Institute For Social Policy Development

Focus: Neurology

European Brain Health

Public Health

Civil-Military Cooperation

1/2026

HealthCare Industry Journal

The future of healthcare is shaped by people knowledge and the courage to innovate

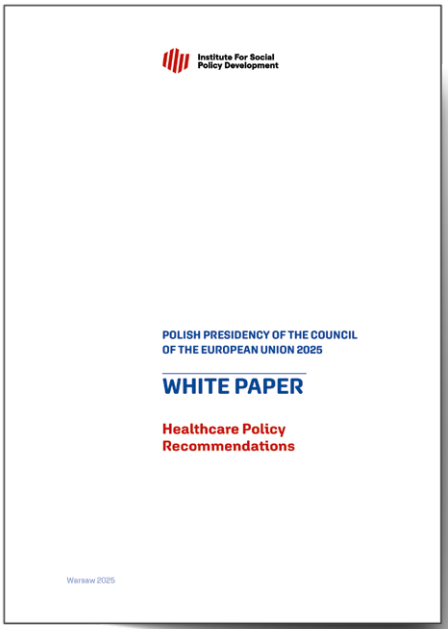
Institute For Social Policy Development

The Institute for Social Policy Development is a civic think tank. It was established to analyse socio-economic phenomena from the perspective of health and healthcare, which affect all aspects of life and economic activity.

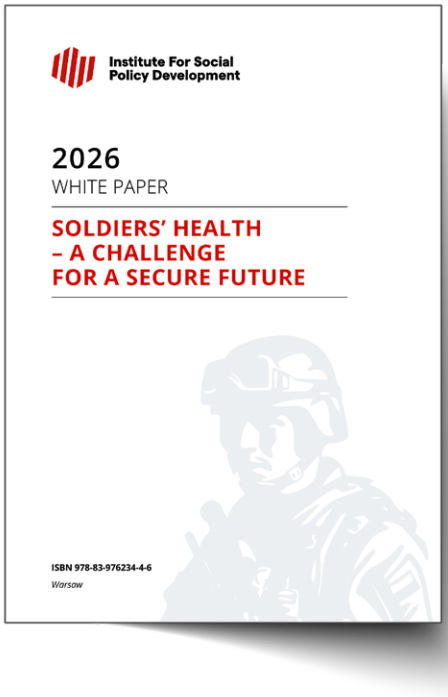
Drawing on the extensive experience of our collaborating experts, we promote public debate and provide a modern platform for discussions on public health, social policy, healthcare policy, policy on ageing, innovation, research, development, and demography. The Institute has published nearly 40 reports and organised over 60 debates across various therapeutic areas.

White Paper: Presidency of the Council of the European Union 2025. Healthcare Policy Recommendations

The publication presents recommendations from over 100 healthcare experts, developed in the context of Poland's presidency of the Council of the European Union. The document is the outcome of extensive collaboration among representatives of public administration, the clinical community, the healthcare sector, and civil society organisations.
The White Paper provides a comprehensive approach to systemic challenges and sets out directions for action at both national and European levels.



Contributors to the White Paper include, among others: Prof. Piotr Czauderna, MD, PhD; Prof. Wojciech Hanke, MD, PhD; Prof. Teresa Jackowska, MD, PhD; Prof. Bartosz Karaszewski, MD, PhD; Katarzyna Kacperczyk; Janusz Meder, MD, PhD; Marek Migdał, MD, PhD; Sibilia Quilici; and Prof. Bolesław Samoliński, MD, PhD.



Soldiers' Health – A Challenge for a Secure Future (2026 White Paper)

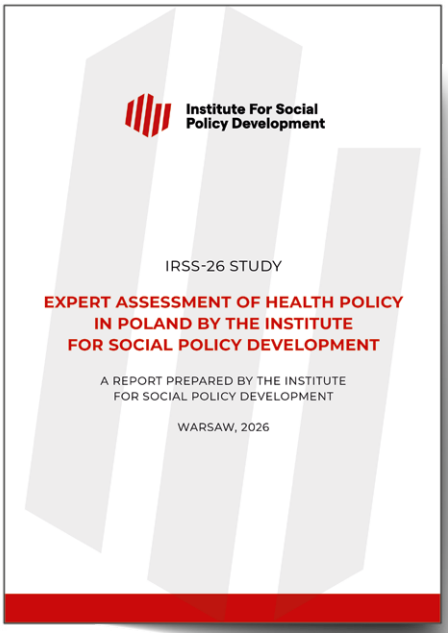
The publication examines soldiers' health as a key pillar of national security. The modern approach extends beyond battlefield medicine to include preventive healthcare, psychological support, and society's ability to function during crises.

The White Paper analyses the current situation and presents conclusions and recommendations relevant to maintaining defence capabilities and state resilience, particularly in the context of current geopolitical conditions.

The authors include, among others: Séamus Boland; Lt. Gen. Prof. Grzegorz Gielerak, MD, PhD; Adam Jarubas, PhD; Col. Tadeusz Nierebiński, MD, MSc; Łukasz Pietrzak; Col. Marek Posobkiewicz, MD; Col. Prof. Andrzej Soboń, PhD; Col. Sławomir Walenczykowski; and Jarosław Waligóra, MD, PhD.

IRSS-26 Study: Expert Assessment of Health Policy in Poland by the Institute for Social Policy Development (March 2026)

This report presents the findings of a survey conducted among healthcare system stakeholders regarding health priorities at the European Union and Poland levels, as well as IRSS's strategic directions. Respondents included experts from the clinical community, public administration, patient organisations, and the health industry and market sector. The findings offer a concise, interdisciplinary assessment of key challenges and a structured map of priorities for further strategic action.



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A Word from the Editor-in-Chief

HealthCare Industry Journal was founded on one simple belief: Polish medicine has much to be proud of, and the voices of our experts, doctors, researchers, innovators and healthcare managers deserve to resonate far beyond a narrow circle of specialists.

Too often, Poland's greatest medical achievements, compelling research projects and bold ideas for developing the healthcare system are lost in the daily flood of information or overshadowed by international publications. I want to change that. I want to create a platform where Polish medical, clinical, scientific and business thinking can speak in its own voice, with pride and confidence.

I write this with 20 years of experience as an editor-in-chief, including at the business monthly *Home&Market* and the English-language monthly *Polish Market*, which presented Poland to international readers primarily from a business perspective, but also through its culture and the arts. I have also worked for publications including the daily newspapers *Rzeczpospolita, Puls Biznesu* and *Parkiet*, as well as the weekly *Wprost*.

This breadth of experience has taught me how to build a publication from the ground up: how to define its direction, establish the right tone, choose contributors and maintain high editorial standards, regardless of the sector it covers. For more than twenty years, I have also shared this experience as a university lecturer, teaching marketing, management and media communication, including at the Faculty of Management and the Faculty of Polish Studies at the University of Warsaw, the Faculty of Law at Kozminski University,

the University of Information Technology and Management in Rzeszów and the Warsaw Management University. Working with students requires much the same discipline as running an editorial team: the ability to explain complex issues clearly and to adhere consistently to the chosen direction.

My connection with healthcare goes beyond professional curiosity. I am the author of rakoboj.com, a website created for the families of cancer patients seeking reliable information and support during a difficult period of illness.

This editorial and teaching background, together with my personal commitment to healthcare, gives me confidence that I can lead *HealthCare Industry Journal* with the same rigour that has defined my work across other sectors for years.

The Institute for Social Policy Development launched this magazine not to comment on healthcare from the sidelines, but to highlight the people who are actively shaping Polish medicine: experts, doctors, scientists, innovators and managers who push its boundaries every day. We want to show how much is happening in the sector, what solutions are being developed and who the people are who are ready to take responsibility for them. And we want to make sure their work is heard.

In the first issue, we are starting with conversations and interviews, and there will certainly be no shortage of these, but they are only the starting point. We will gradually broaden the magazine's scope to include, among other things, columns, analyses and reports, allowing us to present the sector from an increasingly wide perspective.

I do not promise that we will be the fastest. I would rather we were consistent. Each new issue, each new article will be a step forward – sometimes a small one, sometimes a bigger one, but always taken with determination and in the right direction. The progress we care about is not measured by speed alone. It is measured by perseverance too.

So let me say this now: this is only the beginning. We want more: more topics, more experts and more courage to ask questions about the future of healthcare in Poland. We will keep working, growing and raising the bar, because for us ambition is what drives progress, not an end in itself. ■

I hope you enjoy reading it.
Rita Schultz
Editor-in-Chief

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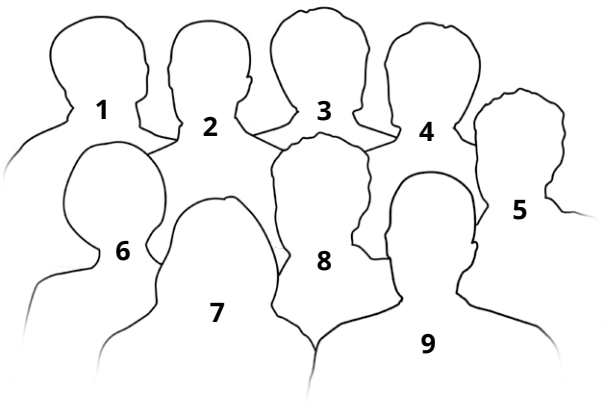

On the cover:
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3. Bolesław Samoliński **4.** Bartosz Karaszewski
5. Konrad Rejdak **6.** Alina Kułakowska
7. Halina Sienkiewicz-Jarosz **8.** Adam Jarubas
9. Piotr Czauderna

Our magazine is published in print and is also available to download from our website at **www.irss.org.pl.**
Visit our website for information about forthcoming issues.

A Word from the Publisher

Dear Readers, I am delighted to present the first issue of *HealthCare Industry Journal*.

We created this magazine because we believe there is a need for more space to discuss the most important challenges facing healthcare in Poland and across Europe. The immediate impetus for its creation came from the work carried out to date by the Institute for Social Policy Development and from our meetings with experts. In June, I opened the debate launching the series Neurology in Poland in the Context of the European Brain Health Plan. It was this meeting – bringing together leading clinicians, healthcare system experts and representatives of European institutions – that made me realise just how many issues in healthcare deserve a broader debate at national, European and international level. It became the starting point for the first issue of our magazine.

I have been a member of the European Economic and Social Committee for many years, and I am currently serving on the Consultative Commission on Industrial Change. My long-standing work at the EESC has given me a European perspective on health issues and shown me how closely they are linked to the social, economic and demographic changes that are increasingly shaping healthcare systems across Europe and beyond.

During the June debate, I emphasised that the decision to organise it was no coincidence. The COVID-19 pandemic permanently changed the way European institutions approach public health, as reflected in a series of strategic initiatives at the EU level. Today, we are also increasingly aware of the need for a systemic approach to brain health and neurological disorders, to name but a few.

The European perspective on these developments was presented during the debate by Adam Jarubas, PhD, Chair of the European Parliament's Committee on Public Health, who also features in the first issue of *HealthCare Industry Journal*.

What I found most significant about the meeting was the convergence of three perspectives, a rarity in public health practice. The first was the European health policy perspective, represented by the European Parliament and the European Economic and Social Committee. The second was the clinical perspective: the voice of the neurology community in Poland and across Europe. The third was the healthcare system perspective, represented by national public institutions and the expert community.

When these three perspectives come together around one table, we can identify challenges more accurately and work together on concrete recommendations that can be put into practice. My belief in the value of such policy-shaping roundtable debates, and in the importance of documenting their conclusions, developing them further and comparing them with the experience of other countries, was one of the main inspirations behind *HealthCare Industry Journal*.

As the magazine's publisher, I am convinced that dialogue between clinicians, experts, institutions and policy-makers is essential if we are to achieve real improvements in the quality of care and patients' quality of life, regardless of the area of healthcare concerned.

Despite advances in medicine and modern technologies, population ageing and the growing complexity of care systems mean that health challenges will become an increasingly serious test for Europe in the years ahead. That is why we need a conversation that goes beyond the boundaries of individual specialities, institutions and countries.

In this first issue, we refer to neurology – one of the areas requiring particular attention today – to place this discussion in a broader context. In doing so, we demonstrate the European perspective, the views of clinicians and experts, and conclusions drawn from work on national and European approaches to brain health. At the same time, we address other important issues, including public health and paediatrics. *HealthCare Industry Journal* is intended to be a forum for discussing healthcare in all its complexity. I invite you to read our first issue and to follow with us the changes, debates and initiatives that will shape the future of healthcare in Poland and across Europe.

Małgorzata Bogusz
Founder of the Institute for Social Policy Development
Member of the Consultative Commission on Industrial Change
of the European Economic and Social Committee 2026-2030

Dear Readers,

It is my great pleasure to present the inaugural issue of *HealthCare Industry Journal,* a quarterly devoted to the key challenges facing modern healthcare and the directions in which it is evolving.

We are living through a period of unprecedented change. Rapid advances in medical science, new technologies and artificial intelligence are creating entirely new opportunities for healthcare systems, while also presenting major challenges in terms of access to care, health security and the effective implementation of innovation. Now more than ever, we need informed dialogue grounded in knowledge, experience and responsibility.

The mission of *HealthCare Industry Journal* is to provide a platform for the exchange of views among representatives of the medical and scientific communities, business, public administration and decision-makers responsible for shaping the healthcare system. We aim to showcase solutions that support the development of modern, effective and patient-centred healthcare, while promoting best practices and innovations that make a tangible difference to the quality of treatment and to the functioning of the system as a whole.

Since its inception, the Institute for Social Policy Development has consistently supported collaboration among experts representing different parts of the healthcare ecosystem. I believe that only partnership and interdisciplinary cooperation can lead to sustainable solutions that respond both to patients' needs and to the challenges of the future.

I would like to extend my sincere thanks to all the authors, experts and partners who contributed to this inaugural issue. I hope that *HealthCare Industry Journal* will become an inspiring forum for the exchange of knowledge and experience, as well as a respected voice in the debate on the future of healthcare. ■

Beata Jasińska, MD, PhD
President of the Board
Institute for Social Policy Development

Institute For Social Policy Development

The Institute for Social Policy Development Foundation

A CIVIC THINK TANK EXPLORING SOCIO-ECONOMIC PHENOMENA FROM A HEALTH AND HEALTHCARE PERSPECTIVE. THE INSTITUTE ORGANISES CONFERENCES AND DEBATES AND PREPARES RESEARCH REPORTS ON EU HEALTH POLICY.

Its flagship project is the Healthcare Policy Summit series, launched in 2022, which brings together experts, representatives of public institutions, parliamentarians and patient organisations to discuss different areas of healthcare, including rare diseases, neurology, infectious diseases, psychiatry, cardiology and lifestyle diseases. Each meeting produces system-level recommendations compiled in a post-conference report.

The Foundation's activities extend well beyond health policy at national level. As an active participant in public debate at European level, IRSS is registered in the EU Transparency Register. The Register is a key European Union tool for ensuring transparency in EU-level decision-making. It is a database of organisations seeking to influence EU legislative processes and policy implementation, and registration demonstrates a commitment to specific ethical and transparency standards in dealings with EU institutions. IRSS's presence in the Register confirms its commitment to shaping policy at European level and its active engagement in dialogue with EU institutions.

IRSS has also joined the Critical Medicines Alliance, an international initiative established in January 2024 by the European Commission's Health Emergency Preparedness and Response Authority (HERA) in cooperation with the Belgian Presidency of the Council of the EU. The Alliance brings together patient organisations, experts and healthcare stakeholders to strengthen pharmaceutical security in Europe by diversifying medicine supply chains and increasing Europe's manufacturing independence for critical medicines. Membership of the Alliance demonstrates IRSS's active engagement in addressing strategic challenges related to pharmaceutical security at European level, extending its work beyond the national context of health policy.

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Demography is Unforgiving

MOUNTING HOSPITAL DEBT, EVER-LENGTHENING WAITING LISTS AND THE RISING COST OF NEW THERAPIES SHOW THAT THE CURRENT HEALTHCARE MODEL HAS RUN ITS COURSE.

Prof. Piotr Czauderna, adviser to the President of Poland and Chair of the Medical Fund Council, talks to Rita Schultz about the need for a fundamental overhaul of the system, access to innovative therapies, Poland's potential in clinical trials and the need to build pharmaceutical sovereignty.

From your perspective as the President's healthcare adviser, how would you assess the state of Polish medicine today and the mood within the medical profession – its prestige, working conditions and sense of agency?

Unfortunately, things have deteriorated very significantly in recent months, particularly in terms of public perceptions of doctors, following the scandal at Warsaw Southern Hospital and a series of media reports about doctors' earnings. This is unfair to a large part of the profession, which is hardly made up entirely of fraudsters or people driven by greed; many doctors are deeply committed to their work. That said, doctors, like many other tightly knit professional communities, are not particularly keen on weeding out their own black sheep. The National Health Fund is in dire financial straits, as are many hospitals, whose debt has reached the astronomical figure of PLN 40 billion. This is beginning to pose a direct threat to patients. I expect waiting lists for hospital and specialist care to grow even longer next year. One could therefore say that the entire healthcare system is on the verge of a heart attack, if not worse. The model on which it was built has simply run its course, because it was designed for a different time and different realities. It therefore needs a fundamental, albeit evolutionary, overhaul based on entirely new paradigms. The system also needs more funding. But all of this will take a decade, so some form of immediate intervention is needed as well.

What is currently the biggest obstacle to introducing innovative medicines and medical technologies into clinical practice?

Funding, certainly. It limits the capacity of the Polish healthcare system to absorb new technologies. The cost of new medicines is simply enormous, and no healthcare system in the world can afford to fund all of them, although much has improved in this area in recent years. Existing mechanisms have been strengthened and new ones introduced, including the presidential Medical Fund and Emergency Access to Drug Technologies (RDTL). The reimbursement process for new medicines has also become faster. Just look at the progress made in treating spinal muscular atrophy (SMA), or the rapid expansion of robotic surgery. Unfortunately, these developments are often very chaotic and lack any long-term plan, as has been the case with robotic surgery.

Prof. Piotr Czauderna, MD, PhD, FACS, FEBPS,

Adviser to the President of Poland, Chair of the Medical Fund Council, Head of the Department and Clinic of Surgery and Urology for Children and Adolescents, Medical University of Gdańsk.

How can we strike a balance between the rising cost of innovative therapies and the need to give patients timely access to treatment?
That is exactly what I was referring to: this tension is clearly growing and is becoming an inherent feature of modern healthcare. We need new funding mechanisms that allow innovative therapies to be tested through early conditional access and evaluated in real-world settings. Unfortunately, not every newly developed medicine stands the test of time.

Does Poland have the genuine potential to become a regional hub for clinical trials in Central and Eastern Europe, and what stands in its way?
Poland is almost there already, but there is certainly scope to develop this potential further. A great deal of progress has been made thanks to the creation of a network of Clinical Trials Support Centres (CTSCs) and the support provided in this area by the Medical Research Agency. Poland currently ranks sixth in Europe in terms of its share of the commercial clinical trials market. We reached that position between 2020 and 2022, but unfortunately, growth has since stalled. To put this in a global context, Poland currently ranks ninth among the world's largest commercial clinical trials markets, and nearly 27,000 patients took part in trials conducted in Poland in 2024. There is therefore still more to be done, especially as a growing number of commercial trials translates into better patient access to new therapies.

The National Health Fund is in dire financial straits, as are many hospitals, whose debt has reached the astronomical figure of **PLN 40 billion.**

What should we do to attract more investment from global pharmaceutical and biotechnology companies, rather than simply serving as a market for their products?
This certainly requires government support programmes, high-level negotiations and attractive conditions for potential investors. At the same time, we need to support the Polish pharmaceutical industry to strengthen the country's pharmaceutical independence.

