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HEALTH SECURITY IN THE *WHITE BOOK ON NATIONAL SECURITY OF THE REPUBLIC OF POLAND* – A REVIEW OF PROVISIONS

The modern world abounds in new dangers as well as new opportunities (*Bezpieczna*, 2003: 14). Health constitutes an essential value of human life and the right to health is a fundamental human right. The fulfillment of this legitimate claim to a degree and extent ensuring health security needs to be supported by an efficient policy of the state (*Stanowisko*).

Health security is one of the primary components of national security (*Bezpieczeństwo*, 2010). Nevertheless, the *White Book on National Security of the Republic of Poland* devotes only two out of 219 pages, including the introduction and conclusions, to this issue! (*Biała*, 2013: 87–88, 184, 227–229).

An inadequate level of health security corresponds to a subjective sense of danger experienced by individuals and their immediate surroundings in the case of the suspicion, emergence or continuation of a defined disease. The mitigation or elimination of this negative sensation can be seen as achieving a certain state of wellbeing, that is a sense of the absence of danger, and hence comprehensive health security. It is strictly related to a patient's unwavering conviction that the required health services are obtainable, while the provider of these health services is fully accessible (Ruszkowski, 2010: 6).

In line with the internal security strategy of the European Union, security is one of the priorities for EU citizens (*Strategia bezpieczeństwa wewnętrznego*, 2010: 7).

It is emphasized that EU action in the field of civil protection must be guided by the objectives of reducing vulnerability to disasters through development of a strategic approach to disaster prevention and anticipation, and by further improvements in preparedness and response, while recognizing national responsibilities (ibidem: 23).

Health security[1] has become a strategic priority of the EU due to the intensification of such health determinants as the following:

– demographic transformations, such as society's aging, resulting in an altered structure of diseases, a considerable increase of costs and threats to the balance of EU health systems;
– altered environmental conditions, including those related to climate, the expanding realm of social disparities and movements of entire groups of people, which is conducive to natural disasters on an extensive, sometimes even global range and increases the risks of epidemics and bioterrorism;

[1] In the United States health security is the awareness of being secure that health is good and if not there are ways to obtain care to return to good health (*Health*).

– development of new technologies revolutionizing the ways to promote health, prevent health hazards and treat diseases.

In the face of the above challenges, the EU Commission has adopted three strategic goals for 2008–2013:

1) promotion of health in an aging Europe;
2) protection of citizens against health risks;
3) monitoring of health systems and new technologies.

The fundamental premise of EU strategy in the field of health security is equality of citizens in accessing health care, so that every person, regardless of age, sex, place of residence and affluence can benefit from adequate health care in the event of a perceived health risk (*Stanowisko*).

In Poland every individual has the right to health protection (*Konstytucja*, 1997: 68). The primary goal of Polish health care system is to ensure the protection of civil life and health regardless of the conditions of operation of the state. Taking into account the increasing threats to the health and lives of large population groups due to terrorist activities, including nuclear, chemical and biological terrorism, as well as mass emergencies and catastrophes, it is necessary to ensure there are adequately prepared forces ready to respond and medical resources at a central, regional and local level. Their purpose should be to quickly identify threats and safeguard the lives and health of the affected population, while not disturbing the basic organizational and functional structure of health protection facilities (*Strategia bezpieczeństwa narodowego*, 2007: 34).

General health security is related to the awareness that health services are accessible, and that it is possible to obtain health services to a degree and extent that satisfies the demand of a given community. Therefore, the accessibility of health services, treated as one of the values of health policy, can imply the level of health security ensured by the health protection system (Ruszkowski, 2010: 3, 6).

The *White Book on National Security of the Republic of Poland* stipulates that the Ministry of Health is in charge of the organization of health protection system and health policy, among other things. The legal instruments at the disposal of the Minister of Health allow him to execute policies fulfilling the constitutional obligation of the state to ensure each citizen's right to health protection and equal access to publicly financed health care (*Biała*, 2013: 87). As concerns the range of tasks stipulated by the law on health care, however, the Minister of Health is in charge in particular of assessing the accessibility of health services together with regional governments (*Ustawa*, 2004: 11). In the opinion of the National Security Bureau's experts, the Minister of Health needs to be active in the field of providing access to health services, while in the government's opinion his role is passive.

Access to health services can be considered in terms of the following:

1) availability;
2) accessibility in terms of
   a) organization,
   b) space,
   c) cost;
3) acceptability.

Availability is the relation between the size and structure of the health care system's resources and the number and structure of the health requirements of the population; for

example the number of various categories of medical personnel (doctors, nurses, paramedics) and medical infrastructure facilities (hospital beds, stations, appliances, vehicles) per population in a given area. The more resources provided by the health care system to a given population of, say, 10,000 the greater the potential availability of health care.

Organizational accessibility is the degree and extent to which the conditions of provision of medical services correspond to the demand, as well as the actual opportunities for patients to obtain them. For instance, the working hours of a given treatment facility and its employees, the principles of patient registering and out-patient appointments, including unannounced patient visits, the possibilities of contacting the treatment facility and its departments via phone, text messaging system or the Internet, and the range of issues that can be handled in this way.

Spatial accessibility is the relation between the location of a health care system's resources and territorial distribution of the population using this health care. For example, the distance between the providers of certain health services and the individuals demanding such services (the time needed to reach a given treatment facility), patient mobility, given local transportation conditions, the ease of using various means of transportation and the cost of covering a certain distance. In practice, the geographical exponent of the distance between the provider of a medical service and the patient is the time required by the latter to reach the requisite treatment facility. Consequently, the more resources of a health care system are available in a given area of, say 100 km^2, the greater potential access to health services.

