refer you to a hospital, and you do not have to pay for hospital treatment. However, you are not entitled to free tests or consultations with a specialist based on a referral from a private physician—only a doctor who has a contract with the National Health Fund or works at a facility with such a contract can refer you. You can also go to the hospital without a referral if you have suffered an accident, poisoning, injury, have gone into labor, or if your life is at risk or your health has suddenly deteriorated. The hospital does not have to admit you immediately for treatment in a hospital ward—this depends on your health condition and the availability of available hospitalization. This rule does not apply if there is a sudden life- or health-threatening situation. In such a situation, the hospital must admit you immediately to save your life and health. If this is not possible (for example, because it lacks the appropriate equipment or there is no department within its structure that deals with your health issue), it must ensure that you are transported to the appropriate hospital by

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<sup>11</sup>Get to know the healthcare system, Website of the Ministry of Health and the National Health Fund, 2022, source: [Get to know the healthcare system | Patient](#)

appropriate medical transport <sup>12</sup>.

In 2023, according to Central Statistical Office data, total spending on current healthcare in Poland was PLN 238,296.3 million, which accounted for 7% of GDP. Of this amount, PLN 194,497.1 million (5.7%) was in the public spending system. Public spending consisted of central and local government expenditure: PLN 25,290.0 million (0.7%) and social security contributions: PLN 169,207.0 million (5%). Private healthcare expenditure in 2023 amounted to PLN 43,799.2 million (1.3%), including PLN 38,578.9 million (1.1%) incurred directly by households <sup>13</sup>.

Despite spending nearly as much on public healthcare as on military equipment, public healthcare in Poland is characterized by inefficiency. This inefficiency manifests itself, among other things, in long wait times not only for specialist appointments but even for appointments with a primary care physician. In some facilities, patients wait several hours before the official opening to receive a "number" for the limited number of appointments scheduled for a given day, which completely discredits the current healthcare system. This state of affairs is attributed to a shortage of medical personnel, which has moved to the private sector, for example. Private healthcare is financed through voluntary social insurance funded by employers or households. Furthermore, many medical services are also paid for by individual households.

## The Concept of Medical Savings Accounts

Medical savings accounts represent an innovative and relatively rarely used healthcare financing mechanism, which accumulates individual savings to cover the costs of healthcare services at the time of consumption. It is undeniable that the liberal concept of medical savings accounts, which emphasizes individual responsibility and their role in shaping the demand for various healthcare services, is quite controversial and, as a result, often meets with strong criticism from researchers. On the other hand, with aging societies, many countries, especially developed ones, are showing increasing interest in programs to finance healthcare services for the public, especially the elderly, based on the concept of medical savings accounts. Examples include Hong Kong (proposal for mandatory health insurance accounts), Australia (proposal for voluntary medical savings accounts), and Canada (proposal for universal medical savings accounts financed from the state budget). In European countries, including the United Kingdom, Germany, and the Czech Republic, discussions are also underway regarding the implementation of savings accounts in the context of obtaining additional financial resources for the healthcare system and involving patients in the process of controlling healthcare costs <sup>14</sup>.

A medical savings account is assigned to a specific individual. This individual can accumulate funds in this account individually or through contributions from other individuals, such as family members or employers. In this way, the latter also refers to private health insurance financed by employers. This idea is somewhat related to the concept of co-governance or public governance, in which the public sector, and in particular the public administration, interacts with members (individuals and groups) of civil society (in the narrower sense) through appropriate participatory and consultation procedures with stakeholders. Governance is characterized by stakeholder engagement, openness and transparency, equality and non-discrimination in access to and use of public services. It also encompasses ethics in public service, accountability, and the pursuit of sustainable development. In this context, medical savings accounts can serve as an instrument for co-governance in the field of medical services, including the assumption of greater responsibility for one's health, which may result in a greater role for preventive healthcare in the structure of medical services.

Typically, such an account operates in conjunction with a specific auxiliary financing mechanism, such as private or public health insurance, designed to cover unexpectedly high healthcare expenses <sup>15</sup>. "As you can see, a medical savings account is very similar to a bank account, with the difference that its purpose is to cover

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<sup>12</sup>There.

<sup>13</sup>Central Statistical Office, Statistical analyses, Health and health care in 2023, Statistical Office in Kraków, Warsaw, Kraków, 2024.