What role can Poland play in Europe's efforts to achieve pharmaceutical sovereignty and reduce dependence on supplies from Asia in medicine production?
I see an important role for Poland here. For example, it would be desirable to build a plant producing active pharmaceutical ingredients, but that would be a major investment. Without institutional support from public authorities, it simply will not happen. Unfortunately, public–private partnership models, which would probably be the most effective approach in this case, are still used far too rarely in Poland. I would say we should also revisit the programme to build a Polish plasma processing plant, although the history of efforts in this area is hardly encouraging. However, the issue needs to be viewed much more broadly, in the context of safeguarding the country's health security. Urgent action is needed, yet only those in government have the mechanisms required to make it happen. The issue is being discussed increasingly often, but we are still a long way from coordinated action on a large scale.

Poland currently ranks sixth in Europe in terms of its share of the commercial clinical trials market.

What reforms are most urgently needed to prepare Europe's healthcare systems for population ageing and the growing burden of chronic disease?

In short, healthcare systems need to be redesigned to integrate healthcare and social care, with more services shifted to outpatient settings.

What one piece of advice would you give today to policy-makers, doctors and representatives of the life sciences sector who are collectively shaping the future of healthcare?

Be proactive and do not wait for life and its challenges to catch us unprepared, as is happening in Poland today. Demography is unforgiving. If I were a senior policy-maker, I would look in the mirror every day and tell myself "Demography, stupid!" Doctors, meanwhile, should not forget that medicine is not only a well-paid, highly skilled profession but also a vocation. That sense of vocation, and the more human side of medicine, are sorely lacking today. After all, medicine is such a wonderful profession... ■

The State of the Military Health Service in Poland. How Can an Effective System of Civil-Military Cooperation in Healthcare Be Built?

SOLDIERS' HEALTH IS NOT JUST A DEPARTMENTAL CONCERN BUT A CRITICAL ELEMENT OF NATIONAL DEFENCE THAT REQUIRES A SINGLE, INTEROPERABLE HEALTHCARE SYSTEM IN TIMES OF CRISIS. **LIEUTENANT GENERAL PROFESSOR GRZEGORZ GIELERAK,** DIRECTOR OF THE MILITARY MEDICAL INSTITUTE – NATIONAL RESEARCH INSTITUTE, DISCUSSES THE CHALLENGES FACED BY MILITARY HEALTHCARE, LESSONS FROM MODERN BATTLEFIELDS, AND HOW AN EFFECTIVE SYSTEM OF CIVIL–MILITARY COOPERATION CAN BE BUILT.

Adapted from the 2026 White Paper Soldiers' Health – A Challenge for a Secure Future, published by the Institute for Social Policy Development, Warsaw, March 2026.

Let us begin with the fundamental question: why do we need a new architecture for civil-military cooperation? We have emphasised repeatedly that when a state is under threat, it must defend itself with every resource at its disposal. In such circumstances, there is no distinction between military and civilian medicine. There is a single healthcare system, which must possess the appropriate capabilities and procedures, and be prepared to efficiently mobilise all available resources to counter threats effectively – whether the crisis is epidemiological or military in nature.

Today's armed operations and security crises are characterised by high intensity, mobility, and volatility, as well as the increasing impact of hybrid factors – from logistical pressures to disruptions of infrastructure and communications. Medical response can no longer rely solely on *(efficient service)* within a single government department; it must be developed as an interoperable, state-wide system, capable of functioning amid resource shortages and mass casualties.

We therefore require a new architecture for civil-military cooperation, based on three pillars: an interoperable system – the joint management of the state's strategic resources; crisis readiness – the capacity to operate under conditions of shortage and mass casualties; and common standards – uniform operating procedures and training for all services.

Soldiers' health, together with the readiness of civilian healthcare, forms a strategic asset that demands joint management, uniform standards, and training. Simultaneously, the system must be effective in peacetime through prevention and early health interventions.

The health profile of Polish soldiers is illustrated by the results of a study conducted and published by the Military Medical Institute – National Research Institute (WIM-NRI) between 2007 and 2016. These findings are from the MIL-SCORE I programme, which involved 9,741 soldiers aged 25-60. The results reveal the extent of the *(silent burden)* of lifestyle-related, non-communicable diseases in the military population. 28% of the study group had arterial hypertension. 61% of soldiers showed abnormalities in their test results. 23% had complex clusters of abnormalities – namely, hypertension and lipid disorders in the form of metabolic syndrome. 22% received new diagnoses of previously unrecognised lifestyle-related conditions.

It is particularly concerning that 22% of the soldiers surveyed were diagnosed with lifestyle-related conditions they had not previously known about – the diagnosis was made only during preventive screening. This highlights a serious access problem – if nearly one in four soldiers learned something significant about their health only through a screening check-up.

Lieutenant General Prof. Grzegorz Gielerak, MD, PhD,

is a graduate of the Faculty of Medicine at the Military Medical Academy, the SGH Warsaw School of Economics, and Kozminski University. He specialises in internal medicine and cardiology and holds an MBA. He has been the director of the Military Medical Institute – National Research Institute in Warsaw since 2007. He is a member of the State Examination Committee for Internal Medicine and Cardiology, the Polish Cardiac Society, the European Society of Cardiology, and the International Society for Holter and Noninvasive Electrocardiology, as well as a member of the Healthcare Council to the President of the Republic of Poland, the Public Health Council to the Minister of Health, and the Prime Minister's Awards Committee. He is also the National Consultant for Defence in Internal Medicine.

88% of excess deaths

occur before reaching hospital and, in theory, could be avoided with faster access to hospital care.

"WHEN A STATE IS UNDER THREAT, THERE IS NO DISTINCTION BETWEEN MILITARY AND CIVILIAN MEDICINE. THERE IS A SINGLE HEALTHCARE SYSTEM."

In high-intensity conflict scenarios, the key issues include the following.

Mass losses and severe polytrauma – complex torso and limb trauma in Ukraine is associated with a 65-70% risk of death, resulting in approximately 440 losses per day. The lesson from Ukraine is a step-change in scale. MASCAL incidents involving more than 100 casualties – evacuation times often exceed 24 hours. Under these conditions, pre-hospital care becomes critical: 88% of excess deaths occur before reaching hospital and, in theory, could be avoided with faster access to hospital care.

The war in Ukraine and the experience of the COVID-19 pandemic have clearly shown that the healthcare system is a core element of national deterrence and defence. Analyses conducted at the Military Medical Institute align with NATO assessments and identify four categories of weaknesses: insufficient reserves, workforce shortages, fragmented decision-making and weak interoperability.

The recommended model for organising medical support in military operations uses a "hub-and-spoke" structure: central trauma centres with high surgical capacity and intensive care capability are supported by smaller satellite units located closer to the line of contact with a potential aggressor. These units provide first aid and stabilisation and are responsible for the rapid evacuation of casualties.

Remote medical support enabled by advanced technologies will be especially important for the future of battlefield medicine. Telemedicine – modern telemedicine systems connect patients and medics in the field with experts in secure locations, including enabling operations with an online specialist providing support. Robotic surgery – robotic systems offer new possibilities for performing on-site procedures in areas of military operations. Drones and autonomous vehicles – unmanned aerial and ground platforms can rapidly deliver blood, medicines, and dressings to the front line. Wearable devices and biometric sensors – miniature sensors worn by soldiers enable continuous monitoring of vital signs on the battlefield.

"MEDICAL RISK MANAGEMENT CANNOT REMAIN SOLELY THE RESPONSIBILITY OF THE MILITARY HEALTH SERVICE; IT MUST BECOME A WHOLE-SYSTEM EFFORT ACROSS THE ENTIRE HEALTHCARE SYSTEM."

To address the challenges of the modern battlefield and maintain high operational readiness, the Polish Armed Forces must urgently implement comprehensive reforms in their healthcare system. Adoption of comprehensive models – introducing a system-wide approach to preventive health, modelled on US Army programmes covering physiotherapy; prevention of lifestyle-related, non-communicable diseases under MIL-SCORE II; recovery and injury prevention under the RECOVERY programme; and strengthening soldiers' mental resilience. Mental health support programme – implementing the Support-Intervention-Monitoring programme through active crisis intervention teams, mental health training, and systematic monitoring of the mental well-being of military personnel. Integration of modern technologies – using telemedicine, wearables, and big data analytics to enable continuous health monitoring, early risk detection, and rapid real-time medical intervention.

Soldiers' health cannot remain solely the responsibility of the military health service; it must become a whole-system effort across healthcare. We need a new framework for civil-military cooperation to safeguard the health security of both soldiers and society, built on three pillars: interoperability, crisis preparedness, and shared standards. ■

Focus of this issue:
Neurology





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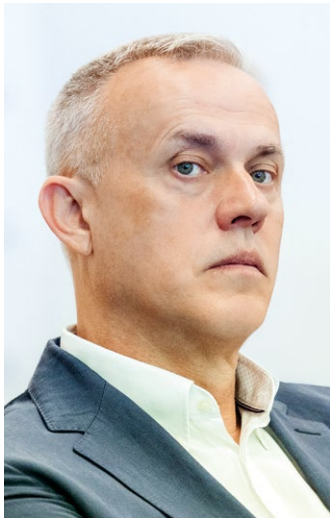

Systemic Aspects of Neurology in Poland

NEUROLOGICAL DISORDERS ARE THE THIRD LEADING CAUSE OF DISABILITY AND DEATH IN EUROPE, AFTER CARDIOVASCULAR DISEASES AND CANCER. AT LEAST ONE IN THREE PEOPLE WILL DEVELOP A NEUROLOGICAL DISORDER DURING THEIR LIFETIME.[1]

Jakub Gierczyński, MD, PhD, MBA

Over the past three decades, the overall burden of disability, illness and premature death attributable to neurological disorders has increased by 18%.[2] Stroke, epilepsy, Alzheimer's disease, Parkinson's disease and migraine account for most of this burden.

In response to these challenges, the European Academy of Neurology launched the Brain Health Strategy in 2022, setting out a holistic approach to brain health.[3] The European Commission is currently developing a European Brain Health Plan, following the model of Europe's Beating Cancer Plan, launched in 2021, and the EU Cardiovascular Health Plan: the Safe Hearts Plan, adopted in 2025.[4]

In Poland, the 2021 report *The State of Neurology in Poland and Directions for Its Development to 2030* identified neurology as a healthcare priority and outlined a model of neurological care designed to bring Polish neurology into line with current European standards. The report identifies four strategic areas requiring organisational reform and a substantial increase in funding: improving the quality and timeliness of patient care, investing in the workforce, advancing innovative technologies, and strengthening prevention and education. A key priority is the establishment of a tiered neurological care network, together with clearly defined diagnostic and treatment pathways for patients with neurological disorders.[5] In 2024, the report *Neurology in Poland: Current State and Future Perspectives* was published, presenting an analysis of real-world evidence on neurological disorders from the perspective of the National Health Fund and the Social Insurance Institution.[6] In 2025, the Ministry of Health defined *"Healthy Heart, Healthy Brain"* as one of its strategic priorities, recognising the growing clinical, social and economic burden of neurological disorders and emphasising that effective neurological care requires coordination, modern therapies and sustainable funding.[7] From the perspective of rare neurological diseases, another key priority is implementation of the *Plan for Rare Diseases*, including the rapid establishment of Rare Disease Expert Centres, with adequate funding for services delivered at this level of care.[8]

Notably, in recent years, Poland has steadily expanded reimbursement for new molecule–indication combinations

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[2] GBD 2021 Nervous System Disorders Collaborators. "Global, Regional, and National Burden of Disorders Affecting the Nervous System, 1990–2021: A Systematic Analysis for the Global Burden of Disease Study 2021." The Lancet Neurology 23, no. 4 (2024): 344–381. https://doi.org/10.1016/S1474-4422(24)00038-3.

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used in the treatment of neurological disorders. According to the Ministry of Health, between 2021 and 2025 a total of 615 new molecule–indication combinations were approved for reimbursement, including 54 in neurology, of which 42 were covered through drug programmes and 12 through the open reimbursement list. Neurologists currently deliver 22 drug programmes, out of 142 across all therapeutic areas, covering reimbursement for 47 active substances.[9] In 2025, approximately PLN 2 billion was allocated to neurological drug programmes, accounting for around 14% of total expenditure on drug programmes. Approximately 50,000 patients received treatment through neurological drug programmes in 2025, representing almost 15% of the 329,000 patients treated under drug programmes overall. In other words, one in every seven patients treated through a drug programme in 2025 had a neurological disorder. Under drug programme B.29, Treatment of Patients with Multiple Sclerosis, approximately 28,000 patients received treatment in 2025. Other programmes included B.28, Treatment of Focal Dystonia and Hemifacial Spasm, with around 10,000 patients; B.57, Treatment of Limb Spasticity with Botulinum Toxin Type A, around 6,000 patients; B.133, Preventive Treatment of Chronic Migraine, around 3,000 patients; B.67, Immunoglobulin Treatment for Neurological Diseases, around 2,000 patients; B.102, Treatment of Spinal Muscular Atrophy, around 1,100 patients; B.90, Treatment of Motor Complications in Advanced Parkinson's Disease, around 700 patients; B.157, Treatment of Generalised Myasthenia Gravis, around 150 patients; and B.138, Treatment of Neuromyelitis Optica Spectrum Disorder (NMOSD), around 150 patients. According to National Health Fund data, reimbursed medicines in neurology (category N – Nervous System) cost the public payer PLN 1.8 billion in 2025, representing approximately 11% of total reimbursement expenditure. Key challenges include ensuring adequate funding and optimisation of existing drug programmes, launching new programmes, for example for Alzheimer's disease, and expanding reimbursement through the retail pharmacy system, for example for oral therapies for chronic migraine.

According to data from the Social Insurance Institution, diseases of the nervous system (G00–G99) generated PLN 3.86 billion in incapacity-for-work benefits in 2024, representing a 25% increase compared with 2012 (PLN 2.89 billion). The total cost of incapacity-for-work benefits paid by ZUS was approximately PLN 57 billion. Neurological disorders therefore accounted for 7% of all ZUS expenditure on incapacity-for-work benefits in 2024. The register of medical certificates recorded approximately 13.3 million days of sickness absence and 1.2 million medical certificates issued because of diseases of the nervous system (covering an individual's own illness, childcare and care for another family member). Compared with 19.9 million days of sickness absence in 2012, this represents a 33% reduction. One of the reasons is improved reimbursement for early diagnosis and effective therapies for neurological disorders. Multiple sclerosis provides an excellent example: access to reimbursed effective therapies has helped many patients avoid disability pensions, while the number of sickness absence days fell by 15% in 2025 compared with 2012 (207,000 versus 244,000 days, respectively).[10] ■

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Brain Health Must Not Depend on Your Postcode

NEUROLOGICAL CONDITIONS, INCLUDING DEMENTIA, ALZHEIMER'S DISEASE, PARKINSON'S DISEASE AND ALS, ARE AMONG THE FASTEST-GROWING BURDENS ON EUROPEAN HEALTHCARE SYSTEMS TODAY.

Rita Schultz speaks with Adam Jarubas, Chair of the European Parliament's Committee on Public Health (SANT), about how the European Parliament intends to respond to this challenge, which regulatory solutions are being prepared and what doctors, pharmacists and payers can expect from them.

What is the European Parliament's Committee on Public Health (SANT), which you chair, and why has neurological health, including brain health, become one of its priorities?
It is an honour for me to represent the European Parliament's Committee on Public Health, the first fully independent legislative committee dedicated to health in the Parliament's history. I have the privilege of chairing the committee, whose remit includes neurological health.

Let us begin with the scale of the problem, particularly in terms of healthcare resource planning. How serious a challenge do neurological diseases pose in Europe?
The scale is enormous. As many as one in three people in the European Union are affected by brain disorders. Their prevalence is slightly higher in Western Europe, although this may reflect broader access to diagnosis, longer life expectancy and more advanced ageing in those societies. When we speak of neurological diseases, we primarily have four groups of conditions in mind. First, dementia, which affects 9.1 million people in Europe. Projections indicate that this figure will rise by more than half, to 14.3 million, by 2050. Second, Alzheimer's disease, which affects up to 7 million people in Europe, with forecasts suggesting that this number may double over the next five years. Third, Parkinson's disease, which affects 10 million people worldwide, a figure that may double by 2050. Fourth, amyotrophic lateral sclerosis, which affects 13 in every 100,000 people in Europe, with the number of cases rising proportionally. These figures are, of course, only examples, as we are well aware that there are many more neurological diseases and many more people affected by them across the EU.

What is driving this increase in cases? To what extent can it be attributed to modifiable risk factors that could be addressed through prevention?
These conditions are not determined by genetics alone. They are also associated with lifestyle, physical inactivity, poor diet, occupation, environmental factors, socioeconomic circumstances, sex and older age.

Beyond the clinical burden and the impact on patients and their loved ones, what costs do these diseases impose on healthcare systems and economies?
Neurological and brain disorders impose very tangible socioeconomic costs because they prevent people from realising their full potential. The cost of Alzheimer's disease

Health depends on your DNA, but it must not depend on your postcode.

Adam Jarubas, PhD,

is Chair of the European Parliament's Committee on Public Health (SANT), the first fully independent, permanent legislative committee dedicated to health in the Parliament's history. It was established following a Polish initiative in January 2025. He represents the European People's Party (EPP).

in Europe is estimated at approximately EUR 250 billion. For dementia, various reports put the figure at around EUR 300 billion. In 2019, the total economic burden of neurological disorders in Europe was estimated at EUR 368 billion per year. There is also the question of care. As Europe's population ages, a growing number of people with brain disorders require long-term care. This further reduces the available workforce, which is already shrinking as a result of the adverse demographic trends affecting an ageing Europe.

Neurological conditions are among the most urgent and fastest-developing health, social and economic challenges facing Europe.

How do you personally, and the committee you chair, approach this issue?
Both I personally and the European Parliament's Committee on Public Health (SANT) regard brain health, and neurological health more broadly, as a priority.

What is driving this commitment? Does it stem from specific political pledges that the sector could view as an indication of the regulatory direction?
Yes, it does. In the European People's Party's Bucharest manifesto for the 2024 European Parliament elections, one of our calls for greater EU involvement in health was for the Union to adopt a neurological health strategy. We want to build on the success of Europe's Beating Cancer Plan, which has been implemented since 2021 and delivers on commitments we made ahead of the 2019 elections. During the current parliamentary term, we have already succeeded in encouraging the European Commission to adopt the EU Cardiovascular Health Strategy, the Safe Hearts Plan, presented in December 2025. I believe the time has now come for a neurological health strategy, including brain health.

Has this issue already been raised at the highest institutional level of the European Union?
Yes. In line with our 2024 commitments, the need for a common EU response to the challenges facing neurological health was highlighted in Ursula von der Leyen's speech opening the current parliamentary term in Strasbourg in July 2024. It was also a key element of the mission assigned by the President to the Commissioner for Health and featured prominently during Olivér Várhelyi's confirmation hearing in the European Parliament.

You described SANT as the first fully independent legislative committee dedicated to health in the European Parliament's history. How was it established?
To address issues such as these and act as a credible partner to the European Commission, with a strong democratic mandate and a clear understanding of citizens' needs across the EU, we established SANT in January 2025, following a Polish initiative. It is the first fully independent, permanent legislative committee dedicated to health in the European Parliament's history.

What work has the committee undertaken on neurological health so far? Have you consulted experts and the clinical community?
Within SANT, we have held a series of public hearings with stakeholders and exchanges of views with experts on neurological health, including brain health. We have addressed this both as a standalone issue and in the context of rare diseases and cancer.