Cost accessibility on a macro scale refers to the principles of granting authorization to use health services. On a micro scale it is perceived by the patient as his readiness to cover the expenses related to establishing and maintaining contact with a specific treatment facility, including for example time lost, remuneration lost, necessary costs, due fees, physical and psychological exhaustion.

Acceptability is the relation between a patient's expectations as to the technological, psychological and cultural aspects of meeting his demand for health services and the degree and extent to which they are actually fulfilled by a given treatment facility, including the level of professional expertise and skills of medical personnel (Ruszkowski, 2010: 6–7).

As regards the availability of even basic health services, the discrepancies between different areas and regions are considerable (Tab. 1). Taking into account spatial, organizational and cost accessibility, as well as acceptability, it can be observed that in a country with a market economy, the influence a Minister of Health has on the creation of the availability of health services is significantly curbed (Fig. 1). It can be therefore concluded that a Minister of Health does not have the efficient instruments at his or her disposal to conduct an effective policy to ensure each citizen's right to health protection and equal access to publicly financed health care.

According to the *White Book on National Security of the Republic of Poland*, the primary operational task of the subsystem of health protection is to ensure continuous operation of treatment facilities and provision of medical services in the case of crises, threats to national security or war. The most important activities in this area include the following:

Table 1

Availability of medical personnel in Poland (areas and regions) IN 2011

Country/area/ region	Medical personnel									
	doctors		dentists		pharmacists		nurses		midwives	
	r	ranking	r	ranking	r	ranking	r	ranking	r	ranking
Country	35.3	×	9.9	×	7.6	×	73.3	×	9.0	×
Center	45.1	I	12.7	I	8.4	I–II	80.6	I	9.3	II
South	36.1	II	9.5	IV	8.4	I–II	75.8	IV	8.9	III
East	31.9	IV	9.0	V	6.9	V	76.8	III	10.3	I
North-West	30.7	VI	9.6	III	6.8	VI	63.2	VI	8.8	IV
South-West	34.3	III	10.3	II	7.4	III	76.9	II	8.0	V
North	30.9	V	8.1	VI	7.2	IV	64.2	V	7.8	VI
Dolnośląskie	37.8	4	11.4	3	8.2	5	79.3	3	8.2	10
Kujawsko-pomorskie	28.8	11	6.2	16	6.5	10	66.7	11	8.6	9
Lubelskie	36.8	6	9.9	8	9.0	3	75.4	7	9.8	4
Lubuskie	23.8	16	7.9	11	5.2	14	63.9	12	8.1	11
Łódzkie	42.2	2	12.2	2	9.2	2	94.4	1	12.1	1
Małopolskie	35.9	8	10.0	7	8.9	4	70.2	9	8.7	8
Mazowieckie	46.5	1	12.9	1	8.0	7–8	74.1	8	8.0	12–13
Opolskie	24.4	13–14	7.2	14	5.1	15	70.0	10	7.5	14–15
Podkarpackie	24.2	15	7.6	13	5.4	12	78.1	4–5	11.3	2
Podlaskie	40.7	3	11.2	4–5	6.9	9	75.8	6	10.3	3
Pomorskie	37.1	5	11.0	6	9.4	1	62.1	16	7.4	16
Śląskie	36.2	7	9.1	10	8.1	6	79.9	2	9.1	7
Świętokrzyskie	27.9	12	7.8	12	5.7	11	78.1	4–5	9.6	5
Warmińsko-mazurskie	24.4	13–14	6.5	15	5.0	16	63.7	13	7.5	14–15
Wielkopolskie	30.8	10	9.4	9	8.0	7–8	63.3	14	9.5	6
Zachodniopomorskie	34.7	9	11.2	4–5	5.3	13	62.7	15	8.0	12–13

Note: ratio (r) per 10,000 population.

Source: Author's analysis on the basis of *Biuletyn statystyczny Ministerstwa Zdrowia* (2012), Warszawa, pp. 21–22.

– creating conditions to safeguard civil health and life, including formal, legal, organizational and logistical conditions;
– preparation and maintenance of the health system's readiness to operate in a state of threat to national security and war;
– mitigation and liquidation of the consequences of threats and reduction of mass losses;
– support to the health system of uniformed services in Poland;
– fulfillment of host country obligations towards allied forces, as provided by the *Program of support offered by the host country* (*Biała*, 2013: 184).

Increasing the efficiency of treatment facilities is becoming the primary goal of health policy (Jacobs, Smith, Street, 2006: 1). On the one hand, efficiency involves the