<sup>14</sup>M. Borda, Medical savings accounts in health care financing. Concept, models, conditions, Poltex Publishing House, Warsaw 2015, pp. 8-9.

<sup>15</sup>LM Nichols, N. Prescott, KH Phua, Medical Savings Accounts for Developing Countries, in: Innovations in Health Care Financing, G. Schrieber (ed.) Proceedings of a World Bank Conference, March 10-11, 1997, pp. 233-245.; A. Dixon, Are Medical Savings Accounts a Viable Option for Funding Health Care? Croatian Medical Journal, 2002, Vol. 27, No. 4, after 1120-1131; J. [Schreyögg](#), Demographic Development and Moral Hazard: Health Insurance with Medical Savings Accounts, The Geneva Papers on Risk and Insurance, 2004, Vol. 29, no. 4, pp. 689-704; M. Borda, Medical..., op. cit., p. 31.

specific healthcare costs incurred by a given individual (or family). In other words, it is a capital-based solution that allows for the spreading of the financial consequences of disease risk over time. Furthermore, unlike a regular bank account, a savings account requires mandatory contributions, regardless of whether participation in the medical savings account program is mandatory or voluntary. This is intended to ensure the systematic accumulation of savings for future healthcare needs, rather than just making incidental payments 16." Currently, various versions of medical savings accounts operate in China, Singapore, Australia, South Africa, the USA, and, among European countries, Hungary.

Singapore is considered the most successful healthcare savings account (MSA) provider. Currently, Singapore's healthcare system is known as 3M and consists of the following programs: Medisave, MediShield, and Medifund. Medisave medical savings accounts (MSAs) were introduced in Singapore after 1984. They are an individual savings plan for healthcare expenses, funded by both the individual and their employer. They are designed to help individuals set aside a portion of their income to meet healthcare needs. The funds set aside can be used for both personal hospitalization and for approved dependents 17. "Medisave accounts are organized under the Central Provident Fund (CPF), whose primary purpose is to accumulate funds for various purposes." Both employees and their employers are required to make monthly contributions, managed by the Central Provident Fund (CPF). These contributions are distributed proportionally to three accounts: the Ordinary Account, which holds savings for investment purposes, such as purchasing a property; the Medisave Account, which holds funds for health expenses; and the Special Account, which holds reserves for future retirement 18. "The amount of contributions paid and the proportions allocated between the individual accounts depend on age. Each account earns interest and offers the opportunity to earn interest that is higher than in banks. The rates are 2.5% for the Ordinary Account and 4% each for the Special Account and Medisave Account." 19

The MediShield Life program was created to protect patients from excessive hospital bills, regardless of their age or health status. It aims to help with hospital bills and selected expensive treatments, such as chemotherapy following a cancer diagnosis. It is designed to subsidize treatment in public hospitals, with some exceptions. For the poor, the Singapore government launched the MediFund program, which provides financial security for health-related issues. It is intended for residents who are unable to pay for treatment despite receiving government subsidies and using MediSave, MediShield Life, and cash. The amount of financial assistance depends on individual financial, health, and social circumstances, as well as the amount of the medical bill 20.

Singapore has also launched the ElderShield program, which protects elderly and disabled people from excessive treatment costs for these groups of people. One such example is the Healthier SG project. "Healthier SG is a national initiative by the Ministry of Health (MOH) that focuses on preventive health, for all Singapore Citizens (SC) and Permanent Residents (PR) aged 40 and above. Under Healthier SG, you can select a family doctor, who will be your primary healthcare partner. Your doctor will work with you to develop a personalized health plan that includes lifestyle changes, health screenings, and vaccinations. This partnership ensures continuous and comprehensive care tailored to your personal health needs. Healthier SG also integrates support from regional health clusters (National Healthcare Group, National University Health System, and SingHealth) to create a health and social ecosystem within each region. To further support your health journey, you will be able to access health-promoting programs and activities from partner agencies, such as the Agency for Integrated Care, Health Promotion Board, People's Association, and Sport Singapore. Seniors can also approach the Active Aging Centers for programs recommended by their regional health clusters and family doctors." Due

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<sup>16</sup>J. Schreyögg, Demographic..., op. cit.; M. Osak, Medical savings accounts as a mechanism for financing health care, "Insurance towards the challenges of the 21st century, UE Scientific Papers Wrocław, 2011, no. 228, pp. 344-351; M. Borda, Medical..., op. cit., p. 31.