Has this work already resulted in a specific committee decision that the sector should be following?
Yes, it has. Last month, together with the coordinators of the political groups in our committee, we decided to request authorisation to draw up an own-initiative report dedicated to a European Neurological Health Strategy, in parallel with a separate report on an EU Mental Health Strategy. I hope that we will receive formal authorisation in June, allowing us to appoint rapporteurs and begin intensive work on the European Parliament's position in September. We should complete this work in early 2027.

Why do you consider this issue so urgent from a healthcare planning perspective?
Neurological conditions are among the most urgent and fastest-developing health, social and economic challenges facing Europe. As the population ages, the incidence of neurodegenerative conditions such as dementia, Alzheimer's disease, Parkinson's disease and ALS will rise sharply, placing growing pressure on healthcare systems, social support structures and carers.

What exactly will the report cover, and which areas will be most relevant to doctors, pharmacists and payers?
SANT's own-initiative report will assess the current situation in the Member States, as well as risk factors and underlying causes such as ageing, lifestyle factors including diet and physical activity, environmental factors such as toxins and pollution, and genetic predisposition. It will also examine scientific and technological advances and future opportunities, together with early diagnosis, research and innovation capable of enabling effective therapies, care and social support. As in other areas, we will also look at inequalities in access to diagnosis, treatment and care, both between and within EU countries, including disparities between cities and smaller communities. As I often say in the European Parliament, health depends on your DNA, but it must not depend on your postcode. Only then will we be able to speak of a genuine European Health Union, which we have been working to build since the pandemic crisis.

I believe the time has now come for a neurological health strategy, including brain health.

What will happen once the report has been adopted by SANT, and what regulatory weight will it carry?
The report drafted and adopted by a vote in SANT will form the basis of the European Parliament's overall position, to be adopted in plenary. It will contain recommendations to the European Commission on the European strategy, as well as recommendations on harmonising action across the Member States.

What message would you like to convey to the medical and expert community following this issue?
I strongly encourage you to follow our work in the European Parliament in this area and to contribute your comments and assessments of the draft provisions and proposed amendments. ■

A Revolution in Dementia Treatment Is Within Reach, but We Need to Build a System

THE SECOND ROUND-TABLE DISCUSSION IN THE SERIES *NEUROLOGY IN POLAND IN THE CONTEXT OF THE EUROPEAN BRAIN HEALTH PLAN*, ORGANISED BY THE INSTITUTE FOR SOCIAL POLICY DEVELOPMENT IN COOPERATION WITH THE COMMITTEE ON CLINICAL SCIENCES OF THE POLISH ACADEMY OF SCIENCES, WILL TAKE PLACE ON 9 SEPTEMBER AT THE ECONOMIC FORUM IN KARPACZ. IT WILL FOCUS ON THE TREATMENT OF NEURODEGENERATIVE DISEASES.

Why this is one of the most pressing problems of modern neurology, alongside the need for integrated treatment for stroke patients, is the subject of a conversation between Karolina Wasielewska and the national lead consultant physician in neurology, Professor Bartosz Karaszewski.

As part of the Economic Forum in Karpacz, the Institute for Social Policy Development is holding its second round-table discussion on priorities in neurology. The first meeting, held in June, focused primarily on the need to introduce integrated care for stroke patients. What will be the main theme of the next discussion?

The first meeting provided a broad introduction to the series as a whole. Its aim was to explain and show why neurology should now be a top priority within the Polish healthcare system. We then moved on to what needs to be done first, considering the expected scale of the population-level health benefit: implementing an integrated care system for stroke patients, including preventive measures for those at high risk of stroke. The complex, 12-domain proposal has already been prepared and is now on the Ministry of Health's agenda. Moreover, it is consistent with the new organisation of acute healthcare services planned for implementation in Poland. Indeed, I personally oversaw its development, but many other experts have been, and remain, involved with me in this work, including the National Council for Neurology.

Could the stroke unit you lead at the Medical University of Gdańsk and the University Clinical Centre serve as a model in this respect?

It could, but the integrated care system goes much further than the role of a comprehensive stroke unit.

It does not end when a patient is discharged home, to rehabilitation or to a long-term care facility. It assumes a systemic continuation of support for patients in need. This care operates in three areas: individually tailored secondary prevention, rehabilitation, and early detection and management of potential stroke complications. Spasticity is a good example: in many cases, it is relatively straightforward to treat, provided the patients affected are identified at the right time and referred to the right centre.

It is worth emphasising that there are few areas in the Polish healthcare system in which a relatively inexpensive intervention – and that is what this integrated care plan represents – can have a major, substantial population-level impact by improving patient outcomes. This project requires only a few investments, such as inter-centre, real-time transfer of clinical, neuroimaging and angioimaging data with automated core analysis, as most of the necessary infrastructure is already in place at our hospitals. We mainly need to fit these existing resources together.

What specifically needs to change?

Each domain of the plan was carefully selected taking into account the country's current resources in order to begin influencing patient outcomes as quickly as possible and to the greatest possible extent.

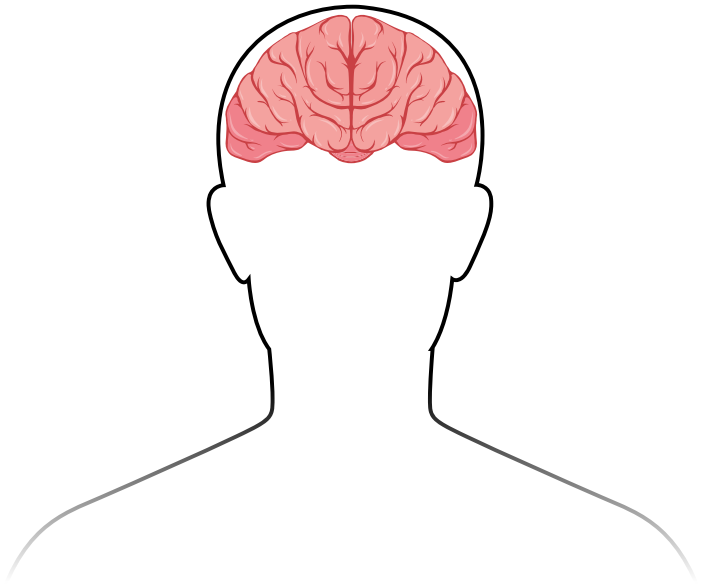
For example, a new code of good practice should be introduced for emergency medical services on the management of patients with suspected stroke, with a similar set of unified rules applied in hospital emergency departments. All stroke units should use a standardised and centralised IT system – including an application for real-time post-processing of neuroimaging data. This would allow us to track every patient in the system, help determine the cause of each stroke and establish the appropriate pathway of care. It would also enable us to create a national stroke registry to monitor stroke incidence, aetiology and treatment. This is essentially the only component that would require substantial public investment, but it is highly cost-effective. Acute inter-hospital transfer arrangements for stroke patients also need to be improved.

Prof. Bartosz Karaszewski, MD, PhD,

is a neurologist and Head of the Chair of Neurology and of the Department of Adult Neurology at the Faculty of Medicine, Medical University of Gdańsk (academic roles), and Head of the Department of Adult Neurology at the University Clinical Centre in Gdańsk (clinical role). He founded the Brain Diseases Centre of the Fahrenheit Union of Universities in Gdańsk and leads groundbreaking research into multiple fields in neurology, including stroke treatment. He has authored numerous publications in leading neurology journals. He has served as Poland's national lead consultant physician in neurology since 17 July 2024 (an expert neurologist selected by the Ministry of Health as the lead physician adviser in the field). He is the President of the Clinical Sciences Committee of the Polish Academy of Sciences and chairs the Cerebrovascular Diseases Section of the Polish Neurological Society. He also serves as a member of the Expert Council for the Supreme Medical Chamber (Neurology).

He is also a member of the Scientific Council of the Institute for Social Policy Development. Outside medicine, he is a fan of theatre and music (including Pink Floyd), and is very active in sport.

Around
80,000
people have
a **stroke** in Poland,
one-third of whom
remain **permanently dependent.**



The subsequent steps comprise all the measures associated with post-stroke care, already mentioned earlier, that are tailored individually by the stroke physician discharging the patient from the stroke unit. Effective implementation of these measures will require the introduction of a stroke care coordinator.

Guidelines for clinical care are constantly being updated by experts. In Poland, our Cerebrovascular Diseases Section of the Polish Neurological Society, which I chair, has been overseeing this process for years.

Severe disability currently places an enormous burden on the system, particularly given that around 80,000 people have a stroke in Poland, one-third of whom remain permanently dependent.

In the first instalment of our series on neurology, we also discussed the *European Brain Health Plan*, an outline of which was presented by Dr Adam Jarubas, Chair of the European Parliament's Committee on Public Health (SANT). Why does Europe need such a plan?

The key aspect is to coordinate action on general neurology priorities and raise the profile of the burden of neurological disease at the European level. Neurodegenerative diseases, particularly Alzheimer's disease, are a prime example of an issue that strongly affects the whole of Europe. Given their epidemiological and societal impact, and considering the revolution in the development of new Alzheimer's disease drugs that has already begun, they are our second-highest priority – and arguably on a par with the stroke care subsystem – and will be the main focus of our next meeting in Karpacz.

The challenge here is access to early diagnosis

Indeed, refining the system for the early detection and accurate diagnosis of dementia is crucial at this stage because it will determine how many patients benefit from these new anti-amyloid therapies, some of which are already in use, and to what extent. These treatments could bring about a revolution on a scale comparable to the one we saw in multiple sclerosis in 2004, when the first effective therapy became available, followed soon afterwards by others that were even more effective. These MS treatments give patients roughly twenty additional years of independent functioning.

In terms of the pace of population ageing, our situation is much worse than the European average.

These MS treatments give patients roughly

20 additional years

of independent functioning.

Again, this is where a European plan can help: it provides a body that highlights the challenges involved in treating this disease. The matter is all the more urgent because, in terms of the pace of population ageing, our situation is much worse than the European average.

Poland now has a National Dementia Action Programme, and a council has recently been established to coordinate its implementation. What outcomes should these measures deliver?

This is an important document – it is excellent that it was introduced – yet it remains only general in nature. Of its multiple domains, I emphasise two as particularly urgent. These include early and accurate diagnosis – determining the aetiology of dementia – and access to therapies with proven efficacy. Fortunately, we now have access to modern, advanced and highly sensitive and specific blood-based diagnostic tests. The key challenge is to integrate them properly into the system, organise access appropriately and ensure that they are used effectively. Obviously, we should also work on developing social care – specifically, in this instance, within a broad, interdisciplinary group of experts and activists. And this is precisely the nature of the council recently established by the government – the one you mentioned – on which I also have the honour to serve.

The treatment of Parkinson's disease and migraine also featured among the priorities you identified for neurology in Poland.

These will be addressed at the meeting too. Several important aspects of Parkinson's disease remain inadequately covered by the current system. Access to treatment for advanced disease continues to be a problem.

In migraine, although the issue is not mortality or cognitive or motor disability, the impact on quality of life is so significant that the condition is rightly regarded as one of the priorities of modern neurology, given its epidemiology and the amount of time people lose to battling the illness. We now have both preventive therapies and treatments for migraine attacks, which gives us the foundations for appropriate access to modern care. The right system needs to be put in place now. There is a possibility that one effective new-generation oral medicine could shortly become available on a standard prescription through pharmacies rather than through a drug provision scheme).

We also need to diagnose headaches more precisely and promptly administer therapies appropriate to the type of pain. As with the early symptoms of dementia, we see a significant complementary role for family doctors in this respect as well. ■

Neurology needs a network, clear referral levels and real funding

NEUROLOGY IS ACHIEVING SOME OF THE GREATEST THERAPEUTIC SUCCESSES IN MODERN MEDICINE, YET AT THE SAME TIME IT IS FACING RISING PATIENT NUMBERS, UNDERFUNDED CONTRACTS AND THE ABSENCE OF A TIERED REFERRAL NETWORK. SPEAKING ON THE SIDELINES OF A CONFERENCE ON THE ORGANISATION OF NEUROLOGICAL CARE IN POLAND, **PROFESSOR ALINA KUŁAKOWSKA,** MD, PHD, PRESIDENT OF THE POLISH NEUROLOGICAL SOCIETY, EXPLAINS WHY BRAIN HEALTH SHOULD BECOME A GENUINE PRIORITY IN NATIONAL HEALTH POLICY RATHER THAN MERELY A SLOGAN.

Interview by Rita Schultz.

Let us start with the basics: whom does the Polish Neurological Society actually represent?
The Polish Neurological Society is a medical association whose members are primarily neurologists and doctors undergoing specialist training in neurology. Around 70% of neurologists practising in Poland are currently members of the Society, which gives us a mandate to speak on behalf of the profession as a whole and to play a meaningful role in shaping neurological care in the country.

Before we turn to the systemic challenges, for readers outside the field: what exactly is neurology, and how does it differ from psychiatry?
I always start with this question: who treats diseases of the brain? The brain is the organ that determines who we are; without it, we would not be ourselves. The diagnosis and treatment of brain disorders are mainly the domain of two disciplines: neurology and psychiatry, together with their paediatric counterparts, paediatric neurology and paediatric psychiatry, which are integral parts of their respective fields. A small proportion of nervous system disorders are treated by neurosurgeons, whom one might describe as surgical neurologists, but this is only a small part of the picture; most disorders of the nervous system are managed non-surgically. One could debate the balance: psychiatrists generally treat more patients, whereas neurologists treat a far greater number of distinct conditions. Historically, the distinction between neurology

Professor Alina Kułakowska, MD, PhD, *is a neurologist and President of the Polish Neurological Society. She holds a professorial post at the Medical University of Białystok and specialises in the diagnosis and treatment of multiple sclerosis (MS). For many years, she has combined clinical practice with research and teaching as Deputy Head of the Department of Neurology at the Medical University of Białystok. A leading figure in Poland's neurological community, she is also the regional neurology consultant for the Podlaskie region and Editor-in-Chief of the journal Neurologia Praktyczna.*


Instytut Rozwoju
Spraw Społecznych

Reimbursement decisions alone are not enough: there must also be actual funding to cover their cost.

and psychiatry depended on whether an organic cause of the condition could be identified: if it could, the condition fell within neurology; if not, within psychiatry. Today, we know that every disorder has some form of biological basis, so from a scientific perspective the two specialties ought to be combined. In practice, however, that is not feasible.

But neurology is about more than just disorders of the brain, isn't it?

Absolutely. Neurology also covers disorders of the spinal cord, the entire peripheral nervous system, the neuromuscular junction and the muscles. If the brain is our command centre, the other components of the nervous system put its decisions into action. The spinal cord is a small organ, but if it is severed, a person cannot move even their little finger. In short, neurology diagnoses and treats a very large number of distinct conditions. Over time, internal medicine has divided into nine or ten separate specialties, while neurology has remained a single, coherent field. I have great respect for my colleagues in internal medicine, and I know how important interdisciplinary care is for patients with nervous system disorders, including the involvement of geriatricians: more than 50% of patients admitted to neurological wards are over the age of 65. However, I want to make one point very clear: neurologists are trained to diagnose disorders of the nervous system, just as specialists in internal medicine are trained to diagnose diseases of the internal organs.

Neurology is often said to have become a therapeutic specialty in recent years. What does that mean in practice?

Over the past few decades, many new drug therapies have emerged in neurology. In a sense, they are relatively easily accessible because most new therapies are reimbursed in Poland. However, reimbursement decisions alone are not enough: there must also be actual funding to cover their cost. Neurologists now deliver more than 20 drug programmes, yet the value of our contracts remains a problem because they are underfunded. This year, once again, we will provide substantial volumes of care above contracted levels and be paid for them late, while hospitals cannot afford to finance patients' treatment up front. On the one hand, we are delighted by the therapeutic success of our specialty; on the other, what keeps us awake at night is whether patients will have genuine access to treatment rather than access that exists only on paper.

What is driving the rise in the number of neurological patients?

The population is ageing. In Poland, as across the European Union, the two fastest-growing categories of conditions are stroke and neurodegenerative diseases, including Alzheimer's disease – precisely the conditions diagnosed and treated by neurologists. Today's environment and living conditions are also not conducive to brain health. As a result, our patient population continues to grow.

In short, rising patient numbers and neurology's therapeutic successes mean an ever-increasing workload. Obviously, we are delighted by these successes, but we face the reality of a system that is failing to keep pace.

Does Poland currently have enough neurologists to meet this increasing demand?

Regrettably, it does not. The average age of neurologists in Poland is around 55, and approximately 30% are already eligible to retire, although fortunately many are still working. However, since neurology was designated a priority specialty, the situation has gradually begun to improve. More doctors are choosing neurology, and more are starting specialist training in the field. At the same time, we must consider revising the training curriculum so that it reflects current medical knowledge. Workforce shortages, however, are only one part of the problem.

The system is failing to keep pace with neurology's therapeutic successes.

More than **50%**
of patients admitted to neurological wards
are over **the age of 65.**

To put it bluntly, the entire organisation of neurological care in Poland is flawed, and the changes we have been calling for over many years are essential. We also lack effective preventive measures.

You mentioned prevention. How many neurological conditions could be prevented if the system placed greater emphasis on prevention?

Many brain disorders are preventable, which means we would not have to treat them later. That is why we established the Brain Health Coalition, an alliance of neurologists, psychiatrists, healthcare experts and patient organisations. We work closely with patient organisations, which are an essential part of this effort. We are all in agreement on the importance of prevention, and that is where we are focusing our efforts.

The Polish Neurological Society has been calling for systemic change for years. Which solutions do you regard as essential?

In 2021, in collaboration with Lazarski University, we produced a report entitled *The State of Neurology in Poland and Directions for Its Development.* It set out the solutions we consider necessary to improve the organisation of neurological care, above all the creation of a neurological care network with clearly defined referral levels for centres. We should not shy away from the term: we want referral levels to become a reality and to be embedded across the provider network, so that clear diagnostic and treatment pathways can be established for patients with the most common neurological conditions. The aim is to avoid paying repeatedly for patients to stay at different centres without receiving either a definitive diagnosis or the initiation of treatment, and to make their pathway through the system straightforward. We also believe that neurology should become a strategic priority in national health policy.

Do you see any signs of a change in approach among policy-makers?

We are very pleased that the European Union also recognises the need to improve neurological care. Another encouraging development is that, almost a year ago, in August 2025, the Ministry of Health designated "Healthy Heart, Healthy Brain" as the clinical priority among its three priorities. This is the first time the Ministry has explicitly referred to neurology and acknowledged the need to establish a neurological care network. We are doing everything we can to turn those words into action. We have seized on that phrase and intend to keep pressing the point, so that people in Poland can genuinely enjoy the best possible brain health.

How does the neurological community work with Parliament and other stakeholders?

We make every effort to work with the Ministry of Health and other bodies, including the Senate Health Committee. We are pleased that neurology is represented in the Senate, and I would like to acknowledge Senator Wojciech Konieczny. The National Council for Neurology, whose members include experts from the Polish Neurological Society and the national consultant, works closely on a day-to-day basis with the Ministry of Health's Department of Coordinated Care. Neurology is an extremely broad field, covering conditions such as stroke, dementia, epilepsy and many others areas, so we understand that not everything can be done at once. To make progress, we believe it is essential to bring together a wide range of stakeholders: Polish and international medical societies concerned with brain disorders, policy-makers, and, crucially, our patients and patient organisations, which are a vital part of the picture. After all, patients are at the heart of everything we do. ■


prof. Halina
Sienkiewicz - Jarc

Dementia and Stroke: Data That Must Drive Systemic Change

ACCORDING TO DATA PUBLISHED BY ALZHEIMER EUROPE, MORE THAN 600,000 PEOPLE IN POLAND ARE CURRENTLY LIVING WITH ALZHEIMER'S DISEASE OR ANOTHER FORM OF DEMENTIA. ACROSS EUROPE, THE NUMBER AFFECTED IS ESTIMATED TO INCREASE BY NEARLY 60% BY 2050. THESE EPIDEMIOLOGICAL DATA, ALTHOUGH STILL INCOMPLETE, SET THE SCENE FOR A DISCUSSION OF THE INSTITUTIONAL CHANGES TAKING PLACE IN POLISH NEUROLOGY.