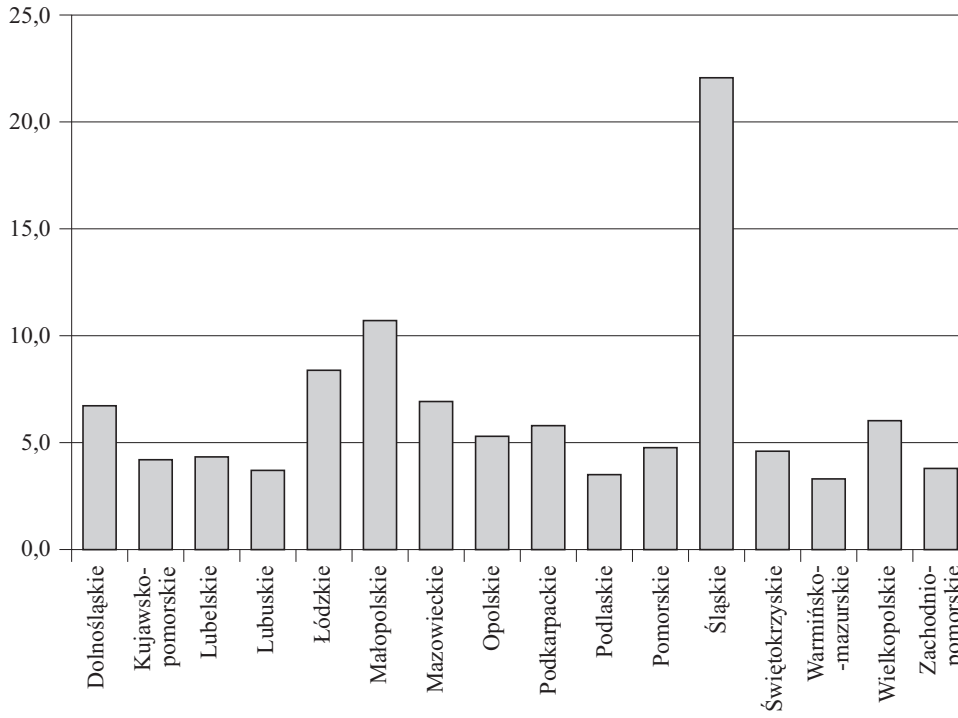

Fig. 1. Spatial availability of outpatient facilities in Poland (by regions, ratio per 100 km^2) in 2011

Source: Author's own analysis.

utilization of medical potential and resources possessed to the greatest degree and extent possible (Hollingsworth, Dawson, Maniadakis, 1999: 161). On the other hand, the efficiency of treatment facilities accounts for utilizing the resources they possess to achieve the most advantageous health results possible (Krot, 2008: 31).

Hospital treatment constitutes one of the crucial elements of the health care system. It provides services to approximately 5–10% of population consuming the largest proportion of financial resources allocated for health care, namely 40–45% (Mikietyński, 2008: 184). Due to the high cost of health services (PLN 27.5 bn was allocated to hospital treatment in 2011, accounting for 47.4% of the total cost of health services provided by the National Health Fund (*Zdrowie*, 2012: 293) the efficiency of hospital treatment needs to be improved.[2]

The following indices are applied in analyses of the efficiency of hospital treatment provided on a national and regional scale (Skarżyński, 2011: 120) (Tab. 2):
– patients per hospital bed annually;
– average duration of patient's stay;
– bed utilization.

[2] In 2005–2008 a total of PLN 72.638 bn was allocated by the National Health Fund to hospital care and PLN 1.420 bn was allocated in the state budget to general hospitals (Skarżyński, 2009: 101–102).

Table 2

The efficiency of hospital treatment in Poland (by areas and regions) in 2011

Country/area/ region	General hospitals						
	patients/bed		average duration of patient's stay		bed utilization		
	persons	ranking	days	ranking	days	%	ranking
Country	43.7	×	5.6	×	244.5	67.0	×
Center	48.2	I	5.3	II–III	254.9	69.8	I
South	39.0	VI	6.3	VI	244.6	67.0	III
East	42.9	IV	5.8	V	251.4	68.9	II
North-West	46.5	II	5.1	I	237.6	65.1	IV
South-West	41.6	V	5.4	IV	235.9	64.6	V
North	43.8	III	5.3	II–III	233.9	64.1	VI
Dolnośląskie	42.1	11	5.2	2–4	234.7	64.3	12–13
Kujawsko-pomorskie	42.0	12	5.4	6–8	228.4	62.6	16
Lubelskie	41.6	13	6.3	15	265.5	72.7	1
Lubuskie	43.0	10	5.4	6–8	232.9	63.8	14
Łódzkie	47.2	3	5.2	2–4	249.9	68.5	4
Małopolskie	43.6	6	5.8	13	254.2	69.6	3
Mazowieckie	48.7	2	5.3	5	257.6	70.6	2
Opolskie	39.9	15	6.0	14	239.5	65.6	9
Podkarpackie	43.2	7–8	5.6	10–11	242.7	66.5	6
Podlaskie	43.1	9	5.7	12	241.6	66.2	8
Pomorskie	46.1	4	5.2	2–4	239.3	65.6	10
Śląskie	36.3	16	6.6	16	239.1	65.5	11
Świętokrzyskie	44.6	5	5.5	9	248.4	68.1	5
Warmińsko-mazurskie	43.2	7–8	5.4	6–8	234.7	64.3	12–13
Wielkopolskie	50.4	1	4.8	1	242.5	66.4	7
Zachodniopomorskie	41.1	14	5.6	10–11	231.1	63.3	15

Source: Author's analysis on the basis of *Biuletyn statystyczny*, op. cit., p. 84.

The advancement of medical technologies and modern treatment methods reduces the demand for inpatient treatment as more and more medical procedures can be effected on an outpatient basis (Witczak, 2009: 70). Therefore, shorter hospitalization facilitates a more effective use of resources, admissions of larger numbers of patients and reduction of costs borne on account of prolonged hospital stays. At the same time, however, it calls for the intensified provision of health services, which generates high cost calculated per day of a patient's stay in hospital. Therefore, shortening of hospitalization is strictly related to the capacity for the absorption of new medical technologies, and increasing the number and extent of medical services provided on a one day basis, which is a resultant of the level of knowledge and qualification of medical staff, as well as the financial potential of the health care system (*Ocena*).