<sup>17</sup>MOH Singapore (2024), Ministry of Health Singapore. Data from the website: <https://www.moh.gov.sg/>. Accessed on April 14, 2024; N. Owczarek, The Singapore health care system – how does it work and is it possible to apply it in Poland, SKN Paradygmat, 2024, source: The Singapore health care system – how does it work and is it possible to apply it in Poland?

<sup>18</sup>J. Cybińska, The role of medical savings accounts in financing health care – Singaporean and American experiences, *Wiadomości Ubezpieczeniowe*, 2, 2014, pp. 145-146.

<sup>19</sup>Singapore's healthcare system – how does it work and is it possible to apply it in Poland, SKN Paradygmat, 2024, source: [Singapore's healthcare system – how does it work and is it possible to apply it in Poland?](#)

<sup>20</sup>MOH Singapore (2024), Ministry of Health Singapore. Data from the website: <https://www.moh.gov.sg/>. Accessed on April 14, 2024; N. Owczarek, The Singapore health care system – how does it work and is it possible to apply it in Poland, SKN Paradygmat, 2024, source: The Singapore health care system – how does it work and is it possible to apply it in Poland?

to Singapore's relative affluence, the government can afford to subsidize medical services <sup>21</sup>, especially for those with chronic illnesses and those requiring long-term rehabilitation. Vaccinations and dental services may also be subsidized.

By introducing medical savings accounts as the dominant form of patient care, the aforementioned transaction costs of healthcare can be optimized. These accounts would replace mandatory or voluntary social insurance and public health programs. Savings generated this way could provide additional financial security for financing the treatment of more serious and chronic conditions.

In Poland, attempts have also been made to popularize the idea of medical savings accounts under the name of individual savings accounts. Zygmunt Hortmanowicz co-invented the idea of individual accounts in 1992.

<sup>22</sup>The co-initiators, along with Z. Hortmanowicz, were Jarosław Góra, Bogusław Dembiński, Waldemar Flisiński, Anna Bielawka-Hortmanowicz, Sebastian Kamiński, Sławomir Krystosiak, Włodzimierz Kucharski, Krzysztof Słoiński, Krzysztof Teodorowicz, and consultant Janusz Kołodziejczyk. These individuals proposed the draft law on healthcare financing on December 17, 1992.

The preamble to this project mentions that the reform of healthcare financing should be based on 4 pillars:<sup>23</sup>

- freelance medical profession,
- free choice of doctor,
- free market for medical services,
- free disposal of payment means by every citizen who has an account in the so-called Health Protection Bank (BOZ).

The aforementioned Health Protection Bank would be the oversight center for Polish medical savings accounts and would be established in place of the National Health Protection Fund, taking over its assets and organizational structure. This bank would hold funds in the family (individual) bank accounts of working individuals, retirees, and pensioners, and would be used solely for healthcare purposes. Transfers for medical services would be made from this account. It would also be possible to grant grants and loans to individuals with serious and chronic illnesses and for life-saving purposes. These loans would be forgivable at 50-80%. The bank would also co-finance the activities of research institutes and medical education institutions from its own resources <sup>24</sup>.

Such family accounts in BOZ would consist of amounts from various sources, including:

- 7% of health insurance premium,
- 5% from Treasury bonds, stock exchange operations, income from deposits, etc.,
- 5-10% from insurance companies (reimbursement of road accident costs), from KRUS (10% of agricultural contributions),
- 10% of funds accumulated in the National and Provincial Environmental Protection Funds,
- 10% of funds obtained from the privatization of State Medical Care Facilities,
- 10% of the income from establishments with harmful workplaces,
- 20% of awarded funds for medical malpractice,
- 3% of drug sales to finance independent research on their effectiveness,
- 1% on the sale of alcoholic and spirits products (except for spirits for medical purposes), tobacco products, non-organic fuels, chemical plant protection products and chemical detergents, as well as cosmetics, food produced using non-organic methods (containing synthetic ingredients that have a harmful effect on health),
- from the part of the state budget allocated to health care (1% of GDP),
- from possible subsidies from the EU,

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<sup>21</sup>Healthy living, source: [Healthy living | Ministry of Health](#)

<sup>22</sup> More on this topic: Z. Grzymała, Towards health. Assessment of the health care system in Poland, in: Paradigms in economic sciences, challenges of the 21st century, edited by R. Bartkowiak, SGH Publishing House, Warsaw 2017, pp. 183-196

<sup>23</sup>There

<sup>24</sup>There

- funds allocated for revaluation due to inflation,
- voluntary contributions from citizens <sup>25</sup>.