Rita Schultz speaks to Professor Halina Sienkiewicz-Jarosz, President-elect of the Polish Neurological Society, Vice-Rector for Research and International Cooperation at Maria Skłodowska-Curie Medical University, and Chair of the National Council for Neurology, an advisory body to the Minister of Health, about the specific system-level decisions introduced during her more than four years at the helm of the Council and about the National Dementia Action Programme, adopted by the Council of Ministers in late 2025.

What is the National Council for Neurology, and what is its remit?

The Council has been operating for more than four years. It was established in response to calls from the neurology community that had been made much earlier, well before 2022. From the outset, it had a broad remit. It was set up as an advisory and consultative body to the Minister of Health on the organisation of healthcare, strategy and proposed measures, standards of medical practice, quality criteria, and recommendations on innovative technologies for neurological conditions, including stroke, dementia, epilepsy, multiple sclerosis and Parkinson's disease. Our initial focus was on aligning the reimbursement system with current clinical practice, including recognition of the diagnostic tests actually performed, such as testing for specific antibodies and measuring blood concentrations of newer antiseizure medications – formerly referred to as antiepileptic drugs. We then took on a major task: working with the Agency for Health Technology Assessment

Professor
Halina Sienkiewicz-Jarosz, MD, PhD,
is a professor of medical sciences, neurologist, healthcare manager and researcher. She specialises in treating epilepsy, neurodegenerative diseases and stroke. She is the author of more than 350 scientific publications and an Alzheimer Europe expert. Professor Sienkiewicz-Jarosz is Vice-Rector for Research and International Cooperation at Maria Skłodowska-Curie Medical University, affiliated with the Institute of Psychiatry and Neurology for more than 25 years. She chairs the National Council for Neurology, is President-elect of the Polish Neurological Society and is a member of the Committee on Neurological Sciences of the Polish Academy of Sciences.

We are on the threshold of a new era in dementia treatment. In this race, both timing and speed of diagnosis are crucial.

and Tariff System (AOTMiT) on setting tariffs for inpatient neurology services, a process completed in 2025. At the same time, we have not lost sight of the strategy for neurology developed in 2021 by the Polish Neurological Society in cooperation with Lazarski University, which set out diagnostic pathways and a framework for a tiered system of specialist centres.

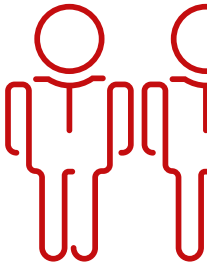
How does the Council conduct its day-to-day work?
The Council brings together specialists from different areas of neurology. We also invite external experts to work with us on specific projects, such as healthcare service tariff-setting and developing the framework for the medical component of the *National Dementia Action Programme*. We normally meet once a month, but throughout the first half of 2026 meetings were held every two weeks, often with additional evening sessions outside the regular schedule to discuss pressing issues.

What system-level changes has the Council helped bring about?
One of the changes we helped bring about was the transition of mechanical thrombectomy for ischaemic stroke from a pilot programme into the guaranteed benefits package. Thanks to our efforts, comprehensive stroke-unit hospitalisations are now funded outside the lump-sum mechanism of the basic hospital care provision system. This does not, however, go as far as we requested. We believe that every hospital admission for stroke should be funded outside the lump sum, as is already the case for myocardial infarction. New tariffs for inpatient diagnosis-related groups have also been in force since last year. We hope that neurology, now included among the state's health priorities, will become a genuinely strategic field, which is fully justified by the prevalence of neurological conditions.

What work is the Council currently undertaking on stroke care?
Together with the National Consultant, we are implementing the "Healthy Heart, Healthy Brain" priority, with a particular focus on stroke care. This includes introducing advanced image post-processing software in every stroke unit, which will shorten the time needed to analyse imaging studies and enable even closer cooperation between stroke units. Until now, such systems have been available mainly in centres providing mechanical thrombectomy. Comprehensive, coordinated stroke care is only the starting point. The entire neurological care system should be integrated and organised around a tiered network of centres. To some extent, a centre's place within that network is also determined by the drug programmes it runs.

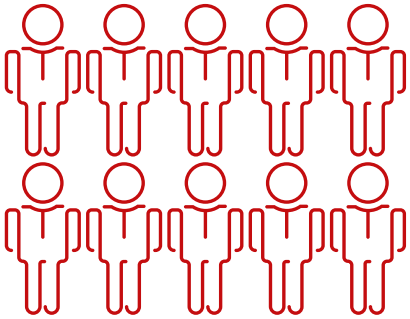
What other areas do you see as priorities for the coming years?
There are so many that it is difficult to list them all. Key priorities include ensuring that patients with drug-resistant epilepsy in Poland have access to epilepsy surgery and invasive pre-surgical diagnostic assessment; providing an appropriate range of outpatient services for patients with Parkinson's disease and memory disorders; updating the services available through specialist outpatient care to keep pace with evolving clinical guidelines; and ensuring a smooth transition to adult neurological care

Effective health policy depends on knowing exactly how many patients there are and what their needs are.



There are around 1.5 geriatricians

per 100,000 people



compared with approx. 10 neurologists

for patients previously treated by paediatric neurologists during childhood and adolescence. The most developed pathway at present is that for continuing treatment under drug programmes for rare diseases. Implementation of the "Healthy Heart, Healthy Brain" priority is planned for 2026 and the following years. An important part of this process is our cooperation with the e-Health Centre to improve the quality of reported data and define the scope of data needed to monitor quality of care and track how the changes being introduced affect the system. The Ministry of Health has also scheduled further conceptual work on the *National Neurological Strategy* for the second quarter of this year. We hope to complete the strategy this year.

What is the staffing situation in Polish neurology today?
The designation of neurology as a priority specialty in 2023, together with significant advances in treating neurological conditions, has increased interest in neurology as a career. This is helping to renew the workforce, as the average neurologist in Poland is over 50 and one third of neurologists have already reached retirement age. Staffing needs therefore remain considerable, particularly in hospital departments.

Please tell us more about the National Dementia Action Programme.
The adoption of the *National Dementia Action Programme* by the Council of Ministers marks a very important moment for Polish neurology and a major step forward for the healthcare system as a whole. Its significance also extends beyond healthcare, as it addresses other aspects of life for people with dementia and their families, including safety and legislation. Broadly, the Programme covers seven main areas: raising public awareness, reducing the risk of developing dementia, supporting early diagnosis, treatment, care and support for people with dementia, support for carers, developing data collection systems, and research and innovation. The neurology community, partly represented on the National Council for Neurology, can support the Ministry of Health in each of these areas, for example by providing expert input on the content of campaigns and educational materials and by advising on neurological risk factors.

Up to
8% of dementia cases
may affect **younger people,** including those under 70 or even **under 60.**

How significant is the burden of dementia in Poland today?
As I mentioned, more than 600,000 people in Poland have Alzheimer's disease or another form of dementia. This figure will rise in the coming years as the population ages. Between 2030 and 2050, the number of people aged 60 or 65 and over is expected to almost double. I should emphasise, however, that the data available to us are extrapolated from Poland's demographic indicators and from data from countries with more reliable reporting systems. The figures reported in analyses by the National Health Fund are affected by reporting and coding errors. Psychiatry has access to a much broader range of ICD-10 codes that can indicate the potential aetiology, whereas in neurology there are only a few dementia-related diagnoses. In addition, there is no requirement to code all comorbidities, and in practice this is often impossible. This is why developing a system for monitoring and collecting data is so important to us.

Public debate has raised the question of who should lead the diagnostic work-up for a patient with dementia: a neurologist or a geriatrician. What is your view?
This discussion has indeed gained prominence recently in the context of the care pathway for people with dementia.

Every hospital admission for stroke should be funded outside the lump sum, as is already the case for myocardial infarction.

Given the way care is currently organised, neurologists should play the leading role in determining the aetiology of dementia, particularly in early or atypical cases and in those requiring more extensive diagnostic assessment. Geriatric medicine, however, remains essential in the care of older patients with multimorbidity. Given the number of patients and the scale of need, this division of roles is also justified by the availability of specialists. Access to geriatric care in Poland is very limited and varies considerably between regions. There are around 1.5 geriatricians per 100,000 people, compared with approximately 10 neurologists. According to data from the health needs maps, around 4,000 neurologists work within the National Health Fund system. The number of neurology consultations in recent years has reached 22 million, with Alzheimer's disease diagnosed during 400,000 consultations each year. By comparison, geriatric services provide a total of around 70,000 consultations relating to dementia in Alzheimer's disease and Alzheimer's disease itself. We should also remember that some patients are diagnosed and treated by psychiatrists. In my view, doctors from all three specialties can and should work together. This is justified by patients' age, multimorbidity and the behavioural symptoms that emerge as the disease progresses. However, at the beginning of the patient pathway, when memory problems have been confirmed by a family doctor, it seems most logical for the diagnostic work-up to be led by a neurologist. This is because the causes of dementia need to be differentiated and additional investigations, including lumbar puncture, may be required. It is estimated that up to 8% of dementia cases may affect younger people,

including those under 70 or even under 60. Time is also critical. We are on the threshold of a new era in dementia treatment. The targeted therapies currently available are indicated for patients with mild cognitive impairment or early dementia, making both the timing and speed of diagnosis crucial.

What work is being done on standards for early diagnosis?
Representatives of the Alzheimer's Section of the Polish Neurological Society, together with members of the Polish Alzheimer's Society, have developed and published a diagnostic pathway for patients with suspected dementia. We had previously recommended screening tools for use in primary healthcare. We are also working to have a meaningful impact on the education and training of the neurology workforce. Our role in supporting carers will be to partner with relevant societies and patient organisations rather than lead these efforts.

Finally, what do you see as the greatest value of the Council's work over the past four years?
I believe the Council is a good example of cooperation between the neurology community, the Polish Neurological Society and the National Consultant, supported by institutions such as the Ministry of Health, the National Health Fund and the Agency for Health Technology Assessment and Tariff System. In my view, it is precisely this cooperation that has made our achievements to date possible. ■

Brain Health from an International Perspective

PROFESSOR KONRAD REJDAK, MEMBER OF THE BOARD OF THE POLISH NEUROLOGICAL SOCIETY AND MEMBER OF THE PROGRAMME COMMITTEE OF THE EUROPEAN ACADEMY OF NEUROLOGY

I represent the Polish Neurological Society, I serve on the Programme Committee of the European Academy of Neurology, and I sit on the International Brain Health Alliance, a body that brings together the world's leading experts in the field, including the President of the World Federation of Neurology. This is not merely a talking shop, but a community that works with hard data – and today, those data carry more political weight than any rhetoric.

In its COIN-EU report, the European Academy of Neurology estimated the annual cost of neurological disorders in Europe at EUR 1.7 trillion. The breakdown of this cost is worth examining, because it is not driven primarily by rare or high-profile conditions: headache disorders account for 45% of the total, sleep disorders for a further 25%, and dementia for 13%. Stroke, widely regarded as a system-level priority, accounts for less than 5%. This breakdown overturns the intuitive hierarchy we tend to have in mind as clinicians and shows that health policy based solely on mortality, rather than population-level burden, systematically overlooks the greatest sources of cost and suffering.

What's more, we are only beginning to understand the full epidemiological scale of the problem. The President of the American Academy of Neurology recently cited data indicating that as many as 40–50% of the population are affected by a neurological disorder at some point in their lives. Neurology is no longer a niche specialty: it addresses one of the central public health challenges of our time, alongside cardiovascular disease and cancer, and may be even more important when measured in years lived with disability.

We can see the scale of this reality in Poland as well. The report *Neurology in Poland*, scientifically edited by Jakub Gierczyński, MD, PhD, Professor Alina Kułakowska, MD, PhD, and myself, showed that in 2022, 208 neurological wards admitted more than 223,000 patients across 262,000 hospital stays, while 1,427 neurological outpatient clinics provided 4.51 million consultations. In 2023, Polish neurologists diagnosed and treated around 6 million patients. This offers a real map of needs and costs – a basis for system-level planning rather than improvisation.

We should keep in mind that brain health is a universal value. It is not the preserve of any one institution or group, but a shared responsibility. The more stakeholders speak with one voice, the greater the chance of turning commitments into actual policy. Professor Steven Lewis, President of the World Federation of Neurology, has made this point explicitly.

I want to emphasise one aspect very strongly: brain health is an exceptionally useful indicator for monitoring the effectiveness of the healthcare system as a whole. It makes it relatively easy to demonstrate progress, or the lack of it, because it brings prevention, treatment and social functioning together in a single measure. It is surprising that expert and policy communities have so rarely used it in this way.

I believe we now need to redefine the concept of brain health itself, because at present it is too broad to serve as an operational tool of health policy. We do, however, already have some concrete starting points.

One starting point is the architecture of the European Academy of Neurology's Brain Health Mission, described in the document *One Brain, One Life, One Approach*. It rests on five strategic pillars: integrating brain health into global and international agendas, supporting policy development at national level, promoting research into the determinants of brain health, educating stakeholders, and raising public awareness. This is complemented by a practical model comprising three concentric spheres of action – preserve, protect, and plan – encompassing everyday individual choices, the prevention of risk factors, and system-level planning and public policy. Every stakeholder has a place within this framework: healthcare professionals, patients, educators, industry, policy-makers, and society. Without political and public support, this change will not happen; that is not a rhetorical caveat but a necessary condition.

This agenda is already translating into concrete institutional action. As a team from the Department of Neurology at the Medical University of Lublin, we are involved in the COMFORTAGE consortium, currently the European Commission's leading funded project in this field. I have also taken part in a public hearing before the European Commission at the invitation of its Chair. This shows that brain health is no longer confined to neurology but has become a global challenge taken seriously by the institutions of the European Union.

We also need to move beyond the idea that brain health is purely a clinical matter. In addition to medical factors, the Brain Health Mission framework explicitly includes the economy, education, politics, air quality and social policy. This is no coincidence. The brain is increasingly becoming an economic consideration: the population's "brain capital", which underpins the productivity of an ageing society. Industry and employers are explicitly called on to treat their employees' brain capital as seriously as financial capital. For an ageing Europe, including Poland, this is not a metaphor but a genuine macroeconomic risk that should concern ministries of finance just as much as ministries of health.

One final point, and a particularly painful one for the neurological community. The Brain Plan for Poland was once the first document of its kind in Europe. That is a source of pride, but also of concern, because it was never implemented. Today, the Polish Neurological Society is taking up this work anew, aware that the pillars jointly identified by the European Commission and the European Academy of Neurology – investment in research, prevention and education – will remain no more than broad aspirations until they are translated into action at local and national level. This is the task I am setting our community for the years ahead. ■


EMHA

A Misunderstood Disease

MIGRAINE IS NOT "JUST A HEADACHE" BUT A CHRONIC NEUROLOGICAL DISEASE THAT PREVENTS MILLIONS OF PEOPLE FROM LIVING NORMAL LIVES. ELENA RUIZ DE LA TORRE, ONE OF THE WORLD'S LEADING PATIENT ADVOCATES, DISCUSSES THE CHALLENGES FACED BY PEOPLE LIVING WITH MIGRAINE, THE PROMISE OF INNOVATIVE THERAPIES, AND THE URGENT NEED FOR CHANGE IN HEALTHCARE SYSTEMS ACROSS EUROPE.

Rita Schultz talks with Elena Ruiz de la Torre, one of the world's leading patient advocates.

Migraine is one of the most common neurological diseases in the world, yet it is still frequently underestimated. In your opinion, why is migraine still not recognised as a public health priority?

I think there is a lack of information, and also a big misunderstanding around migraine in society. It looks like migraine is seen as "just a headache, a bit stronger," and only those affected know it is much more than that. Episodically, in the best cases, something happens in our brains that causes an explosive pain, makes us feel extremely tired, with nausea and vomiting, plus hypersensitivity to light and sounds, and in many cases an inability to find the words to speak. It lasts from 4 to 72 hours if you don't take treatment, and it keeps us hidden at home until it is over. Nobody sees us in that moment, and those who don't suffer from it can't figure out the real situation we have gone through. Once it's over, we don't even want to think about it, and we try to smile and hide it. We know people don't understand it, and that we will probably be questioned about our weakness, our low pain threshold, or what's wrong in our minds... And the truth is very difficult to explain.

It might look like a rare condition, but it is actually very prevalent, affecting three times more women than men. Apart from the big socioeconomic cost, it also has a huge personal one. This is a disease you learn to live with, and only on a few occasions does it require a visit to the emergency room. Besides, people with migraine pay for their own treatments out of pocket. Therefore, nobody sees us, society only hears what we tell them, healthcare systems are not overcrowded with migraine, and the enormous stigma around it makes everybody doubt the urgent need for care and support.

Elena Ruiz de la Torre

is a leading global patient advocate and researcher for headache disorders. Founder of Spain's Migraine and Headache Association, she now leads the European Migraine and Headache Alliance (37 patient associations) and its global arm, IMHA. She has authored key studies including Eurolight, My Migraine Voice, and Migraine at Work, and serves on several advisory bodies, including the Brain Health Mission Steering Committee and EAN Scientific Panel on Headache.

Everybody deserves good care, a good diagnosis, access to the best treatments, and understanding.

What are the biggest barriers that people living with migraine face today in accessing timely diagnosis and effective, modern treatment across Europe?
The stigma I mentioned before makes healthcare systems think migraine is not important enough. One important reason is that diseases are measured by how fast they kill you, and we don't die because of migraine. This neuro-biological disease may not kill us, but it will affect our way of living, friendships, relationships, family, and work careers. Depending on the severity you have, you will be more or less affected, but in cases of level 3 or 4 (following the EMHA's new scoring system, going from 1 to 4), you are going to have a tough life unless you have the best treatment and knowledge.

The European Migraine & Headache Alliance represents the voice of patients at the European level. How has EMHA contributed to bringing about real changes in healthcare systems and public health policy?
We represent those patients and, as you say, we give them a voice. Something that is not asked for or requested will never be a public health priority or even a need. There are so many problems, diseases, and issues in the world that you only fight for the ones you have a stake in. That's what we do. We create scientific data, projects, and activities to try to change the future. Everybody deserves good care, a good diagnosis, access to the best treatments, and understanding – more than what I have had to live with. It's our responsibility to inform, educate, and change wrong perceptions to really leave a better life for the next generations.

Innovative migraine therapies have transformed the lives of many patients, but access to these treatments remains unequal. What should governments and healthcare systems do to ensure that effective migraine care is available to more people who need it?
I would say that the first thing governments and healthcare systems should do is get involved in the change. Listen to science and listen to real-world experiences. Only ignorance can stop the right evolution of something that is already scientifically demonstrated and proven. As I understand it, innovation has finally brought our community good, targeted treatments, and I cannot understand how the healthcare system is not providing them to the people that need them to live. Do we have the right to wonder why someone who needs a treatment that already exists – and has been researched for that very purpose – cannot get it? Can any of us deny others the right to live with dignity? Do they know the real burden that withholding those treatments places on a person who really needs them? Do they really know how much those innovative therapies are helping so many people, even though they are not giving them access to them? Are we all really equal in Europe, when in some countries there is high access, and in the ones right next door, there is no access at all?

Migraine may not kill us, but it affects the way we live, our friendships, relationships, family life, and careers.

Migraine lasts from 4 to 72 hours

if you don't take treatment, and it keeps us hidden at home until it is over.