The *White Book on National Security of the Republic of Poland* states that in order to ensure national health security under the conditions of its threatening and war it is

necessary to expand the capacity of hospital facilities to the level of at least 75 hospital beds per 10,000 population, with 50% being surgical beds, including those dedicated to the needs of the armed forces of Poland, allied forces, and the organs and organizational units subordinate to the *Minister of Internal Affairs* and the *Internal Security Agency*. When planning the expansion of hospital facilities, the possibility of increasing the number of hospital beds in existing general and specialist hospitals, care and treatment institutions, nursing homes, sanatoria and spa facilities should be taken into account. For this purpose, the managers of such institutions should be obliged to present an exhaustive account of the possibility of increasing the number of beds, adapting administrative and social facilities into hospital wards, and defining their needs in this respect. Having conducted an analysis of threats, needs and possibilities, they should undertake implementation operations (*Biała*, 2013: 228).

Current (as of December 31, 2011) number of potential hospital beds that can be qualified as hospital facilities to ensure the health security of Poland in the situation of a threat to national security amounts to 281,161 beds (Tab. 3).

Table 3

Number of potential hospital beds in Poland in 2011

No.	Hospital type	Beds
1.	General stationary hospitals	188,996
2.	Psychiatric hospitals	17,761
3.	National and regional forensic psychiatry facilities	245
4.	Alcohol abuse treatment centers	1,069
5.	Drug addiction rehab centers	1,368
6.	MONAR rehab facilities	1,067
7.	Psychiatric care and treatment facilities	4,682
8.	Psychiatric nursing facilities	331
9.	Hospice units	1,263
10.	Care and treatment facilities	16,436
11.	Nursing facilities	5,368
12.	Sanatorium and spa treatment facilities	39,473
13.	Inpatient therapeutic rehabilitation facilities	3,102
Total		**281,161**

Source: Author's analysis on the basis of *Zdrowie i ochrona zdrowia*, op. cit., pp. 232, 259–262, 265, 267.

Taking into account the population of Poland (as of December 31, 2011) this amounts to 73 beds per 10,000 population. This means that the potential hospital capacity needs to be increased by additional 7,708 beds.

The actual population of the country is significantly lower, though. In 2011 over 2,017,000 permanent residents of Poland spent over three months out of the country. Nearly 78% of émigrés, that is approximately 1,564,000, were abroad for a period exceeding twelve months, while nearly 453,000 were abroad for 3–12 months (*Informacja*, 2013: 1–2).

Taking into account the economic emigration of Poles, it has to be clearly stated that the actual population living in Poland is considerably lower than the officially registered population, therefore the requirement (75 hospital beds per 10,000 population) imposed by the *White Book on National Security* is not only fulfilled, but exceeded (Tab. 4).

Table 4

Availability of hospital beds to ensure national health security in a situation of a threat to national security and in case of war (as of 2011)

Specification	Beds	Population [10,000]	Availability rate [beds/10,000 population]
Registered population	281,161	3,853.8447	73
Population excluding: – long-term émigrés – long-, and short-term émigrés	 281,161 281,161	 3,697.4447 3,652.1447	 76 77

Source: Author's own analysis.

Given the current market reality and permanent underfunding of healthcare it is irrational to aim to increase hospital capacity, the more so as there is no basis to justify this. In order to ensure national health security it is necessary to maintain the required number of reserve beds in hospitals at an optimal, rather than excessive level. Since it is necessary to have an adequate number of reserve beds in case of contingency, and given the specific nature of some specializations resulting from, for instance, the seasonality of diseases it is recommended that the rate of bed utilization is initially assumed at a level of 75% (*Ocena*). It should, however, be a target to achieve an optimal level of bed utilization rate of no less than 85% (Mikietyński, 2008: 185). The bed utilization rate recommended by the World Health Organization is supposed to be at a level of 80%, the optimal level being 85%, with the exception of selected medical specializations, such as contagious diseases, pediatrics, and approximately 15% of beds reserved for contingencies and temporary situations (*Odpowiedź*).

Bed utilization is highly diversified in different areas and regions. Taking into account the 15% rate of spare beds recommended by the WHO as optimal, the underutilization of hospital beds ranges from 15.2–20.9% in different areas and from 12.3–22.4% in different regions (Figs. 2 and 3).

Taking into account the hospitalization potential of general hospitals only, the total of reserve beds amounts to 62,369. Maintaining the current number of hospital beds in the face of their underutilization constitutes an economically unjustified burden for hospitals, which translates into increased operational costs of the entire system of health protection on a national scale (*Ocena*). In order to curb the costs generated by general hospitals, the number of hospital beds in their possession should immediately be reduced by 21.18% leaving 22,346 reserve hospital beds. The current situation of the publicly financed health care system is calling for this, as at the end of 2012 the debt of public hospitals reached the highest level in their history, amounting to nearly PLN 11 bn and counting (wpolityce). It needs to be observed here that during the Russian-Georgian