The account holder or a family member authorized by them would be the administrator of the funds. The funds accumulated in these individual family accounts would, upon the owner's death, be transferred to the account of the heirs or the person designated in the deceased's will. The funds accumulated in these accounts would provide, among other things:

- free choice of place of using medical services (in doctor's, dentist's, nursing, obstetrics, physiotherapy, therapeutic massage offices),
- clinics, including specialist clinics,
- laboratories and diagnostic facilities,
- sanatoriums and preventive care facilities,
- purchase of medicines, dressings, ophthalmological, orthopedic, dental equipment and hearing aids,
- covering the costs of servicing the BOZ account up to 0.03%,
- mutual assistance up to 15-20% for people who have exhausted these funds from their account and have health needs.

For those under supervision—for example, the unemployed, the homeless, and others dependent on social welfare—the costs of medical services would be covered by the Local Social Welfare Facility. The essence of Z. Hortmanowicz and his team's idea also referred to promoting a healthy lifestyle, promoting not only physical activity but also proper nutrition, animal husbandry, and plant cultivation. Preventive care financed from these Polish medical savings accounts would, among other things, reduce the incidence of chronic diseases and other conditions requiring high treatment costs.

## **Clinical and ethical implications of Hortmanowicz's model in the light of contemporary medical practice**

Analyzing Hortmanowicz's model from the perspective of contemporary clinical medicine, it is important to note the significant discrepancy between the assumptions of the savings model and the actual costs of procedures based on *evidence-based medicine* (EBM). Formulated in 1992, the concept addressed a reality in which the most cost-intensive procedures were complex surgical procedures. A transformation occurred at the turn of the 20th and 21st centuries with the dynamic development of molecular biology, which introduced monoclonal antibodies and targeted therapies into therapeutic standards. Remedial medicine, previously based primarily on low-cost pharmacotherapy and surgical interventions, evolved toward personalized medicine, permanently changing the structure of public payer spending. Current treatment methods, utilizing advanced drug technologies and genetic engineering, generate costs in the hundreds of thousands, and in extreme cases, millions, of zlotys per patient. This makes the financing model based on a 7% contribution from remuneration, collected in the planned Health Protection Bank (BOZ), economically inefficient and raises a justified question about its historical nature, which is inadequate to contemporary pharmacoeconomics.

Oncology is a prime example, where immunotherapy using drugs such as pembrolizumab or nivolumab has become the standard treatment for many cancers, such as melanoma, non-small cell lung cancer (NSCLC), renal cell carcinoma (RCC), and Hodgkin's lymphoma. The cost of a single dose ranges from PLN 10,000 to PLN 20,000, and the therapeutic process lasts many months or years, generating annual costs per patient ranging from PLN 200,000 to PLN 400,000. Considering that approximately 170,000 new cancer cases are diagnosed in Poland each year and tens of thousands of patients require systemic treatment, the scale of the budgetary burden is significant. A special case is targeted therapies and chimeric antigen receptor T-cell (CAR-T) technology in hemato-oncology, used in conditions such as refractory diffuse large B-cell lymphoma (DLBCL) and acute lymphoblastic leukemia (ALL), where the one-time cost of administering genetically modified lymphocytes ranges from PLN 1.5 to 2 million. Although approximately 100–200 patients per year currently qualify for this procedure in Poland, the number of indications is growing rapidly. The average citizen, accumulating 7% of the average salary (approximately PLN 500 per month) in their BOZ account, would have to save up for this single procedure for over 300 years.

A similar cost disparity occurs in the areas of intensive care and emergency medicine. A patient's daily hospitalization in the Intensive Care Unit (ICU) generates costs of PLN 3,000–10,000, particularly in cases

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<sup>25</sup>There

requiring renal replacement procedures or mechanical ventilation. Statistical data indicate that over 100,000 patients are treated annually in Polish ICUs, with the average hospitalization duration ranging from 9 to 12 days, extending to several weeks in severe conditions. In cases of extreme respiratory failure requiring extracorporeal *membrane oxygenation* (ECMO), daily costs increase to tens of thousands of zlotys, meaning a month-long stay in the ICU costs PLN 150,000–300,000. Equally expensive is the treatment of a patient with polytrauma, where a traffic accident victim requires neurosurgical and orthopedic interventions, as well as long-term rehabilitation. Costs in the first year of treatment often exceed PLN 200,000–500,000. This problem affects a population of several thousand of the most severely injured patients each year. Rare diseases and gene therapies should also be considered, such as the treatment of spinal muscular atrophy ( *SMA* ) with Zolgensma, which costs approximately PLN 9–10 million. This affects a population of approximately 50 newborns per year nationwide. Although these procedures are rare, they are statistically predictable on a population scale.