One of the greatest challenges remains the stigma surrounding migraine. How can we change public perception and help people understand that migraine is not "just a headache," but a serious neurological disease?
We need to change a perception that has been established in society for centuries, and it's not easy or fast, but we're getting there. Women, who are the most affected due to our complex hormonal system, didn't work generations ago and could suffer in private at home with no visibility at all, but nowadays, women need to be at their best to advance in their careers, to be supported in their lives, and to get help with their migraine attacks, and more and more we will make it visible.

With migraine, there are different severities, and not everybody suffers it the same way. Those who are less affected need to understand that there are people much worse off, and those who don't suffer it need to understand that helping, supporting, and understanding the disorder will only improve productivity, wellbeing, and human relations. Everybody knows someone with migraine, and it goes from generation to generation, without us yet having the key to stop the inheritance.

We need to change the perception that migraine is "just a headache." It is a serious neurological disease that millions of people live with every day.

If you could make one change over the next five years that would have the greatest impact on the lives of people living with migraine across Europe, what would it be, and why?
If I had a magic wand, tomorrow everybody would wake up understanding what living with migraine really means. I would create a world in which people with migraine had the same rights and opportunities as everyone else, rather than being prevented from living a normal life by a disabling, hidden condition.

Society would be much better if this community of people affected by migraine could have less stigma and better access to treatments. ■

Migraine Is Not Just a Headache. It's a Neurological Disease We Still Underestimate.

POLAND HAS MADE MEANINGFUL PROGRESS IN EXPANDING ACCESS TO INNOVATIVE NEUROLOGICAL THERAPIES, YET MANY PATIENTS STILL REACH SPECIALISTS TOO LATE. IN THIS INTERVIEW, THE GENERAL MANAGER OF TEVA POLAND **EWA KRÓLIKOWSKA** EXPLAINS WHY THE FUTURE OF NEUROLOGICAL CARE DEPENDS NOT ONLY ON NEW MEDICINES, BUT ALSO ON EDUCATION, COORDINATED CARE, AND THE RESPONSIBLE USE OF ARTIFICIAL INTELLIGENCE.

Neuroscience is one of Teva's key therapeutic areas globally. How does Poland compare with other markets where Teva operates when it comes to introducing new neurological therapies?

One of Teva's strengths is the depth of experience we have built globally in neuroscience over several decades. From multiple sclerosis to migraine, movement disorders and severe mental illness, we have continuously expanded our understanding of neurological diseases and the needs of patients living with them.

Neuroscience remains one of Teva's strategic priorities globally, not only because of the significant unmet medical needs in this area, but also because advances in neurological care have the potential to transform patients' lives over the long term. Poland is an important market in this context, not only because of the significant healthcare needs and growing societal impact of neurological diseases, but also because of the meaningful progress that has been made in expanding patient access to innovative therapies in recent years in selected areas such as migraine. At the same time, the pace at which patients gain access to new treatments depends on a number of factors, including reimbursement processes, healthcare system capacity and the organisation of care.

Our ambition is to contribute not only by providing therapies, but also through an innovative approach to education, scientific exchange, and collaboration with healthcare professionals, patient organizations and policymakers helping to create conditions that enable patients to benefit from health technologies as early as possible.

Ewa Królikowska,

is General Manager of Teva Pharmaceuticals Poland. With more than 20 years of experience in the healthcare and pharmaceutical sectors, she is responsible for the company's operations, strategy execution and business growth in Poland. In addition to her leadership role at Teva, she is actively engaged in industry organizations, contributing to discussions on the future of healthcare and the pharmaceutical sector.

Migraine is much more than a headache. It is a serious, chronic neurological disease.

Which areas of neuroscience will be priorities for Teva in Poland in the coming years, and what determines these choices?

Our priorities in neuroscience are driven by where we believe innovation can make the greatest difference for patients. In Poland, migraine is a particularly important area because our experience suggests that it remains underdiagnosed and often underestimated despite its important impact on patients' personal, social and professional lives.

At the same time, neuroscience is much broader. Teva's focus includes multiple sclerosis (MS), movement disorders, severe mental illness including schizophrenia and neurodegenerative conditions. This reflects both the scale of neurological diseases and our long-standing commitment to supporting patients across different stages of life and care.

Looking ahead, neuroscience will become an increasingly important area for healthcare systems, society and companies committed to addressing unmet medical needs, reinforcing the need for timely diagnosis, effective treatment and ongoing patient support.

How is the role of a pharmaceutical company changing from a medicine provider to a partner supporting the entire patient care pathway?

The role of a pharmaceutical company has evolved significantly. Today, responsibility extends well beyond providing and distributing medicine. Increasingly, companies are partners of every local healthcare system and are expected to support the entire patient journey, from awareness and diagnosis to treatment, education and long-term disease management.

This approach is reflected in Teva's activities in Poland. In migraine, for example, we support educational initiatives addressed to patients, healthcare professionals and the broader public. We believe that access to knowledge is as important as access to treatment because timely recognition of symptoms often determines how quickly patients receive appropriate care and benefit from effective treatment.

At Teva, we view innovation broadly. It encompasses not only developing new therapies, but also supporting education, generating evidence, sharing knowledge, and helping improve patient experiences through the care journey. Ultimately, our goal is to help create a healthcare ecosystem that is more effective, more coordinated, and easier for patients to navigate.

From the perspective of a General Manager, which elements of the Polish healthcare system most affect the pace at which neurological patients gain access to new therapies?

Several factors play an important role here. Access to innovative therapies depends on reimbursement mechanisms, the efficiency of healthcare pathways and the healthcare system's capacity to respond to patients' needs, and the ability to translate scientific advances into everyday clinical practice.

However, access is not only about product availability or its reimbursement. It is also about whether patients are diagnosed early enough and whether they quickly reach the right specialist and treatment centres. In neurology, this can make a significant difference, as earlier diagnosis and earlier intervention often lead to better outcomes and improved quality of life. This is particularly true in conditions such as migraine, where effective treatment introduced early may help reduce the long-term burden of disease and improve patients' ability to remain active and productive, which benefits not only the individual patient, but also society and the healthcare system as a whole.

Another important aspect is the organisation of care. Neurological patients often need to navigate complex care pathways, and in some cases may encounter delays before reaching the appropriate specialist or treatment center. Continued efforts to strengthen coordination between primary care, outpatient specialist care and hospital-

based treatment may further improve access and make the patient journey more efficient.

Coordinated care and clearly defined patient pathways are becoming increasingly important. The more predictable and integrated the journey from symptoms to diagnosis and treatment becomes, the better the chances for patients to benefit from available therapeutic opportunities. Education targeted on increasing patients' awareness also plays an important role as it helps patients to navigate the healthcare system more effectively.

Are there European countries whose approaches to access to neurological therapies could serve as inspiration for Poland?

Every healthcare system operates in a different context, so I do not believe there is a single model that can simply be copied. However, there are certainly experiences from other European countries that can provide valuable insights and inspiration as Poland continues to strengthen neurological care.

Particularly valuable are solutions that strengthen early diagnosis, improve coordination of care, and create clearer patient pathways. Faster access to specialists, better collaboration between different levels of care, and more effective use of health data can all contribute to better outcomes for neurological patients. Across Europe, healthcare systems are exploring different approaches to providing earlier access to treatment and improving long-term patient outcomes. In migraine, for example, several European markets have expanded access beyond the most severe patient populations, creating opportunities to intervene earlier and potentially reduce the long-term burden of the disease.

Poland has made significant progress in expanding access to innovative neurological therapies in recent years, demonstrating a strong commitment to addressing unmet patient needs. The next stage of development may focus on further strengthening care pathways, early diagnosis and coordinated care. With ageing populations and a growing burden of neurological diseases across Europe, investing in effective neurological care is becoming increasingly important.

Migraine is still often underestimated despite being a serious neurological disease. What role should pharmaceutical companies play in changing this perception?

Migraine is much more than a headache, as commonly believed. It is a serious, chronic neurological disease that can significantly affect every aspect of a person's life, including professional and family responsibilities, as well as social interactions. Yet it is still frequently misunderstood and underestimated.

Pharmaceutical companies can support reliable education and help to challenge outdated stereotypes. Beyond developing innovative treatments, companies can help improve public understanding of neurological diseases through responsible education and awareness initiatives. By working with healthcare professionals, patient organizations and the wider community, we can help patients and their loved ones recognise symptoms earlier and encourage people living with migraine to seek professional medical care and start effective treatment.

At Teva, this commitment is reflected in our educational initiatives, including the *Nie mam do tego głowy. Idź z migreną do neurologa (I Don't Have the Headspace for This. See a Neurologist About Your Migraine)* campaign encouraging patients to seek specialist neurological care. We also recognize that awareness needs to extend beyond the healthcare system and into workplaces and society as a whole. Employers have an important role in creating understanding and reducing stigma around neurological diseases. People living with migraine can remain active,

The true measure of innovation is not the molecule alone, but the difference it makes in people's lives.

Access to innovative therapies begins with early diagnosis and a well-coordinated patient pathway.

productive and professionally successful when they receive timely diagnosis and effective treatment. Supporting people to remain active and engaged in work benefits not only individuals and their families, but the whole society. That is why building awareness matters.

Artificial intelligence is increasingly influencing the pharmaceutical sector. Where do you see the greatest potential of AI in neuroscience?

I see tremendous potential for AI in areas that help us better understand diseases, accelerate research and support more personalised patient care – and we are already exploring many of these opportunities in our daily work at Teva.

Importantly, neurological diseases are often complex, and digital tools can help generate insights that were previously difficult to obtain. AI has the potential to support earlier diagnosis, improve disease monitoring, and facilitate access to high-quality information. Moreover, I view AI not as a replacement for healthcare-related activities, but as a tool that can support faster and better decision-making with better outcomes for patients.

A practical example is Neuron, our AI-powered educational assistant available on migrena.pl. Neuron helps patients and healthcare professionals quickly access reliable information about migraine on a dedicated website and demonstrates how technology can support education and patient engagement in a responsible way.

How do you think neurological care and access to therapies will look in Poland in ten years' time?

I would like to see neurological care becoming more understood, coordinated, more accessible, and much faster in terms of diagnosis. With an ageing population, neurological conditions will inevitably become an even greater priority for healthcare systems. My hope is that patients will benefit from a clearly defined care pathway, early diagnosis, as well as faster and broader access to innovative treatments.

Companies such as Teva can contribute by developing innovative treatments, supporting education, and partnering across the healthcare ecosystem. We want to contribute not only through medicines, but also by supporting healthcare professionals, pharmacists, patients, caregivers, and policy-makers through education, collaboration, and responsible innovation. Ultimately, the true measure of innovation is not the molecule alone, but the difference it makes in people's lives.

If you could introduce one systemic, regulatory or organisational change that would most improve the situation of neurological patients in Poland, what would it be?

If I had to choose one priority, it would be the development of a coordinated neurological care model with a clearly defined patient pathway.

Patients should know where to seek help, healthcare professionals should have clear referral pathways, and different parts of the healthcare system should work together more seamlessly. Such an approach could help reduce delays in diagnosis and treatment, improve patient outcomes, and make better use of existing healthcare resources.

Importantly, this is not about replacing what already exists, but about strengthening the progress that has already been made. Stronger coordination would make the entire patient journey more predictable, more efficient, and ultimately more centred around patient needs.

If we can achieve that, more patients will receive the right diagnosis and treatment at the right time. That is something we should all strive for. ■

Neuroscience will become an increasingly important area for healthcare systems, society and companies.

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The Future of Public Health

CAN PUBLIC HEALTH BECOME A PILLAR OF NATIONAL SECURITY? PROFESSOR BOLESŁAW SAMOLIŃSKI ARGUES THAT WITHOUT A HEALTHY SOCIETY THERE CAN BE NEITHER A STRONG ECONOMY NOR EFFECTIVE NATIONAL DEFENCE. IN THIS INTERVIEW, HE EXPLAINS WHY THE FUTURE OF HEALTHCARE DEPENDS ON SCIENCE, PREVENTION, INTERDISCIPLINARY COLLABORATION, AND A PATIENT-CENTRED SYSTEM DESIGNED TO DELIVER BETTER HEALTH OUTCOMES.

Prof. Bolesław Samoliński, MD, PhD, in conversation with Rita Schultz

I would like to begin our conversation with a law called "Lex Szarlatan" (the "Anti-Quackery Act"). I believe the issue will remain relevant regardless of whether the bill is ultimately signed into law, because it is deeply disturbing how easily people can be misled today, despite the many tools available for verifying information. Do you believe that legislation of this kind offers a genuine opportunity to combat health misinformation and medical quackery?
There is an enormous amount of fake news in the public sphere today. That is one issue. The fact that it also concerns health and healthcare is another, and the problem has many dimensions.

First, the authority of doctors and of the medical profession as a whole has declined. Instead of consulting a doctor or nurse, patients turn to the internet, find various recommendations there and place greater trust in them than in a specialist – whom, incidentally, they may find it very difficult to see in the first place. This creates a communication barrier between patients and healthcare professionals. At the same time, the measures taken by the Ministry of Health to promote reliable medical information remain fairly limited. During the COVID-19 pandemic, answers to the most fundamental questions – whether there was an epidemic and whether vaccines were safe and effective – were available on the Ministry's website. Yet had I not been preparing a lecture for my students at the time, I would not have known they were there myself; even then, they were difficult to find. That is why I argued for reliable information to be made readily available in the public sphere, addressing the fundamental questions that cause patients uncertainty – in effect, for the creation of a kind of health Wikipedia. Without such a resource, we surrender the field to those who find it easier to reach internet users. Today, the average citizen also turns to artificial intelligence, which learns from the content that is most prominent and popular online. Inevitably, therefore, it encounters precisely those influencers who disseminate false information.

The second issue is that we are not educated in the spirit of evidence-based medicine. People are not taught that what matters is not merely the information itself, but also how it was produced, how reliable it is and whether it meets the standards of objectivity. Schools should teach pupils to approach information critically and to recognise legitimate authority. This would help curb the influence of such phenomena. In highly developed countries, including Poland, medical practice is governed by standards developed through scientific work and presented at international congresses. We know how complex and demanding the scientific process has become – from individual studies, through the synthesis and appraisal of evidence, to the final conclusions. It is impossible to explain that entire

process to the public on every occasion, so we communicate the conclusion. Yet if people are to believe us, we need an informed partner on the other side: a patient intellectually equipped to engage with a professional and prepared to respect that professional's authority. Such respect grows out of an understanding of how modern medicine and science are developed. This is why we teach research methodology to public health students. It gives them the foundation they need to distinguish fake news from scientific truth.

Today, medicine can achieve ten times more than it could twenty years ago, and we owe that progress to science. Those who fail to recognise this are susceptible to the polished rhetoric of charlatans – to someone more accessible and persuasive who promises that miraculous herbs can replace surgery. The result may be serious harm through omission: a patient abandons effective treatment because a charlatan has persuaded them to do so.

"Developing health-promoting policy and conducting the research essential to public health depend above all on bringing different professional communities together – doctors working alongside epidemiologists, analysts and other specialists. Today, only interdisciplinary teams are capable of generating genuinely new knowledge."

Prof. Bolesław Samoliński, MD, PhD

Without health security, there can be no military or energy security. Anyone who fails to understand this, acts to the detriment of the country's security as a whole.

What alarms me most is that, in recent years, political figures – who are regarded as authorities by certain sections of society – have tolerated anti-scientific attitudes and even actively promoted them. That demonstrates a lack of responsibility for the state and for the health of its people. Democracy, unfortunately, permits virtually every view to be voiced, and those who practise quackery exploit that freedom most readily. This is why we need the Anti-Quackery Act: to protect health security and give the authorities the tools to punish those whose actions bring tragedy upon others.

It is important to state the facts clearly. Poland has 160,000 doctors, of whom 120,000 are medical practitioners and the remainder dentists. Within this vast professional community, there have been isolated individuals – occasionally even persons holding professorial titles – who denied the existence of COVID-19 or adopted anti-vaccination positions, recommending enormous doses of ineffective medicines instead of vaccination. Yet COVID-19 subsided as vaccination coverage increased. The epidemiological relationship was evident worldwide: countries with vaccination rates above 90% brought the pandemic under control far more rapidly and effectively than those with rates below 60–70%, where the chain of transmission could not be broken. This is robust scientific evidence, and yet people continue to question it.

You mentioned that COVID-19 demonstrated how important public health is. Do you believe that health security should now be regarded as equally important as military and energy security?

Without health security, there can be no military or energy security, because both ultimately depend on people and therefore on their health. Anyone who fails to understand this and relegates health to a secondary concern acts to the detriment of the country's security as a whole. Even soldiers, who face the greatest risk of injury, are protected by a dedicated system comprising appropriate training, education and standards for rapid evacuation to facilities where they can receive treatment.

The Anti-Quackery Act is only one element of a much broader public health agenda. Public health provides the scientific basis for health policy, which in turn encompasses disease prevention, health promotion and health education. Promoting healthy behaviours from early childhood through to old age means, above all, encouraging a proper diet, avoiding harmful substances, including nicotine and alcohol, and maintaining an appropriate level of physical activity. These are the fundamentals and, if implemented effectively, they lead to longer lives. Yet the range of factors that shape health continues to expand, and public health must evolve in response to new climatic, chemical and technological developments, to name just a few. One example is the growing problem of social isolation, driven by reduced face-to-face interaction, retreat into the online world, susceptibility to fake news and the dominance of social media, all of which can contribute to various forms of harm, including mental health problems.

This is why there is a growing argument that children under the age of fifteen should not have access to mobile devices at school. Such devices disrupt concentration and the learning process, disengage children from classroom participation and make education less effective. We now have robust scientific evidence to support this. And this is precisely how public health operates: clinical observations reveal an emerging health problem, we identify the factors that contribute to it, and on that basis we develop the scientific rationale for intervention through health policy. This is how the case for restricting mobile devices in schools is built. I experienced this myself during one of my recent classes. At a certain point, I lost the attention of the entire group because everyone had started looking at their phones. I therefore prohibited the use of mobile devices during classes in our department unless the lecturer expressly permits it. The change in the atmosphere was striking: we were able to talk again, the students listened and they responded. These devices are so absorbing that no lecture can compete with what is happening on the screen.

Poland has **160,000 doctors,** of whom **120,000** are **medical practitioners** and the remainder dentists.

So is the way children concentrate itself changing?
Exactly. There are also other problems, such as damage to eyesight. In children, constant distraction can even change how the brain functions.

And what about the other end of the age spectrum, in light of the demographic changes affecting older people?
Today, more than 10 million people in Poland are over the age of 60, and nearly 2 million are over 80. What does this have to do with public health? Clinicians are sounding the alarm because they are struggling to cope with the growing number of patients, multimorbidity and the age-related progression of lifestyle diseases that ultimately lead to disability. Therefore, cardiologists, oncologists, gastroenterologists, and rheumatologists have joined the movement for prevention and health promotion, having realised that without these measures they will not be able to address the epidemiological changes in highly developed societies.

We can enter later life in good health, remaining professionally, physically, mentally and socially active, or we can experience the exact opposite: poor health, a life organised around medical appointments, moving from one consulting room to another, and withdrawing from all forms of activity. That is a path leading first to physical disability and then to social exclusion. Health security must therefore be understood as a lifelong educational endeavour that promotes healthy attitudes and behaviours, with benefits that extend into later life and affect entire families. Imagine one family in which the great-grandparents remain fully independent and another in which they are disabled. Family life will be entirely different in each case. In the first, the family benefits from the older generation's health and independence; in the second, the need to provide care becomes a major preoccupation, with consequences for the whole family.