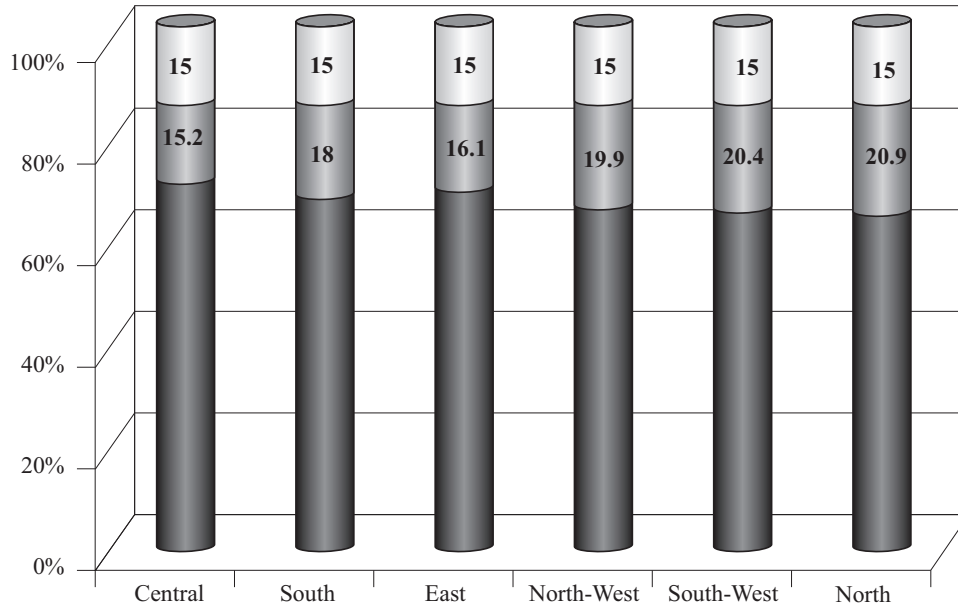

Fig. 2. Reserve beds in general hospitals in Poland (by areas) in 2011

Source: Author's own analysis.

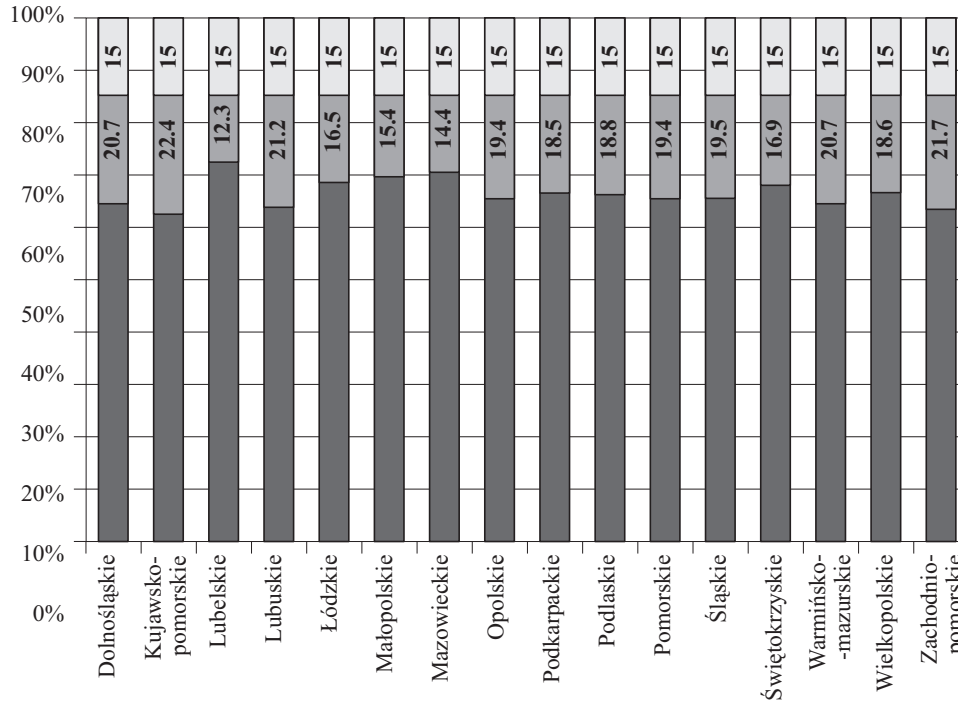

Fig. 3. Reserve beds in general hospitals in Poland (by regions) in 2011

Source: Author's own analysis.

war in 2008, approximately 400 Georgian soldiers, policemen and civilians died and a further 1,500–2,000 were wounded (Micek). Losses were relatively low, then, even though the Russians did not apply any technologically advanced precise weapons allowing for 'surgical cuts' to be made in order to reduce collateral damage among civilian population. Given the development of advanced means of combat, such as drones, it can be envisaged that in the future armed conflicts losses will continue to drop.

Having analyzed the provisions of the *White Book on National Security of the Republic of Poland*, it can be concluded that during World Wars I and II quantitative ratios were of crucial importance in hospitalization, such as the number of hospital beds and medical personnel directly involved in the provision of health services. As time went by, the significance of quantitative ratios successively decreased in favor of qualitative ones. What counts most in the 21st century is quality, meaning state-of-the-art medical equipment, advanced medicines and highly qualified medical personnel. This follows from the results of their operations, as the higher the level of diagnostics and treatment the faster the recovery of patients, which can, additionally, frequently be achieved in an outpatient setting, not requiring hospitalization at all.

Treatment facilities differ in terms of advanced medical equipment which does not correspond to current needs, given the level of health services contracted (Tab. 5). Taking into account the saturation of the health care system with modern medical equipment, one can observe that an increased number of hospital beds will bring about further limitation of the already low access to technologically advanced health services and, by this token, worsen the chances of the rapid recovery of the sick and wounded. Therefore, increasing the number of hospital beds is not the right measure to be taken in order to ensure the health security of victims in a state of threat to national security or war, but it is rather improved modern equipment provided for treatment facilities to decrease disparities in this respect, and the dissemination of modern medicines.