Although highly specialized procedures constitute a smaller percentage of all services (estimated at 5–10% of the volume), they consume a disproportionately large portion of the budget, reaching 40–50% of hospital expenditures. It should be emphasized that in the current system, inpatient care consumes over 50% of the total healthcare budget, while outpatient care—understood as Primary Health Care (PHC) and Outpatient Specialized Care (AOS)—represents a significantly smaller portion of expenditures, indicating the main sources of costs. This leads to the conclusion that the individual account model remains effective in treating minor illnesses, but loses financial liquidity when confronted with the costs of modern, life-saving medicine.

The implementation of market mechanisms also carries the risk of altering patient decisions, leading to the phenomenon of "symptomatic savings." The mechanism of inheriting funds from the BOZ account creates a significant economic incentive to avoid contact with the healthcare system. Literature in health economics and sociology, analyzing systems such as Medisave in Singapore or high-deductible plans in the US, confirms that patients—particularly seniors—consciously forgo necessary diagnostic procedures, driven by the so-called bequest motive . The transfer of capital to descendants becomes a priority, not their own health well-being, a universal phenomenon consistent with evolutionary psychology. The introduction of savings accounts institutionalizes the dilemma of resource allocation, figuratively conceptualized as a choice between treatment and financial support for family. In clinical practice, this results in significant delays in referrals, leading to patients arriving at treatment facilities in advanced stages—with ulcerated cancerous lesions, advanced heart failure, or surgical complications. Treating such complications is many times more expensive and less effective than early intervention, which reduces the system's efficiency. It is estimated that stage IV cancer treatment is five to ten times more expensive than stage I cancer, with a significantly poorer prognosis. Similarly, in cardiology, the cost of treating advanced heart failure with left ventricular assist device ( *LVAD* ) implantation is many times higher than the cost of early pharmacotherapy for hypertension.

Another significant problem is the apparent freedom of choice in emergency medicine and emergency care. It is estimated that in Poland, approximately 60–70% of all hospitalizations in surgical and medical wards are emergency, via hospital emergency departments (ERs) or admission rooms. In such circumstances, the patient does not act as an informed customer making a market choice, but rather as a patient in an emergency, often with limited judgment due to pain, anxiety, or impaired consciousness. In the case of a stroke, a patient with aphasia is referred to the nearest stroke unit, where the cost of treatment (thrombolysis, thrombectomy, rehabilitation) is PLN 30,000–80,000. In acute coronary syndromes, the time it takes to reach the catheterization laboratory is crucial, and the cost of angioplasty and care ranges from PLN 15,000–40,000 (in the case of cardiogenic shock, it is many times higher). Treating sepsis and septic shock in the ICU generates an average cost of PLN 40,000–150,000, while rescuing a patient in a Trauma Center in the first few days can exceed PLN 100,000. In Hortmanowicz's model, patients would be charged significant costs for services provided by facilities they did not choose, which undermines the fundamental premise of the free market in medical services.

The discussed model also generates ethical dilemmas and leads to a redefinition of the doctor-patient relationship. From the perspective of role conflict psychology (agency theory), the introduction of a market relationship activates defense mechanisms typical of commercial transactions in the patient. Due to information asymmetry, the patient may perceive medical recommendations as attempts to induce demand ( *supplier-induced demand* ), leading to a loss of trust and a focus on verifying the doctor's economic intentions rather than on the therapeutic process. This results in the phenomenon of defensive medicine and non-compliance with medical recommendations . Furthermore, Hortmanowicz's model is based on the assumption of idealism of entities in market conditions, which contradicts behavioral psychology, which argues that incentive systems shape behavior. If the financial system rewards the performance or omission of procedures, it is difficult to expect full independence of clinical decisions from economic factors. This leads to the erosion of the therapeutic alliance, based on trust that the doctor acts solely in the patient's best interests ( *salus aegroti suprema lex* ). Moreover, this system is in direct conflict with the Code of Medical Ethics (KEL). Article 2, paragraph 2 of the

KEL stipulates that medical assistance cannot be contingent on the patient's financial situation, and Article 30 imposes an obligation to provide assistance in life- or health-threatening situations. A system that conditions treatment based on account balance or creditworthiness presents physicians with a dilemma: provide care "on credit," risking the facility's insolvency, or refuse assistance, violating the foundations of professional ethics.