Public health is therefore a foundation of national development, including in terms of financial security. An unhealthy society faces economic and fiscal strain: fewer people are able to work, while expenditure on healthcare rises. We can reverse this by strengthening national security through better population health. This would reduce spending on both healthcare and social support. Healthy people are also better able to contribute to economic development and to care for others, particularly when they are responsible for supporting people with disabilities.

We often hear that Poland has outstanding doctors, researchers and experts whose achievements are recognised internationally. This was one of the reasons behind the idea of launching our English-language quarterly, which we hope to distribute not only in Poland but also abroad. In your view, how can Polish medical research and innovative healthcare solutions be promoted effectively?
The first fundamental point is that without recognised authorities whose standing is built on committed, demanding research and the discovery of new knowledge, there would be no future generations of doctors, nurses, midwives or physiotherapists. Someone must possess that knowledge in order to pass it on. In accordance with the Bologna Process, academic education must be centred on individuals of genuine authority who actively contribute to the advancement of science. High-quality education, whether at university or postgraduate level, cannot be built without strong expert communities.

The second point is that anyone seeking to change the healthcare system and improve patients' health prospects must recognise that the debate about the future of healthcare is, in essence, a debate about how to optimise health outcomes for individual patients. This applies not only to the organisation of care, but also to technological progress and its contribution to patient safety. That is the heart of the matter. We need to create a system that brings medical, organisational and financial expertise together into a coherent whole, with the aim of improving patient safety, including protection from adverse consequences arising within the system itself. If a patient has to wait six months for care, their condition may deteriorate and their safety may be compromised. The way the system is organised therefore has a direct impact on patient health and safety.

Recently, I read a brief statement by Rector Małgorzata Gałązka-Sobotka, who said that we must first define what we want to achieve and only then amend the law. I agree with her entirely. I believe that the central priority in both public and expert debate must be the health outcome itself, with patient safety as one of its essential components. As doctors, when we see a patient with a particular condition, our primary aim is to improve that person's health while minimising the risk of adverse effects associated with treatment. Sometimes, when a complete cure is not possible, that improvement may instead consist in effective symptom management.

The difficulty with this debate, as with public health more broadly, is that it must bring together a wide range of professional communities: doctors, because there can be no public health without them; health educators and health promotion specialists; patient communities; as well as nurses, midwives, physiotherapists, dietitians, paramedics and many others. This is a major undertaking that requires broad participation, because I am acutely aware of the limits of medical competence. Those limits are reached when effective care requires input beyond the doctor alone, while still remaining part of the broader health response. This includes, for example, care for people with disabilities, restoring function in patients with musculoskeletal impairments through physiotherapy, and the involvement of specialists in phoniatrics, psychology and dietetics. As doctors, we work within a wider network of professionals whose combined expertise is essential to achieving the desired outcome – an improvement in the patient's health. This debate should take place within such a multidisciplinary forum.

In your view, what can realistically be achieved over the next ten years? What should be the priority if healthcare in Poland is to improve in a meaningful way?

I believe the first priority must be to reform the way healthcare services are financed by building an integrated care model centred on health outcomes – and it is those outcomes that should be rewarded. Integrated care means a pre-planned pathway based on coordinated cooperation between all the professionals needed to improve a particular patient's health. A planned pathway must follow established standards and ensure that it is not the patient who has to search for help and find the right specialist, but the system that directs the patient to the healthcare professionals they need. In such a model, one issue is how care is organised; another is how providers are paid. The care team should be paid not for carrying out procedures, but for improving the patient's health. This is the way to shorten waiting times, improve the efficiency of care and optimise costs. Delaying diagnosis or treatment is not financially efficient, nor is fragmented care, because it fails to produce the health outcomes for which the National Health Fund should pay. This is a complex issue that requires a rigorous analytical and expert approach. Changes of this kind must not be introduced wholesale across every area at once, as that would create disorder. We should begin with the most common conditions and then extend the model gradually. What is needed is evolution, not revolution.

In terms of healthcare financing, expenditure in Poland is already relatively high. Naturally, there is never enough money, so the claim that the system is underfunded will always be relevant. Nevertheless, we must define the limits of what the public payer should cover. We also need to invest in modern technologies, assessed in terms of their cost-effectiveness. One unresolved issue in Poland is whether patients should be allowed to pay an additional amount towards a procedure – for example, to receive a higher-quality implant made from a better material than the standard option funded by the National Health Fund. I believe that such co-payment should be possible within an integrated care system.

The care team should be paid not for carrying out procedures, but for improving the patient's health. What is needed is evolution, not revolution.

There are many other issues concerning the operation of hospitals, on which I am less qualified to comment because they require the perspective of someone working as a clinician on a daily basis. One fundamental change, however, is clear: Poland must improve access to care outside the hospital setting. Diagnostic hospitalisation should not exist at all. It should be replaced by streamlined outpatient diagnostics that are not spread over an extended period. At present, a patient may receive referrals for ten different tests and then be left to arrange them one by one. That is not integrated care. Integrated care means that once a patient enters the system and a doctor orders the necessary tests, those tests are scheduled automatically and carried out as quickly as possible, ideally on the same day, so that by the end of that day the patient has both a diagnosis and a proposed treatment plan. This would generate real savings and represent genuine optimisation. Contrary to appearances, we cannot afford any other approach. It would reduce the need for repeated appointments, lower expenditure on disability benefits and sickness absence, limit the decline in workforce participation, and ease the burden on families. In other words, it would reduce the indirect costs of illness, many of which fall outside the healthcare system itself.

The healthcare system today is not patient-centred. It is designed around controlling and financing services, administering public expenditure within the legal framework, and ensuring that providers account for funds correctly. The patient is simply absent from this model. Our system has no mechanism for assessing health outcomes – that is, whether the patient's condition has actually improved.

Thank you very much, Professor. I hope the system will finally become genuinely patient-centred. ■

You Can't Put a Price on Health with an Algorithm

RITA SCHULTZ INTERVIEWS **MAREK MIGDAŁ,** DIRECTOR OF THE CHILDREN'S MEMORIAL HEALTH INSTITUTE.

How would you assess the health of children and adolescents in Poland? Which health risks are currently growing most rapidly?

As the Children's Memorial Health Institute, we stand at the top of the healthcare pyramid, so growing problems are particularly visible to us, especially those affecting the mental health of children and adolescents. This was one of the reasons we decided to establish a comprehensive child and adolescent psychiatry service at the Institute, comprising an outpatient clinic, a day ward for 30 patients and a 30-bed inpatient ward. The service began operating in January 2025. Almost from the outset, it became clear that this was not enough: at times, we had to add as many as 40 extra beds, meaning 70 patients in a space not designed to accommodate them. We provide round-the-clock emergency cover separately for children under 14 and for adolescents aged 14 to 18, and ambulance crews or the police often

Marek Migdał, MD, PhD,

paediatrician and respiratory medicine specialist, has been Director of the Children's Memorial Health Institute since 2018 and has worked at the Institute since 1979, initially in the Department of Paediatrics and, from 1986, in the Intensive Care Unit. He is the author of more than 230 publications and has coordinated five European grants at the Institute. Since 2007, he has been a member of the Paediatric Committee of the European Medicines Agency and of the boards of the European Children's Hospitals Organisation and the Children's Hospitals International Executive Forum. In 2025, he was appointed by the European Commission as a member of the Hospital Managers Advisory Group.

bring us minors requiring immediate hospitalisation, sometimes straight from the street. Despite the launch of the reform of child and adolescent psychiatry and various media campaigns, including those funded by the TVN Foundation, this is still not enough. It shows that the way services are planned does not reflect actual needs.

Another problem is the growing number of children who are overweight or living with obesity and who need support from a multidisciplinary team comprising a paediatrician, gastroenterologist, dietitian, physiotherapist and psychologist. Obesity is closely linked to mental health problems. Children who are bullied at school can become trapped in a vicious circle in which psychological problems and compulsive eating reinforce one another. This is also linked to the harmful effects of digital device use among children as young as a few years old, which can displace normal relationships with peers and family. Complex mental health problems, together with overweight and obesity leading to lifestyle-related diseases, are the two main threats. If we do not ensure children develop properly now, in twenty or thirty years we will have a generation of unhealthy adults.

How would you assess public confidence in vaccination and medical advice in Poland? How does this affect public health?

In today's world, it is impossible to protect population health without vaccination. Some of the excess deaths during the COVID-19 pandemic undoubtedly occurred among unvaccinated people. Vaccines are medicines that are tested and authorised for use under strictly defined procedures, including clinical trials, overseen in Europe by the European Medicines Agency. Their benefits must always outweigh their risks, both for individuals and for the population as a whole. Anti-vaccination movements are part of a broader trend towards methods presented as alternatives to medicine despite lacking scientific evidence. The medical profession should take a clear stand against this, which is why there is an ongoing debate about legislation such as "Lex Szarlatan" (the "Anti-Quackery" bill), aimed at those who knowingly mislead people who lack the expertise to distinguish fact from falsehood.

Are we spending enough on disease prevention, or do we still focus mainly on treatment?

Funding highly specialised medicine often delivers very good outcomes. In areas such as rare diseases and transplantation, well-targeted investment can significantly improve patients' health or give them a chance of survival. Paediatric oncology differs from adult oncology in that children have a much greater chance of being completely cured – at present, this is the case for 82–85% of patients. Five years after completing treatment, such a patient can be regarded as cancer-free for the rest of their life.

If we do not ensure children develop properly now, in twenty or thirty years we will have a generation of unhealthy adults.

We now know of around

8,000 rare diseases.

Neonatology offers another example: if we save a newborn without long-term sequelae, we are investing in a person who will go on to pay taxes for the next forty years. Paediatrics is an excellent illustration of how investment in highly specialised medicine benefits society as a whole. Of course, equally important are all the preventive measures that these centres can initiate and implement.

Is the oncology department of the Children's Memorial Health Institute organised into organ-specific specialities?

At the Institute, we treat solid tumours rather than haematological malignancies, as paediatric haemato-oncology centres in Poland have divided these areas of care among themselves. We treat cancers of the central nervous system, kidneys, liver and other organs, working closely with surgical departments and diagnostic units. Modern paediatric oncology requires collaboration among many specialists, the use of advanced diagnostic techniques – including imaging, histological and genetic methods – and close cooperation across clinical teams. One example is liver transplantation for selected liver cancers, which in Poland is available to children only at our centre.

What needs to change in how the healthcare system is organised so that children can see the right specialist sooner?

Cardiology and oncology offer useful examples of how coordinated care can be organised. A coordinator helps the patient move through all stages of treatment within the same healthcare provider, in line with an agreed diagnostic and treatment plan. Many years ago, Poland had a well-functioning system of integrated healthcare institutions, in which paediatric departments worked closely with family doctors. The doctors attended regular training provided by these departments and could also consult more difficult cases with department heads. Today, care provided close to home is often disconnected from highly specialised care. Some drug programmes are attempting to recreate this model: once patients have been enrolled in a programme, their ongoing care is provided as close to home as possible, with periodic follow-up at a specialist reference centre. In practice, however, highly specialised care is still often disconnected from primary healthcare.

So the system is not ready for the growing number of children with chronic conditions?

Poland's demographic situation continues to deteriorate, with the number of births falling to around 230,000 a year. At the same time, advances in medicine mean that increasing numbers of children are being diagnosed with rare metabolic and neurological disorders. A good example is the introduction of newborn screening for spinal muscular atrophy (SMA), which now makes it possible to use gene therapy before clinical symptoms appear. The treatment costs more than PLN 9 million per dose, but offers a very high chance of halting disease progression. The proportion of children requiring long-term treatment for rare diseases will continue to grow, which will require a substantial increase in funding.

One area of paediatrics that requires more investment is advanced genetic diagnostics. We now know of around 8,000 rare diseases. Even at the world's leading centres, after five or six years of diagnostic work-up, up to 40% of patients may still remain undiagnosed; there is a dedicated ORPHA code for this group. Fewer and fewer children are being born, but those who are born require ever greater investment in diagnosis and treatment.

Is there a shortage of paediatricians and paediatric nurses in Poland? What are the main consequences of these shortages today?

The medical workforce is distributed fairly unevenly across Poland. In August 2026, our Institute employed 483 doctors and was training nearly 280 doctors in different specialties. Of these, 75 were training in paediatrics. The average number of doctors per 1,000 people in Poland does not differ significantly from the European average. The disparities concern particular specialties and the uneven distribution of doctors across regions. Young doctors often choose specialties other than paediatrics and are more likely to remain in large academic centres, despite being offered less favourable financial terms than hospitals in more remote locations, which may offer salaries several times higher because their need for staff is greater.

Nursing education has changed since Poland joined the European Union: nurses now need at least a bachelor's degree, and growing numbers also choose to complete a master's degree. Our Institute employs 830 nurses. Unlike doctors, who begin specialist training immediately after their internship, nurses must first gain around five years of professional experience before they can start specialist training. There are ongoing discussions about extending this training to three years. Completing a degree and obtaining a specialist qualification also brings higher pay. We have been gradually lowering the average age of our nursing workforce, which this year stands at 41 in our hospital.

How can we retain young doctors and nurses in the public healthcare system?

Attracting doctors starts much earlier than residency. We teach paediatrics to students from their third year onwards, have active student societies and encourage fifth- and sixth-year students to get involved in research with us. Many of our residents also work towards a PhD while completing their specialist training, so they finish well prepared for independent practice. Money is not always the deciding factor. We are at the forefront of innovation and introduce new diagnostic and treatment methods. Our mentoring programme is also crucial: the involvement of department heads makes young doctors want to stay and work here afterwards.

How are new technologies and artificial intelligence changing care for young patients? Could telemedicine become standard practice in paediatrics too?

Telemedicine has enormous potential, particularly for monitoring patients with chronic conditions, including rare diseases. We are the only centre in Poland performing both liver and kidney transplants in patients under 18 years of age. These patients live across Poland and require, among other things, regular monitoring of immunosuppressive drug levels. For the past two years, we have been using a new analytical method that allows two drops of blood, collected on dry filter paper at the patient's home, to be sent to us by post. The test result is then sent to the patient's family or their local doctor, without the need to travel to our outpatient clinic. We similarly monitor the function of implanted pacemakers and cardioverter-defibrillators remotely.

The use of artificial intelligence in paediatrics differs from its use in adult medicine. In adult diagnostic imaging, radiologists now use AI support in 90% of examinations to flag potential abnormalities, although the final assessment is always made by a doctor.

In paediatrics, the volume of data available to these systems is still insufficient because of the diversity


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Fewer and fewer children are being born, but those who are born require ever greater investment in diagnosis and treatment.

of conditions and overlapping stages of development, for example in the brain. This is likely to change over time as more data become available, but a doctor will always be needed for the final assessment. The number of wearable devices collecting data that could provide a fuller picture of the patient is also growing, but there is still debate over which of them generate reliable medical data within the meaning of the new EU regulation on medical devices. We need to remain cautious. A pulse oximeter, for example, will continue to generate a signal if the sensor shifts, but that signal may no longer reflect the patient's actual blood oxygen saturation.

If you could introduce three key reforms to the Polish healthcare system, what would they be?

First, a completely different funding model for highly specialised medicine is needed. Under the diagnosis-related group system, highly specialised paediatric care is often not reimbursed at an appropriate level because too few patients are treated in exactly the same way to form a sufficiently large reference group.

Second, there should be a clear separation between public and private healthcare, as in other European countries. When public resources are limited, public providers should be funded first, as they must accept every patient regardless of existing risk factors, such as comorbidities. Today, many non-public providers carry out simple procedures funded by the public payer while selecting only patients without risk factors and referring them to public hospitals if complications arise.

Third, the algorithm used to allocate National Health Fund resources should take account of patients travelling outside their home regions to highly specialised centres. Over the past two years, disparities between regional NHF branches in their capacity to fund healthcare services have become an increasing problem. The principle we have been discussing for more than thirty years – that funding should follow the patient – is simply not working. Last but not least, it would be worth linking funding to treatment outcomes.

What is the biggest challenge you face today as the director of one of Poland's largest and most highly specialised paediatric centres?

We are an exclusively paediatric hospital, and since 2021 paediatric services have, by law, not been subject to volume limits. Unfortunately, for more than a year we have faced a growing problem with restrictions on funding contract amendments. As a result, a substantial share of services already provided is classified as so-called excess activity, leading to delays of several months in payment for these services, including those provided in situations involving an immediate threat to health or life. There is a lot of talk today about excessive or unethical remuneration in healthcare, but this is a pathology affecting a small group of doctors or institutions, not the system as a whole. It cannot be used to justify underfunding healthcare for patients who genuinely need help. The algorithm used to allocate funding should reflect actual health needs. We provide the service immediately, but can only issue the invoice many months later. It is as if a garage repaired your car and then was told: "We'll pay you – someday." ■

The Future of Medicine Lies in Value, Data and Collaboration

POLAND HAS WORLD-CLASS DOCTORS, SCIENTISTS AND INNOVATORS, YET IT IS STILL NOT MAKING FULL USE OF THIS POTENTIAL.

Rita Schultz speaks to Małgorzata Gałązka-Sobotka, PhD, Rector of Lazarski University, about why the future of healthcare lies in value-based systems, how artificial intelligence will transform medicine, and why health should be regarded as an asset that underpins socio-economic development.

Poland has outstanding doctors, scientists and experts whose achievements are gaining increasing international recognition. What needs to be done to raise the global profile of Polish medicine and Polish innovation even further?

Poland has no shortage of talent. We have excellent doctors, scientists, engineers and clinical teams. Yet we still too rarely manage to turn individual achievements into a strong and lasting international reputation for Polish medicine.

Above all, we need stronger ecosystems that bring together research, clinical practice, industry, technology, regulators and patient organisations. Participation in international consortia should be seen not only as a way of securing funding, but also as a means of building reputation and gaining access to data, infrastructure and partners. The European Reference Networks are a good example, bringing together more than 1,600 specialised centres across the 27 EU Member States and Norway.

The second requirement is more effective translation of knowledge: moving from publication or patent to implementation, scaling and market entry. A scientific idea alone is not enough. We need a professional pathway from the laboratory to the patient.

We also need to communicate Polish achievements more effectively by demonstrating their clinical and system value. International recognition is built not through the volume of publicity, but through evidence that a solution has improved treatment outcomes, patient safety or system efficiency.

Polish medicine will gain greater international visibility when we begin to build lasting, interdisciplinary and international networks around its strongest achievements.

Małgorzata Gałązka-Sobotka, PhD,
is Rector of Lazarski University, an economist and an expert in public health, leadership and healthcare organisation. Since 2015, she has served as Vice-Chair of the National Health Fund Council. She is also Director of the MBA in Healthcare programme and the initiator of the Sector Skills Council for Healthcare. She has written numerous academic publications, promotes the concept of Value-Based Healthcare and is actively involved in reforming and developing Poland's healthcare system.

The European Reference Networks are a good example, bringing together more than

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across the 27 EU Member States and Norway.

Our contribution to building this innovation ecosystem is the MBA Healthcare Innovation & Technology programme. Developed with the support of a Medical Research Agency grant, it has shown how strong the demand is for management expertise capable of bringing researchers and business together around the development and commercialisation of innovation.

Artificial intelligence, digitalisation and data analytics are transforming the way diseases are diagnosed and treated, as well as how healthcare is managed. Which technologies do you believe will have the greatest impact on medicine over the next decade?

The greatest change will come not from any single technology, but from integrating multiple technologies to make better use of patient data.

Artificial intelligence will support diagnostic imaging, histopathology, medical record analysis, risk prediction and clinical decision-making. Its greatest value will lie not in replacing doctors, but in reducing analysis time, improving diagnostic accuracy and freeing up healthcare professionals to spend more time with patients.