Table 5

Availability of medical equipment in general hospitals in Poland (by areas and regions) in 2011

Country/area/ region	Indicator						
	BioAn	GamCam	Litho	LINAC	X-rayImage	CT	MRI
1	2	3	4	5	6	7	8
Country	2.0	0.3	0.4	0.3	2.7	1.0	0.3
Center	2.0	0.4	0.3	0.2	2.7	1.1	0.4
South	2.5	0.2	0.4	0.3	3.1	1.0	0.3
East	2.1	0.2	0.5	0.3	2.4	1.0	0.3
North-West	1.5	0.2	0.3	0.3	2.7	1.0	0.2
South-West	1.8	0.3	0.4	0.2	2.3	0.7	0.3
North	2.1	0.3	0.3	0.2	2.6	0.9	0.3
Dolnośląskie	1.8	0.2	0.3	0.2	2.3	0.8	0.3
Kujawsko-pomorskie	2.2	0.4	0.2	0.3	2.2	1.1	0.4
Lubelskie	2.4	0.4	0.8	0.3	2.9	1.2	0.3
Lubuskie	1.5	0.4	0.2	0.3	3.0	0.8	0.3
Łódzkie	1.9	0.4	0.4	0.2	2.4	1.0	0.4

1	2	3	4	5	6	7	8
Małopolskie	3.0	0.2	0.3	0.3	2.8	1.0	0.2
Mazowieckie	2.1	0.4	0.3	0.2	2.8	1.2	0.4
Opolskie	1.8	0.4	0.7	0.2	2.3	0.6	0.1
Podkarpackie	1.8	0.1	0.3	0.2	2.1	1.0	0.3
Podlaskie	2.4	0.2	0.7	0.4	3.1	0.3	0.2
Pomorskie	2.1	0.3	0.4	0.3	3.1	0.9	0.3
Śląskie	2.1	0.2	0.4	0.4	3.3	1.0	0.3
Świętokrzyskie	2.0	0.2	0.2	0.3	1.6	1.3	0.2
Warmińsko-mazurskie	1.8	0.2	0.1	0.0	2.5	0.8	0.1
Wielkopolskie	1.4	0.2	0.3	0.2	2.2	1.1	0.2
Zachodniopomorskie	1.8	0.3	0.5	0.4	3.6	0.9	0.2

Note: indicator per 100,000 population for the following medical appliances: biochemical analyzer, gamma camera, lithotripter, linear accelerator, X-ray imaging device, computed tomography, magnetic resonance imaging.
Source: Author's own analysis on the basis of *Biuletyn statystyczny*, op. cit., pp. 112–114.

As part of its duties as a host country, the national health protection system is supposed to be ready to provide health services to allied armies. The outlays on health protection are significantly different in various NATO states, which translates into the level and range of medical services provided (Fig. 4).

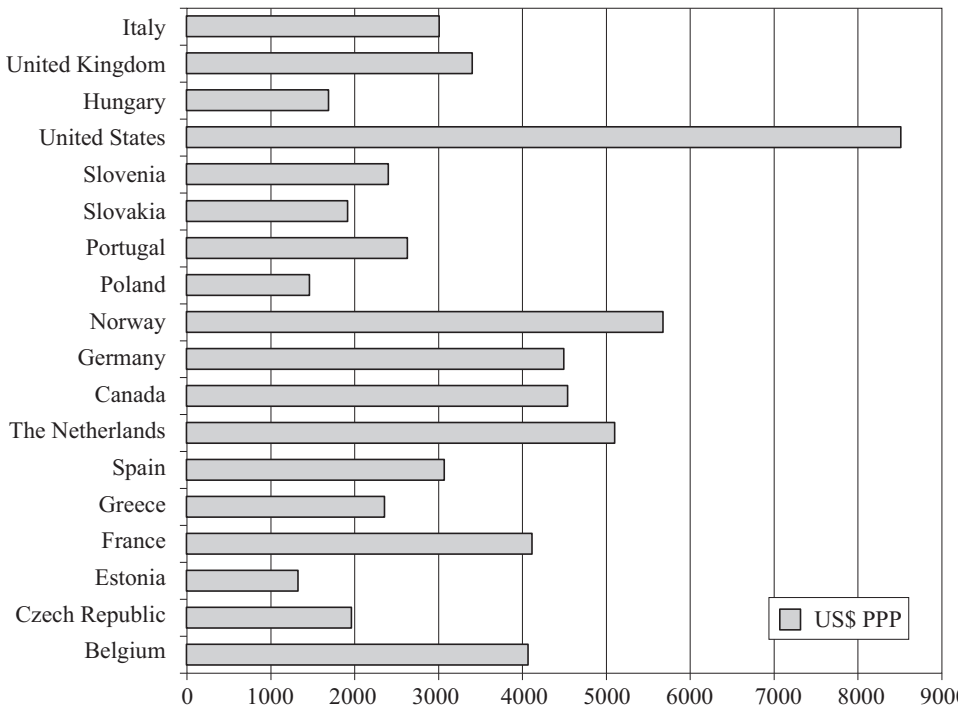

Fig. 4. Total expenditure for health protection (in USD in terms of PPP/head) in NATO states in 2011

Source: Author's analysis on the basis of *Narodowy rachunek zdrowia za 2011 rok* (2013), Warszawa, p. 7.

