This Health System Summary is based on the *Poland: Health System Review* (HiT) published in 2019 and relevant reform updates highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition, key data have been updated to those available in July 2022 to keep information as current as possible. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.


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How is the health system organized?

ORGANIZATION

Poland’s health system is based on social health insurance (SHI). It is fairly centralized, with governance concentrated in the Ministry of Health and purchasing in the National Health Fund (NFZ). Some of these roles have been decentralized to the regions (16), counties (314) and municipalities (2477), and the regional branches of the NFZ.

The regions own the generally larger regional hospitals while counties own smaller county hospitals. Municipalities own some primary care practices although the majority of these practices are private. Municipalities are also responsible for certain public health tasks, but their health budgets are very limited. There is little coordination between these three administrative levels, which obstructs coordination of care and other activities. The regional branches of the NFZ are charged with the purchasing of services in their respective territories, which is open to both public and private providers. The basket of guaranteed services is set centrally and there is little scope to adapt purchasing to local needs.

PLANNING

Planning is the responsibility of the central government, particularly the Minister of Health and the regions (voivodeships). The key strategic planning document Healthy Future. A Strategic Framework for the Development of the Health Care System for 2021–2027, with a perspective until 2030 was published in 2021 and sets out priorities for the entire health system. The National Health Programmes set out priorities in public health, with the current edition (2021–2025) focusing on increasing the healthy years lived and reducing social health inequalities. The annual health needs maps, introduced in 2015, are meant to support contracting and priority setting in the system, but do not always lead to real changes in contracting (Box 1).

Although the health system is fairly centralized, coordinating activities between the administrative levels has been difficult.

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BOX 1 | EVALUATING PRIORITY SETTING AND PLANNING

Despite the existence of a number of strategic documents, the health care system has until recently lacked a long-term strategic vision and a unified strategy. Even the national policy in the area of public health, set out in the National Health Programmes since 1990, was not comprehensively regulated until the adoption of the Public Health Act in 2015. Planning of health services provision has been traditionally determined by the NFZ and the Polish Health Technology Assessment (HTA) agency (established in 2005). The introduction of the health needs maps, published annually since 2015, was meant to support a more effective planning of provision, but this remains largely determined by the existing health infrastructure rather than needs. Planning in some other crucial areas, including human resources planning, has been underdeveloped.

The publication of the National strategic framework – policy paper for health protection for 2014–2020, which set out priorities for the health system in connection with the support from EU structural funds, paved the way for a more holistic planning that encompasses the entire health system. The new strategic framework published in 2021 extended this beyond the EU funds. However, strategic planning has so far been dominated by the Ministry of Health and subordinate institutions, with not much input from other stakeholders. One exception was the experts’ debate entitled Together for Health – we talk, listen, act, which was initiated in early 2018 by the Minister of Health with the aim to create a widely accepted strategy for the health system. With the change of Health Minister in 2020, further work on the proposals laid out in this debate was abandoned, although some of them can be recognised in the 2021 framework. This lack of comprehensive stakeholder involvement is visible in the various pilots implemented in recent years (see below), which were often difficult to implement in practice and had to be adapted because they did not reflect the realities on the ground.
PROVIDERS

Most of primary health care and specialist outpatient care is provided in solo private or (usually small) group practices. Both can provide services under contracts with the NFZ or to private, self-paying patients. The majority of hospitals are public and most of them are owned by the territorial self-governments (regions and counties), with county hospitals providing less complex care than the tertiary-level hospitals owned by the voivodeships. Highly specialist clinics and institutes are owned by medical universities and the Ministry of Health. Private provision within public hospitals is only permitted in those hospitals that operate as Commercial Code Companies (about 15% of all hospital beds).

How much is spent on health services?

FUNDING MECHANISMS

Health insurance contributions (an earmarked payroll tax) are the main source of public health care funding, accounting for about 60% of current spending on health. These funds are allocated to the regional branches of the NFZ, which contract with providers of health services. This allocation takes into account the number and risk profile of inhabitants but also the distribution of physical and human resources. Taxation accounts for about 10% of current expenditure and is used to finance outpatient medical emergency services, public health programmes and benefits for population groups exempt from paying SHI contributions, among other things. Household private spending is the second most important source of funding, accounting for close to 30% of current health spending.