The second major breakthrough will be personalised medicine, combining clinical, genomic, imaging and environmental data. We will increasingly move away from a one-size-fits-all model towards treatment tailored to the biology of the disease and the individual patient's profile.

Health is not a cost. It is a key driver of social and economic development.

The European Health Data Space will also play a major role. It has the potential to improve interoperability, the quality of research, the development of AI and countries' ability to make data-driven decisions. At the same time, we will see further advances in telemonitoring, wearable devices, home-based care and virtual human twin technology.

As an economist, however, I always stress that technology alone does not create health value. That value emerges when it improves treatment outcomes, safety, access or the patient experience relative to cost. This is why we now need systematic evaluation of innovative models of care from clinical, social, ethical and economic perspectives. Only robust scientific evidence will allow us to adopt solutions that deliver tangible health gains. We do not want to remain passive observers in this field; we want to be active participants. The Lazarski Health Technology Evidence Lab, which has just launched, will support technology providers in evaluating their solutions in real-world healthcare settings and assessing their clinical and economic value.

In your publications, you often emphasise that health is not a cost but an investment. How can we persuade policy-makers and the public to see health as a strategic national asset?

First, we need to change the language we use to talk about health. Today, the focus is largely on tackling diseases whose treatment comes at enormous cost. If we frame health solely as expenditure, there will always be pressure to cut costs. Yet health is a key driver of social and economic development. A healthy society means greater labour market participation, higher productivity, lower absenteeism and less spending

on disability benefits and care. Poland continues to pay a high price for the limited effectiveness of prevention and interventions designed to restore health. Life expectancy remains below the OECD average, while avoidable mortality rates are markedly higher.

These are health indicators, but economic ones as well. They represent lost years of life, work and social participation. That is why we should measure the return on investment in health: hospital admissions avoided, earlier diagnoses, additional years lived in good health and reductions in social costs.

Health should be treated as both an individual and a public good – an asset whose value can be built up or eroded.

Society needs a stronger sense of personal responsibility for health, supported by health education at every stage of life. However, research on the determinants of health clearly shows that looking after health cannot be treated solely as an individual responsibility. A modern state should use public policy to support healthy choices and create conditions that make prevention easier and more natural. The principle of "Health in All Policies" must therefore be more than a catchy slogan; it must translate into health-promoting living conditions across education, culture and sport, agriculture, infrastructure, food policy and fiscal policy.

If you could point to one decision or reform that would do most to improve the quality of healthcare in Poland, what would it be and why?

If I had to choose one reform, it would be to replace payment for procedures with a model that rewards health outcomes and assigns clear responsibility for patients' health across the entire care pathway.

Today, the health insurance system does not link an individual's risk of developing a disease or complications either to the contribution they pay or to the revenue healthcare providers receive from the National Health Fund. In general, we pay for individual services: appointments, tests, hospital stays or procedures. We provide far weaker incentives for active engagement in prevention, good treatment outcomes, coordination, avoiding complications, improvements in quality of life and a better patient experience.

This fragments care. Patients neglect their preventive responsibilities and, when they become ill, enter a system whose financing model is not designed to respond quickly, minimise the risk of their condition worsening or manage disease effectively in the most cost-efficient way. The pathway from primary healthcare through specialist care and diagnostics to hospital is long and complex, while accountability for the overall process remains dispersed. Each provider delivers its part of care, but no one is clearly accountable for the final outcome. We are spending more and more on health, yet the return on that investment falls far short of expectations.

We therefore need a model that rewards not only what has been done, but also what has been achieved. Value-Based Healthcare, which is being developed around the world, offers an alternative: it aligns everyone in the system around a shared focus on health gains, making health outcomes the primary objective rather than treating financial balance and cost minimisation as ends in themselves. This requires redesigning the insurance system to include incentives for health-promoting behaviour, as well as a framework for evaluating and monitoring treatment outcomes based on clinical standards and integrated medical and economic data. We need a system built on a new paradigm for measuring outcomes and payment models that reward quality.

The most important change, then, would be to replace the question, "How many procedures have we performed, and what kind?" with: "What difference have the procedures we performed and the costs we incurred made to the patient's health, both in the short and long term?"

The most important change would be to replace the question, "How many procedures have we performed, and what kind?" with: "What difference have the procedures we performed and the costs we incurred made to the patient's health?"

A good leader does not need to know the answer to every question. They need to create the conditions in which the right people can work together to find the best solution.

Modern healthcare can only advance through cooperation between doctors, researchers, public administration, industry and patient organisations. How would you assess the current level of cooperation in Poland, and what should be done to harness the combined potential of all those involved in the system more effectively?

In my view, cooperation between the key participants in Poland's healthcare system is gradually improving, but it is still driven more by individual projects than by systemic solutions. We are seeing more joint initiatives involving public administration, the medical and research communities, industry and patient organisations, particularly in innovation, clinical research and coordinated care. One example is the Warsaw Health Innovation Hub, launched by the Medical Research Agency. However, we still lack durable mechanisms for managing cooperation and ensuring shared accountability for health outcomes.

From a Value-Based Healthcare perspective, we need to move away from thinking in terms of individual institutions and instead view the entire care pathway as a shared process of creating health value – a process that always depends on the combined efforts of multiple stakeholders. The greatest challenge today is the lack of solutions that clearly define the roles of individual partners. We also need ways to assess whether they actually deliver the value they promise for patients and for the system as a whole. We still measure mainly activity and procedures, whereas VBHC requires us to measure health outcomes, patient experience and the efficient use of resources.

Our approach to public–private partnerships also needs to change. In Poland, they are still too often viewed through the lens of party-political divisions rather than judged by the value they bring to public health. We need to challenge the deeply rooted belief that any cooperation between the research community and industry is a form of lobbying. Lobbying, understood as representing the interests of a particular group, must be clearly distinguished from joint advocacy for public health and the co-creation of solutions that address society's genuine health needs. In countries developing the VBHC model, dialogue between regulators, healthcare providers, the research community, industry and patient organisations is regarded as essential to creating innovative and effective health policies. The answer is not to restrict cooperation, but to ensure transparency, clarity of purpose and accountability for results.

The ability to build such "coalitions around health" will be one of the most important conditions for the successful transformation of Poland's healthcare system in the years ahead.

You have been educating healthcare leaders for many years. What skills does a modern leader need to manage the healthcare system effectively at a time of such rapid change?

Modern healthcare leaders must recognise that they are not simply managing an organisation, but an entire web of interdependencies. Every clinical, financial, workforce or technological decision has consequences elsewhere in the system.

The first essential skill is systems thinking: the ability to see the entire patient pathway and the connections between primary healthcare, specialist outpatient care, hospitals, pharmacy services, social care and long-term care, wherever the patient enters the system.

The second is the ability to work with data and evidence. Leaders should ask themselves what problem they are trying to solve, what data their decision is based on and how they will measure its impact.

The third is an understanding of economics and value. Limited resources are a permanent feature of every system, so leaders must be able to assess opportunity costs, efficiency and the consequences of allocating resources in a particular way.

A modern leader must also be able to build trust, foster interprofessional collaboration, and remain open to learning and change. Ethics and accountability also matter, because management decisions in healthcare always affect access to care, patient safety and working conditions.

A good leader does not need to know the answer to every question. They need to create the conditions in which the right people can work together to find the best solution.

If you were to describe healthcare in Poland in 2035, what would you want it to look like? What values, solutions and priorities should define it?

By 2035, I would like Polish healthcare to have moved beyond a system focused primarily on responding to illness and become one that actively manages population health through integrated, cross-sector public policy.

It should be one of the strengths of a state that treats health capital as a foundation of social and economic development. Its defining features should be prevention, early detection and the reduction of health inequalities. It must also be value-based, focusing on treatment outcomes, quality of life and accountability across the entire patient pathway rather than on isolated interventions.

The system should be digital, but not dehumanised. Data should follow the patient, while technologies such as AI, telemonitoring and interoperable health records should help doctors manage health more effectively while strengthening, rather than weakening, their relationships with patients.

We also need greater geographical equity, a new distribution of responsibilities across healthcare professions, and Poland's active participation in the European ecosystem of research, data and innovation.

The most important values should be accountability, solidarity, transparency, quality and trust. Patients should not be confronted with the system's organisational boundaries. They should be confident that they will reach the right place at the right time and receive care from the right team.

It should not be a system that simply delivers more services or has more resources at its disposal. Above all, it should be capable of generating greater health capital. ■

System Resilience Is Built Before a Crisis, Not During One

AN AGEING POPULATION, THE RISING COST OF CHRONIC DISEASES AND WORKFORCE SHORTAGES ARE FORCING POLAND TO RETHINK ITS HEALTHCARE SYSTEM.

Rita Schultz speaks with Radosław Sierpiński, MD, PhD, University Professor at Cardinal Stefan Wyszyński University (UKSW), Dean of the Faculty of Health Sciences and co-founder of the Medical Research Agency, about why health expenditure should be seen as an investment, how artificial intelligence will transform diagnostics and why coordinated patient care should become the top priority.

In recent years, there has been growing recognition that healthcare spending is not merely a cost but an investment in economic development and national security. How can policy-makers and the public be persuaded to adopt this way of thinking?

We need to start measuring health not only by the number of services delivered, but also by its impact on the economy, the labour market, productivity and social security. A healthy population remains economically active for longer, is less reliant on social benefits and is more resilient to crises. Every effective investment in prevention, early diagnosis or appropriate treatment reduces the future costs of absenteeism, disability and lost productivity. We also need to change the language of public debate. We should ask not only how much the system costs, but also what health, social and economic value we obtain from the resources invested. This approach requires transparent data, the measurement of treatment outcomes and the consistent implementation of Value-Based Healthcare principles, or even a Value-Based Policy.

Poland's healthcare system is undergoing rapid change. Which developments do you consider most important over the next ten years, and which challenges will be critical to its future development?

The greatest challenge will be adapting the system to an ageing population, the rising burden of chronic disease and increasingly severe workforce shortages. Simply increasing the volume of services will not be enough. We need to change how care is organised, moving from the treatment of isolated episodes to the long-term management of patients' health. Key priorities will include expanding coordinated care, strengthening primary healthcare, improving integration between the healthcare and social care sectors, and transferring some services from hospitals to outpatient and home-based care. A second fundamental priority is digitalisation. Without open data, quality measurement and the use of modern technologies, we will not be able to manage either patients' needs or the system's limited resources effectively.

Artificial intelligence, digitalisation, data analytics and personalised medicine are transforming how patients are diagnosed and treated. Which of these technologies do you believe will have the greatest impact on the development of medicine and the organisation of healthcare over the coming decade?

In my view, the greatest change will come from combining artificial intelligence with high-quality medical data. Technology, however, is not an end in itself. It creates real

Radosław Sierpiński, MD, PhD, Professor at Cardinal Stefan Wyszyński University

A medical doctor and healthcare executive specialising in healthcare management, clinical research, health technology assessment (HTA), and medical devices. He is Dean of the Faculty of Health Sciences at Cardinal Stefan Wyszyński University (UKSW) and a public health specialist. Over the past seven years, he has worked in the public sector, where he was responsible for establishing and overseeing the Medical Research Agency. He led the development of grant programmes for the biomedical sector worth more than €1 billion. He also contributed to the Clinical Trials Act and the Government Programme for the Development of the Biomedical Sector. Previously, as an adviser to the Minister of Health, he focused on innovative medical technologies and the digitisation of the healthcare system. Radosław Sierpiński completed his doctorate at the National Institute of Cardiology in Warsaw and received his habilitation at Wrocław Medical University on the basis of his research achievements. His current research interests include modern technologies in medicine, health inequalities, and health policy.

value only when it helps clinicians make faster diagnoses, predict risk, select the right treatment or relieve staff of repetitive administrative tasks. I see particularly strong potential in clinical decision support systems, medical image analysis, chronic disease risk prediction and the automation of organisational processes. Personalised medicine, meanwhile, will enable therapies to be tailored ever more precisely to each patient's biological and clinical profile. Success will nevertheless depend on data security, clear accountability for decisions and preserving the human relationship, which technology should never replace.

What is your assessment of the potential of Poland's research and medical sectors? What needs to be done to make Polish research, innovation and clinical achievements more competitive and more widely recognised internationally?

Poland has excellent researchers, strong clinical centres, a large patient population and a growing biotechnology

By 2035,

I would like healthcare in Poland to be predictable, coordinated and focused on delivering value for patients

We should ask not only how much the system costs, but also what health, social and economic value we obtain from the resources invested.

and technology sector. The problem is not a lack of ideas, but too often discontinuous funding, weak project management and ineffective commercialisation of research findings. Based on my experience of establishing the Medical Research Agency and developing funding programmes for the biomedical sector, I know that well-designed public instruments can unlock the enormous potential of the research community. However, we need to concentrate more resources on high-quality projects, develop professional clinical research centres, strengthen support for intellectual property protection and full-lifecycle international research consortia, rather than partnerships formed only at the publication stage.

Modern medicine can only advance through close cooperation between universities, research centres, hospitals, public administration, industry and patient organisations. How would you characterise the current level of cooperation in Poland, and where do you see the greatest potential for building lasting partnerships?

Healthcare cooperation in Poland is growing, but it is still too often confined to individual projects and short-term initiatives. Different communities come together at conferences or through grant programmes and consultations, yet we still lack permanent platforms where they can jointly identify problems, develop and test solutions, and then implement them on a larger scale. I see the greatest potential in partnerships focused on clinical research, digital health, prevention, coordinated care and data analytics. Universities can contribute independence, methodological rigour and research expertise. The business sector can provide the capacity to implement solutions and scale them up. Public administration can create the right system-level conditions, while patient organisations can contribute first-hand knowledge of patients' real needs. This is the model of cooperation we want to use in developing the Faculty of Health Sciences at UKSW.

As Dean of the Faculty of Health Sciences, you are responsible for educating the healthcare workforce of the future. Which professional, digital and organisational skills will be most important for graduates of medical and health-related programmes in the coming years?

Tomorrow's graduates must have strong professional expertise, but they also need to understand the entire patient care pathway. They should be able to work in interdisciplinary teams, communicate effectively with patients, analyse data, use digital tools and assess the quality and effectiveness of their work. Skills related to artificial intelligence, change management, data security, health communication, and the organisation of care will become increasingly important. We need not only professionals who can perform procedures, but also leaders who can improve processes and introduce innovation responsibly. At the same time, ethics, empathy and responsibility towards the patient must remain central to how we educate future healthcare professionals.

Prevention, public health and personal responsibility for health are receiving increasing attention. How can we make preventive care a natural part of everyday life in Poland and a genuine priority of health policy?
Prevention cannot be reduced to a one-off campaign held once a year. It should be embedded in primary healthcare, workplaces, schools, local communities and people's everyday surroundings. Patients need clear, practical information about their individual risks, the tests they should undergo and the specific steps they can take. We should also make better use of data and digital technologies to invite patients proactively for screening and to remind them of recommended actions. Personal responsibility for health, however, must not mean shifting the entire burden onto the individual. The state should create conditions that make healthy choices easier and reduce the inequalities that still make access to prevention dependent on where people live, their level of education or their financial circumstances.

Health security has become one of the pillars of national security. What role should medical universities and the research community play in making the healthcare system more resilient to future crises and threats?
Universities should serve as independent sources of analysis and expertise for the state. Their role is not only to educate future professionals, but also to analyse risks, develop crisis scenarios, assess system resilience and provide policy-makers with reliable data. We need to prepare professionals to respond effectively in emergencies, while strengthening epidemiology, disaster medicine, cybersecurity and research into pharmaceutical and medical device supply chains. System resilience is built before a crisis, not during one. This requires sustained cooperation between the research community, public administration, the military, industry and healthcare providers.

Funding should reward quality, continuity of care and health outcomes, rather than simply the number of procedures performed.

We need not only professionals who can perform procedures, but also leaders who can improve processes and introduce innovation responsibly.

If you could introduce one change that would have the greatest impact on the quality, efficiency, and accessibility of healthcare in Poland, what would your priority be, and why?
I would introduce a universal model of coordinated care built on accountability for patient outcomes. Today, the system remains fragmented across many services and institutions, leaving patients to navigate it largely on their own. Every patient, particularly those living with a chronic condition, should have a clearly defined diagnostic and treatment pathway, a designated coordinator, and access to information about each successive stage of care. Funding should reward quality, continuity of care and health outcomes, rather than simply the number of procedures performed. This would improve the patient experience, reduce unnecessary duplication of tests and make better use of the available healthcare workforce.

Finally, what would you like healthcare in Poland to look like in 2035? Which values, solutions and priorities should define a modern healthcare system for the future?
By 2035, I would like healthcare in Poland to be predictable, coordinated and focused on delivering value for patients. It should be a system that acts before disease reaches an advanced stage, actively identifying risk, supporting prevention and guiding patients throughout their treatment journey. It should harness data and artificial intelligence while remaining profoundly human-centred. Modernisation must not come at the expense of human relationships, trust or accountability. Its defining values should be safety, quality, accessibility, solidarity and equal opportunities for better health. Poland's ambition should be not merely to keep pace with change, but to help shape European standards in medicine, research and the organisation of care. ■

Prevention Must Be Seen as an Investment, Not a Cost to the Healthcare System

PAWEŁ ŁANGOWSKI, DIRECTOR OF PUBLIC AFFAIRS AT MEDICOVER AND BOARD MEMBER OF CMD, DISCUSSES THE NEED TO SHIFT THE HEALTHCARE SYSTEM'S FOCUS FROM TREATMENT TO PREVENTION, THE ROLE OF LIFESTYLE MEDICINE, NEW FINANCING MODELS, AND THE USE OF TECHNOLOGY AND PUBLIC–PRIVATE PARTNERSHIPS TO IMPROVE POPULATION HEALTH.

Paweł Łangowski,
is an opinion leader, healthcare expert, and a member of the Presidium of the Tripartite Team at the Ministry of Health and Chair of the Healthcare Sub-Team within the Social Dialogue Council. He is a Board Member of the Employers' Association of Private Healthcare, and a member of the Telemedicine Working Group and the Supreme Council of the Polish Hospital Federation. He is Director of Public Affairs at Medicover and a Board Member of Damian Medical Center. He also chairs the Healthcare Committee at SGI Europe, one of the European Commission's social partners.

Lifestyle medicine is increasingly recognised as one of the pillars of chronic disease prevention. What systemic changes are needed now to make prevention a genuine priority for the Polish healthcare system, rather than merely a stated ambition?

The greatest challenge today is to change the philosophy underpinning the system – from a model that rewards the effective treatment of disease to one that rewards the maintenance of health. This effort needs to come from both the healthcare system and patients themselves. The vast majority of funding still goes towards interventional medicine, while prevention remains fragmented and often underfunded, with data showing that only a few per cent of the National Health Fund budget is allocated to this area.

Above all, we need a long-term public health strategy covering every stage of life, together with stable funding for preventive measures. It is equally important to harness the potential of employers, local authorities, the private sector and civil society organisations – the healthcare system alone cannot improve population health. All social partners need to be involved in this process.

The system should reward the maintenance of health, not just the treatment of disease.

It is also essential to move away from one-off initiatives towards continuous health management. Regular physical activity, healthy eating, mental health prevention and early diagnosis should be embedded in the system's day-to-day functioning rather than confined to occasional campaigns.

Poland faces the challenges of an ageing population and a rising number of patients with lifestyle-related diseases. How should public health policy evolve to respond more effectively to these trends over the next 10–15 years?

The coming years will require a move away from a reactive model of healthcare. As the population ages, a growing proportion of patients will be living with multimorbidity and will need long-term support rather than isolated medical interventions. We also need an effective system for continuously monitoring health needs; without it, we will not be able to respond to these challenges effectively.