According to the plans of defense disclosed, in the event of armed aggression against Poland or the Baltic countries, combat operations are to be executed by nine NATO divisions from the United States, United Kingdom, Germany and Poland, among others, and by the American and British navies. Taking into consideration the striking disproportions in the levels of health protection financing in different NATO countries, it can be expected that instead of using local hospital facilities, the allied forces will endeavor to evacuate their wounded and sick, in order to ensure a higher level and range of health services in domestic countries.

Having reviewed the issues of health security presented in the *White Book on National Defense* the following conclusions can be drawn:

1) health security is not given priority in the *White Book*, although it is a strategic issue in the EU;
2) the accessibility of health services is considered in the *White Book* solely in terms of availability. Under current market economy conditions, the legal instruments available to the Minister of Health do not allow him to exercise a policy to create a system that provides every citizen with equal access to health services financed by public means as guaranteed by the constitutional right to health protection;
3) the requirement to maintain and increase the number of hospital beds to be made available in a state of threat to national security or war, stipulated in the *White Book*, should be reviewed in view of ensuring ongoing, widespread health security (in peace time).

* * *

In conclusion, it can be said that, in conformity with the *White Book on National Security*, the threat of a large conventional conflict in this part of Europe is extremely low at present (*Biała*, 2013: 103). Therefore, current plans to outlay considerable funds to increase the level of military security could arouse controversy in the face of the permanent underfunding of the health care system, which translates directly into lowered health security in Poland. The costs of the multiannual program *Priority tasks of technical modernization of the Armed Forces of Republic of Poland under operational programs* in 2014–2022 will amount to PLN 91.5 bn, including over PLN 15.9 bn to be spent in 2014–2016 (https://www.premier). A law to this effect was adopted by the government of Poland at a time when Poland ranks 22nd out of 28 EU countries in the field of cancer treatment, with cancer diagnosed in 160,000 patients annually, a majority of whom die (Ambroziak). Five-year survival rates of oncologic patients are ten percentage points lower in Poland than the EU average (www.eonkologia). There are also huge differences from region to region as concerns the provision of chemotherapy services. The largest proportion of chemotherapy services provided within inpatient care is financed in the łódzkie (82%) and opolskie (81%) regions whereas the smallest on in the pomorskie region (39%) (Gałązka-Sobotka, 2013: 94).

In this situation, the dilemma, that has succinctly been formulated as ‘missiles versus health’, should definitely be resolved in favor of health. The improved health conditions of a given population promote its development opportunities, thus providing a foundation for continued economic growth (Włodarczyk, Pożdzioch, 2000: 19). The

increase in state budget revenues allows military expenditure to grow gradually, which translates into increased military security, which is equivalent to health security, and also into increased social security (reduced unemployment, elimination of poverty, advancement of education, population growth). It can be thus concluded that health security is a primary issue among other categories of security, and should therefore be approached in correspondence to the role it plays in modern societies.

Bibiography

Ambroziak A., *Zapaść w onkologii*, http://www.naszdziennik.pl/polska-kraj/59642,zapasc-w-onkologii.html (12.12.2013).

Analiza dostępności do leczenia onkologicznego oraz finansowania świadczeń z zakresu chemioterapii w 2012 roku ze szczególnym uwzględnieniem nowych terapii onkologicznych (2013), (red.) M. Gałązka-Sobotka, Warszawa.

Bezpieczeństwo zdrowotne. BBN a ochrona zdrowia (2010), Biuro Bezpieczeństwa Narodowego, http://www.bbn.gov.pl/pl/wydarzenia/bezpieczenstwo-zdrowot/2046,BBNaochronazdrowia.html (14.12.2013).

Bezpieczna Europa w lepszym świecie. Europejska strategia bezpieczeństwa (2003), Rada Unii Europejskiej, Bruksela.

Biała Księga Bezpieczeństwa Narodowego Rzeczypospolitej Polskiej (2013), Biuro Bezpieczeństwa Narodowego, Warszawa.

Biuletyn statystyczny Ministerstwa Zdrowia (2012), CSIOZ, Warszawa.

Health Security Law & Legal Definition, USLegal, http://definitions.uslegal.com/h/health-security/ (14.12.2013).

Hollingsworth B., Dawson P. J., Maniadakis N. (1999), *Efficiency measurement of health care: a review of non-parametric methods and applications*, "Health Care Management Science", Vol. 2, No. 3.

Informacja o rozmiarach i kierunkach emigracji z Polski w latach 2004–2012 (2013), GUS, Warszawa.

Jacobs R., Smith P. C., Street A. (2006), *Measuring Efficiency in Health Care. Analytic Techniques and Health Policy*, Cambridge.

Konstytucja Rzeczypospolitej Polskiej (1997), Warszawa.

Krot K. (2008), *Jakość i marketing usług medycznych*, Warszawa.

Leczenie pacjentów nowotworowych w Polsce odbiega od standardów europejskich i światowych (2013), Onkologia.pl, http://www.eonkologia.pl/Leczenie-pacjentow-nowotworowych-w-Polsce-odbiega-od-standardow-europejskich-i-swiatowych,10037.html (12.12.2013).

Micek A. (2010), *Wojna gruzińsko-rosyjska z 2008 r.*, http://www.militis.pl/1990/wojna-gruzinsko-rosyjska-z-2008-r-dp1 (13.12.2013).

Narodowy rachunek zdrowia za 2011 rok (2013), GUS, Warszawa.

Ocena sytuacji – uwarunkowania projektu, Ministerstwo Zdrowia, http://www.mz.gov.pl/wwwmz/index?mr=q101&ms=&ml=pl&mi=&mx=0&mt=&my=0&ma=07234 (14.12.2013).