The assumption of health determinism and the patient's full responsibility for their health should also be critically examined. The suggestion that diseases are primarily lifestyle-related is a misconception from a medical perspective, especially when it comes to the most cost-intensive conditions, which are the result of biological conditions. There is a clear disproportion between lifestyle-dependent and non-lifestyle-dependent diseases. Dependent conditions (e.g., uncomplicated hypertension, obesity) are relatively inexpensive to treat on an outpatient basis (PLN 50–200 per month), and the BOZ model could be effective here. However, diseases with biological and genetic etiologies generate costs that exceed individual financing options. Type 1 diabetes requires expenditures of several thousand zlotys annually; the annual cost of cystic fibrosis treatment with CFTR protein modulators is approximately PLN 1 million; oncological treatment for a child with leukemia costs PLN 200–500,000, and mental illnesses require lifelong therapy. This system appears to be unfair because it financially favors people with favorable genetic conditions and burdens those with negative conditions, leading to their insolvency for reasons beyond their control.

Ultimately, Hortmanowicz's model encounters a barrier in the form of demographic challenges, specifically the phenomenon of multimorbidity and population aging. In 1995, average life expectancy was approximately 67 years for men and 76 years for women, while in 2015 it increased to 73 and 81 years, respectively. This medical success, however, is associated with extended survival from chronic disease. Currently, there is a significant increase in multimorbidity, which affects 60–75% of people over 65. The typical profile of today's patient is an elderly person with type 2 diabetes, hypertension, hyperlipidemia, and osteoarthritis, generating fixed costs resulting from polypharmacy and frequent hospitalizations (costs three to four times higher than in the general population). These patients lack the ability to accumulate capital – pension benefits are lower than wages, which translates into lower revenues for the Health Insurance Fund (BOZ) while simultaneously increasing healthcare expenditures. This leads to a rapid depletion of resources and permanent dependence on social assistance or credit instruments, which means that this model, although theoretically effective for a young and healthy population, loses its *raison d'être* when faced with geriatric reality.

## Summary

Despite numerous attempts to reform it, Polish healthcare and its financing continue to generate dissatisfaction among patients. "Overall, Poles have a poor opinion of public healthcare. The average rating of this system on a scale of 1 to 10, where 1 means "very bad" and 10 "very good," was only 4.3. Over a third of respondents (36%) rated healthcare 3 or lower, and only 15% gave a rating of 7 or higher. This low rating could stem from a perception that the system is not fulfilling its role. Every second respondent (53%) states that due to problems with accessing public healthcare, they often or always have to use private services. The public healthcare system faces difficulties accessing medical services, cited by exactly half of the respondents. Other problems include a lack of specialists (28%) and poor management (21%). The chart below presents spontaneous responses from Poles, grouped into key problem categories. Long waits are a major problem in healthcare in Poland. This forces patients to use private services and contributes to the perception that the system is poorly managed. Public healthcare is also struggling with staffing shortages. Public proposals, such as a central appointment registration system or notifications of upcoming appointments, may not be enough to improve the low ratings of Polish healthcare."<sup>26</sup>

Data indicates increasing healthcare spending in Poland, which still fails to address emerging healthcare challenges. Doctors often refer patients to private facilities that provide specialized health tests. The general trend is to shift the financial burden of healthcare onto the shoulders of patients themselves. The Polish healthcare system, similar to other countries, experiences high levels of so-called medical transaction costs, which could likely be reduced with optimization. Optimization could involve establishing a single entity that, using modern digital tools, including artificial intelligence, would better coordinate the flow of information, for example, about hospital vacancies, access to specialists, preventive healthcare, and so on. This single entity could also manage improved Polish medical savings accounts, which could incorporate many solutions similar

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<sup>26</sup>T. Ogłaza, Challenges for the healthcare system in Poland, Ipsos, 2025, source: [Challenges for the healthcare system in Poland | Ipsos](#), access: 18/02/2026.

to the Singapore model. The debate on creating medical savings accounts in Poland to optimize the current, inefficient healthcare system should be reopened.

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