Health policy should focus on maintaining people's functional ability and independence for as long as possible. This means strengthening prevention, rehabilitation, mental healthcare and coordinated care, as well as using digital tools that enable health to be monitored outside clinical settings. Community-based care is another vital component of this ecosystem, and is currently overlooked in discussions about population health.

This is why interventions in the places where people spend much of their lives – workplaces, schools and local communities – should play a greater role. These are the settings where healthy habits can be fostered effectively and chronic diseases prevented before costly treatment becomes necessary.

There is growing discussion about the need to shift funding from treatment to prevention. What organisational and economic mechanisms could encourage all participants in the system to invest in population health?

The key is to create the right incentives. If the system rewards the volume of healthcare services provided, it will naturally focus on treatment. If it instead rewards improvements in population health outcomes, prevention becomes a rational investment.

We should develop financing models that reward health outcomes, drawing on the principles of Value-Based Healthcare, expand the role of prevention programmes, and create incentives for employers to invest in their employees' health. The benefits extend beyond the healthcare system to the wider economy through higher productivity and lower sickness absence. Possible measures could include prevention or health vouchers, or tax deductions for people who regularly look after their health and avoid exacerbations of chronic conditions.

Another important element is making better use of public–private partnerships. The private sector has organisational, technological and analytical expertise that can support the delivery of public health objectives while preserving the universal nature of the system.

Pharmacists, primary healthcare doctors, specialists and the private sector have enormous potential to contribute to health education. How should these groups work together to make prevention more effective and improve population health?

The greatest problem today is not a lack of expertise within individual professional groups, but insufficient coordination between them. Patients often receive multiple, sometimes conflicting messages instead of a single coherent plan of action.

We need a model in which every participant in the system has a clearly defined role. The primary healthcare doctor coordinates prevention, the pharmacist supports patient education and treatment adherence, specialists provide more in-depth diagnostics, and the private sector contributes expertise in the organisation of care, new technologies and health programmes. Where rapid intervention is needed, the private sector can also complement the public system or, where necessary, supplement it by providing timely access to care.

It is also essential to develop shared standards for evidence-based health education. In prevention, consistency of messaging is particularly important, regardless of which part of the healthcare system a patient comes into contact with.

New technologies, data analytics and artificial intelligence are playing an increasingly important role in healthcare. How can they contribute to better public health policy planning and more effective prevention programmes without undermining patient trust?

The greatest value of new technologies lies not in automation itself, but in their ability to identify health risks earlier and personalise preventive measures. By analysing data, we can determine which population groups are likely to need specific interventions instead of acting only once problems arise.

Artificial intelligence can support both doctors and policy-makers, from planning healthcare resources to designing more effective public health programmes. This requires high-quality data, system interoperability and full transparency about how the data are used.

Population health is built through the combined efforts of the state, employers and the private sector.

Patient trust remains absolutely fundamental. Technology should support clinical decision-making, not replace the doctor–patient relationship. At the same time, patients need to be confident that their data are secure, used in accordance with the law and help to improve the quality of care.

Drawing on the experience of international organisations and the Polish healthcare sector, which solutions from other countries would be worth adapting in Poland to make public health and lifestyle medicine initiatives more effective?

Poland does not need to start from scratch. Many European countries have successfully adopted solutions based on a long-term approach to prevention, a strong role for primary healthcare and extensive use of data in health policy planning.

We should develop models that integrate healthcare with social policy, education and the labour market. Health is not solely the responsibility of the healthcare system; it is shaped primarily where we live, learn and work.

Another direction is to make greater use of public–private partnerships. In many countries, the private sector plays an active role in delivering prevention programmes and bringing innovative organisational and technological solutions. Poland already has many good examples of this type of cooperation, and we should make wider use of them while focusing on what matters most: improving population health and the efficiency of the system as a whole. ■

Violence in Healthcare: Another Case Every 20 Hours. Are Medical Staff Prepared?

EVERY 20 HOURS, ANOTHER CASE INVOLVING VIOLENCE AGAINST HEALTHCARE STAFF REACHES A PROSECUTOR'S DESK. IN 2025, NEARLY FOUR IN FIVE NURSES AND MIDWIVES SURVEYED EXPERIENCED AGGRESSION AT WORK, AND TWO MEDICAL PROFESSIONALS WERE KILLED IN ATTACKS WHILE ON DUTY. THE WHO OFFICE IN POLAND HAS DESCRIBED ATTACKS ON HEALTHCARE WORKERS AS A PUBLIC HEALTH CRISIS. **ŁUKASZ OSIECKI**, LECTURER AND COACH IN MENTAL AND PHYSICAL DEVELOPMENT AND FORMER INSTRUCTOR WITH THE POLISH MILITARY POLICE SPECIAL UNITS, ASKS A PRESSING QUESTION: ARE POLAND'S MEDICAL STAFF ADEQUATELY PREPARED WHEN A SITUATION TURNS VIOLENT?

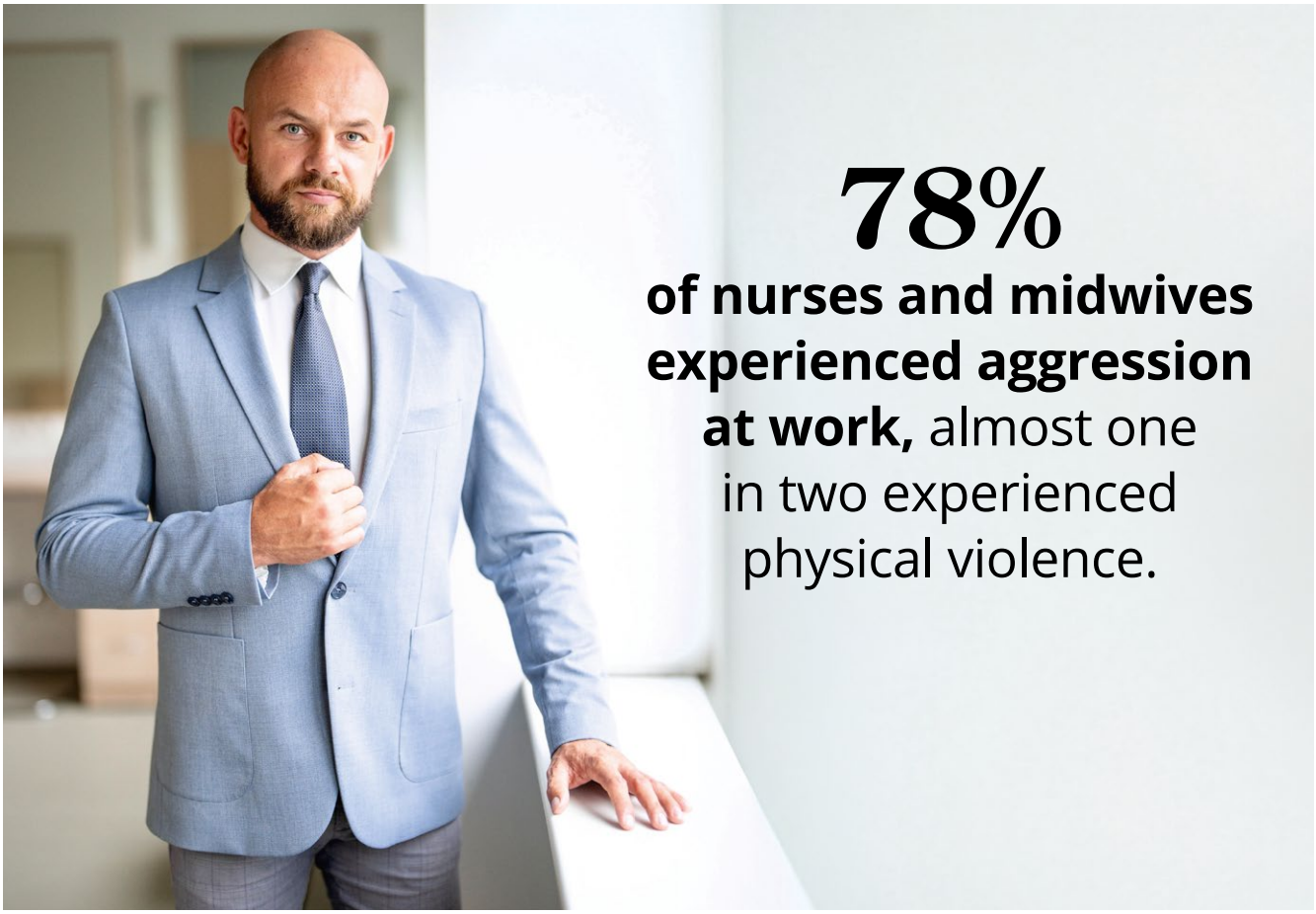
Aggression against medical staff is no longer a marginal phenomenon. In 2024 alone, the National Prosecutor's Office reviewed 432 proceedings involving crimes committed against people providing healthcare services. That is **more than one such case every day.** In 2025, 78% of nurses and midwives surveyed experienced aggression at work, **almost one in two experienced physical violence,** and 91% faced verbal abuse. Two **medical professionals were killed** in attacks while on duty in Poland – a paramedic and a doctor.

Aggression against healthcare workers is a global phenomenon. WHO points out that healthcare workers are among the groups particularly vulnerable to workplace violence, with patients and their companions being the most common perpetrators. The risk is particularly high in situations involving severe stress, pain, mental health disorders, intoxication or disputes over medical care. Unfortunately, the statistics suggest that the problem will continue to grow in the years ahead – according to Dr Nino Berdzuli, Director of the WHO Office in Poland, attacks on healthcare workers have become **a public health crisis.**

Security personnel, CCTV and panic buttons cannot be the only response to the threat. These are important security measures, but when a situation escalates, the first person who has to respond is usually the medical professional with the patient. Their preparedness determines whether they recognise the warning signs, maintain a safe distance, avoid being cut off from an exit, call for help, attempt to de-escalate the situation appropriately, and ensure a safe evacuation.

This is why the specialist training programme *Medical Staff Safety* was developed to address real-life situations encountered in healthcare facilities. Its aim is not to teach staff how to "fight a patient", but to develop real-world response skills that increase the chances of avoiding confrontation and, when confrontation becomes unavoidable, safely disengaging and protecting themselves, their colleagues and other patients.

Key areas covered by the programme include recognising signs of escalation, managing one's own emotions, de-escalation, directive communication, maintaining a safe distance, using physical barriers, calling for assistance, evacuation and warning others. In the event of a direct attack, participants learn principles of self-defence focused on creating an opportunity to escape rather than engaging in prolonged confrontation. Post-incident response is also an important component: checking for injuries, providing assistance, completing an incident report and assessing how well the procedures worked.



A core element of the programme is **scenario-based training.** A threat presents differently in a consultation room, at the reception desk, in an emergency department, on a psychiatric ward or during a home visit. Training should therefore reflect the actual layout of the facility, how alarms can be raised, access to exits, how the team works together and the nature of contact with patients. Only then does **a security procedure stop being merely a document and become a tool** that can be used under time pressure and stress.

The *Medical Staff Safety* programme is delivered in a format tailored to the specific needs of the facility and the team concerned. It **has already been tested in pilot training sessions for LUX MED staff** and has been recommended for inclusion in the training offered to teams at LUX MED medical centres. The training is intended for organisations that want to treat staff safety as part of a systematic approach to risk management, rather than as something addressed only after another incident occurs.

As aggression against healthcare workers increases, staff preparedness is becoming an essential part of responsible facility management. Medical professionals should therefore be trained before a situation arises in which someone's health or life may depend on their knowledge, reactions, and learned responses. ■

Column

Healthy Living, Healthy Habits

Witold Strobel
Board Member
Institute for Social Policy Development

We live in an age of affluence our parents and grandparents never knew. We have everything, or almost everything, at least in material terms. And yet there is something we all want. Apart from happiness, that is surely health.

It is an illusion to think we can buy it. One therapy, procedure or miracle cure after another turns out to be little more than a marketing promise we are all too willing to believe. I am not, of course, talking about the undeniable advances in medicine and scientific knowledge that save countless lives around the world every day. When we spend money on supplements, diets or appointments at clinics promising miracles, we buy ourselves a little reassurance and quiet the guilt that comes from neglecting healthy habits day after day. Yet it is those habits that are priceless if we want to stay fit and well into old age.

Here I have to go back to my own childhood, to the 1970s. Like any typical boy, I would come home from school, toss my schoolbag into a corner and run outside. We all played football and badminton, ran around, had jumping contests and even such odd events as racing one another up trees. The girls were just as active – they played hopscotch and elastics and stayed outdoors until late in the evening.

We avidly followed the Peace Cycling Race and celebrated the successes of Polish athletes. There were only two television channels, and once a month, on the first Saturday off, we would be drawn to the screen by Studio 2, a hugely popular entertainment programme. We were certainly a far fitter generation than today's teenagers. There were very few overweight children and – it is worth saying today, without condoning such behaviour – they were sometimes mocked because of it.

In the late 1990s, I visited China. I was struck by the slim older people practising tai chi in large groups in the parks of Harbin. Locals explained that this was no passing fad but a reflection of a genuine commitment to staying healthy and fit in old age.

Today, millions of Poles are overweight or living with obesity, and the problem increasingly affects children as well. What happened that made us abandon the good habits we had a few decades ago? There are many reasons: the affluence I mentioned at the outset, the abundance of processed food, endless ways to fill our free time and stave off boredom, and a lifestyle built around convenience and too little physical activity.

Smartphones are ubiquitous among children today. They can type on on-screen keyboards at speeds that those of us from an older generation can only admire. Far fewer, however, regularly take part in sport or spend their free time being active. Global restaurant chains serving highly processed, calorie-dense food have no shortage of customers in Poland either. Young people readily reach for fizzy, sugary drinks and energy drinks. You are far less likely to see them with a bottle of water in hand.

Busy parents do not always have the time or opportunity to consistently instil good habits in their children. As a result, marketing and peer influence are playing an increasingly important role in shaping those habits.

We discussed these issues with experts, doctors and representatives of non-governmental organisations in April 2026 at the round table *Public Health Economics – How Can We Stop the Obesity and Diabetes Epidemic in Poland?*, organised by the Institute for Social Policy Development in cooperation with the Children's Memorial Health Institute.

A few months on, I am left with one further thought: it is time to put a stop to this madness. If the government and schools are not instilling good habits, or are not doing so effectively enough, then a huge responsibility falls on parents.

We really should make sure that, from an early age, our children grow up in an environment where they are not only given everything they need but, above all, taught healthy habits. Those habits have a profound impact on their health and quality of life later on.

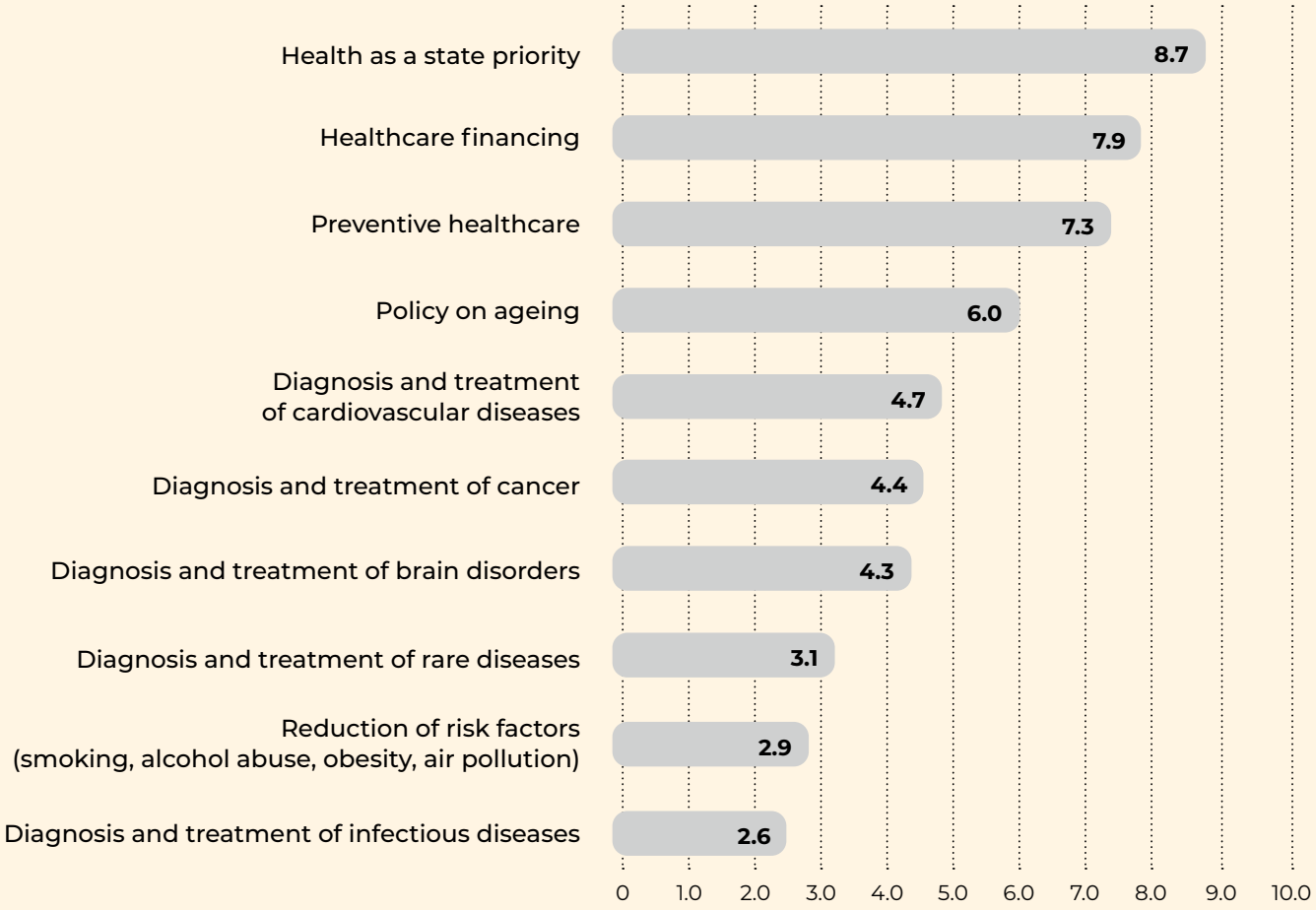
So, whatever we have done up to now, let us start tomorrow by taking better care of our children – and of ourselves. Let us begin with simple things: more exercise, less highly processed food, less screen time and more time outdoors. We do not need miracle cures or expensive prescriptions for good health. ■

What we need are good habits.
Let's get to it.

KEY AREAS OF DEBATES FOR THE INSTITUTE FOR SOCIAL POLICY DEVELOPMENT FOR 2026–2027

In a survey, respondents assessed, respondents assessed the importance of the areas of debate on which the Institute for Social Policy Development should focus on its programme work and expert activities in 2026-2027. Participants were asked to rank the proposed topics on a scale from 10 to 1, where 10 represented the area of greatest strategic importance and 1 the least significant in terms of its impact on the healthcare system and public policy. The highest average score (8.7 points) was assigned to the area of health as a state priority.

This result points to a clear expectation that health should be treated as a central element of public policy, not only in sectoral terms, but as a horizontal issue linked to social, economic, education and security policy. From an expert perspective, this implies a call to strengthen the Health in All Policies approach, under which decisions taken in other sectors take account of their impact on population health. The high ranking of this area suggests that respondents expect the Institute to initiate debates of a systemic nature, going beyond current operational problems.



Institute For Social Policy Development

As assessed by respondents (importance scale 10–1), n=39

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DISCIPLINED EXECUTION

INTEGRITY

STRATEGIC PARTNERSHIPS

ADAPTABILITY AND RESILIENCE

ADVOCACY

INNOVATION

VISION GROUP

Executive Advisors

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