Odpowiedź podsekretarza stanu w Ministerstwie Zdrowia – z upoważnienia ministra – na interpelację nr 20276 w sprawie niewykorzystanych miejsc szpitalnych (2011), Sejm Rzeczypospolitej Polskiej, http://orka2.sejm.gov.pl/IZ6.nsf/main/485362BE (14.12.2013).

Oświadczenie ZK OZZL w sprawie aktualnej sytuacji w ochronie zdrowia finansowanej ze środków publicznych (2012), http://polityce.pl/artykuly/41702-ogromne-zadluzenie-szpitali-publicznych-osiagnelo-najwyzszy-w-historii-poziom-prawie-11-mld-zl-oswiadczenie-zk-ozzl (12.12.2013).

Podstawy zarządzania zakładem opieki zdrowotnej (2008), (red.) M. Dobska, K. Rogoziński, Warszawa.

Ruszkowski J. (2010), *Zwiększenie bezpieczeństwa zdrowotnego*. Projekt ekspertyza finansowana ze środków projektu nr POPT.03.04.00-00-019/07 w ramach Programu Operacyjnego Pomoc Techniczna 2007–2013 wykonana na zlecenie Ministerstwa Rozwoju Regionalnego, Warszawa.

Skarżyński M. (2009), *Finansowanie zadań w opiece zdrowotnej*, "Pielęgniarstwo Polskie", No. 2.

Skarżyński M. (2011), *Wydajność polskiego lecznictwa szpitalnego w latach 2000–2009 (w kontekście strategii bezpieczeństwa)*, in: *Zdrowie publiczne. Aktualne uwarunkowania i zmiany*, (red.) M. D. Głowacka, J. Zdanowska, Poznań.

Stanowisko Rządowej Rady Ludnościowej w sprawie "Bezpieczeństwo zdrowotne ludności Polski" (2008), Rządowa Rada Ludnościowa, Warszawa.

Strategia bezpieczeństwa narodowego Rzeczypospolitej Polskiej (2007), Biuro Bezpieczeństwa Narodowego, Warszawa.

Strategia bezpieczeństwa wewnętrznego Unii Europejskiej. Dążąc do europejskiego modelu bezpieczeństwa (2010), Bruksela.

Tajny plan NATO: obrona przed Rosją (2010), Polskie Radio, http://www.polskieradio.pl/5/3/Artykul/280476,Tajny-plan-NATO-obrona-przed-Rosja (13.12.2013).

Uchwała w sprawie ustanowienia programu wieloletniego "Priorytetowe zadania modernizacji technicznej Sił Zbrojnych RP w ramach programów operacyjnych", przedłożoną przez ministra obrony narodowej (2013), Kancelaria Prezesa Rady Ministrów, https://www.premier.gov.pl/wydarzenia/decyzje-rzadu/uchwala-w-sprawie-ustanowienia-programu-wieloletniego-priorytetowe-zadania.html (12.12.2013).

Ustawa o świadczeniach opieki zdrowotnej finansowanych ze środków publicznych z dnia 27 sierpnia 2004 r. (tekst jednolity) (2008), Dz. U. Nr 164, poz. 1027.

Witczak I. (2009), *Ekonomika szpitala. Uwarunkowania, elementy, zasady*, Warszawa.

Włodarczyk C., Poździoch S. (2000), *Pojęcie i zakres zdrowia publicznego*, in: *Zdrowie publiczne. Wybrane zagadnienia*, (red.) A. Czupryna, S. Poździoch, A. Ryś, W. C. Włodarczyk, Kraków.

Zdrowie i ochrona zdrowia w 2011 r. (2012), GUS, Warszawa.

ABSTRACT

The paper reviews the provisions of the *White Book on National Security of the Republic of Poland*. It states that the issue of health security is not given adequate significance there. The accessibility of health services is considered, in general, solely in terms of their availability. The assumptions concerning the concept of providing the number of beds required in a state of threat to national security and in time of war do not take into account the current socio-economic conditions and need to be reviewed. The conclusions emphasize the dilemmas that emerge as a result of the unilateral promotion of a single category of national security, that is military security, in the context of ensuring health security.

BEZPIECZEŃSTWO ZDROWOTNE W BIAŁEJ KSIĘDZE BEZPIECZEŃSTWA NARODOWEGO RZECZYPOSPOLITEJ POLSKIEJ – WERYFIKACJA USTALEŃ

STRESZCZENIE

W artykule dokonano weryfikacji ustaleń zawartych w *Białej Księdze Bezpieczeństwa Narodowego RP*. Stwierdzono, że problematyka bezpieczeństwa zdrowotnego została ujęta nieadekwatnie do jej współczesnego znaczenia. Dostępność do świadczeń zdrowotnych rozpatrzono ogólnie, gdyż tylko w aspekcie ich osiągalności. Założenia, zaś koncepcji tworzenia potencjału łóżkowego planowanego do rozwinięcia w sytuacjach zagrożenia bezpieczeństwa państwa i w czasie wojny nie uwzględniają obecnych uwarunkowań społeczno-ekonomicznych i wymagają przewartościowania. W podsumowaniu zwrócono uwagę na dylematy, jakie się pojawiają w przypadku jednostronnego promowania jednej z kategorii bezpieczeństwa narodowego, tj. bezpieczeństwa militarnego w kontekście zapewnienia bezpieczeństwa zdrowotnego.