HEALTH EXPENDITURE

In 2019, health expenditure accounted for 6.45% of gross domestic product (GDP) (Fig. 1), which is much lower when compared to the EU/EEA/UK (8.49%) and the WHO European Region (7.63%) averages. At 2207 US$ PPP, per capita health expenditure was equivalent to approximately half of the EU/EEA/UK average (Fig. 2). In 2018, the government pledged to progressively increase public spending on health as a percentage of GDP (see Box 5).

In the same year public sources accounted for just over 71% of current expenditure on health, a share which has remained fairly unchanged over the past 20 years. Out-of-pocket (OOP) payments make up about one fifth of current health spending and the share of voluntary health insurance (VHI) is also substantial (8%). VHI is mainly in the form of group insurance packages covering occupational health and other health services purchased by employers for their employees.
FIG. 1  TRENDS IN HEALTH EXPENDITURE, 2000–2019

Note:
PPP = purchasing power parity

FIG. 2  CURRENT HEALTH EXPENDITURE (US$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2019

Notes: CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity; UK: United Kingdom.
Data for Albania is from 2018.
OUT-OF-POCKET PAYMENTS

In 2019, OOP payments made up just over 20% of health spending. Primary care, outpatient specialist care and hospital care (including inpatient pharmaceuticals) within the publicly financed health system are provided free of charge. Cost-sharing is also not applied to dental care, but most dental services are excluded from the benefits package and purchased privately. In contrast, cost-sharing is widely applied to outpatient pharmaceuticals, with private payments on outpatient medicines accounting for the largest share of OOP payments by far (Fig. 3). Use of non-prescribed medicines purchased over the counter is very high and they account for over three quarters of all OOP spending on medicines.

FIG. 3  COMPOSITION OF OUT-OF-POCKET PAYMENTS, 2019

Coverage

The public system covers 91% of the population but is essentially universal, with most of the uninsured living abroad but remaining registered as residents. People without SHI coverage have access to outpatient emergency medical care and primary care. The scope of services covered under SHI is broad, but there are important coverage gaps (Box 2).

Box 2 | What are the key gaps in coverage?

There is no formal patient cost-sharing for the use of primary care, outpatient specialized care and hospital care provided within the publicly financed system. While inpatient pharmaceuticals are provided free of charge, outpatient medicines are subject to patient cost-sharing. Public spending accounts for only about a third of spending on pharmaceuticals and for a similar share of spending on therapeutic appliances, such as vision and hearing aids. This is a major coverage gap and may lead to patients foregoing necessary care. Most dental services are excluded from the benefits package and there is no possibility of extra billing, which means that most dental care must be purchased privately. There is also little public provision of long-term care, which is highly reliant on informal carers.
PAYING PROVIDERS

The NFZ uses prospective payment methods and total budgets for contracted services are mostly fixed in advance. Service-based payments such as diagnosis-related groups (DRGs), introduced in 2008, dominate but pay-for-performance (P4P) and quality-based payments are slowly emerging (Fig. 4). The use of DRGs has been associated with obstructing coordination of care and with distorting coding of deaths, because many hospitals struggle with indebtedness and some DRG codes attract higher payments. Since 2017, most public hospitals have been included in the hospital network and receive biannual lump sum payments (based on DRGs), which are meant to cover both inpatient and outpatient services. It is hoped that this will improve continuity and comprehensiveness of care.

FIG. 4 | PROVIDER PAYMENT MECHANISMS IN POLAND

<table>
<thead>
<tr>
<th>GPs</th>
<th>Specialists</th>
<th>Acute Hospitals¹</th>
<th>Hospital Outpatient services¹</th>
<th>Dentists</th>
<th>Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capitation (age adjusted), fee-for-service, lump sum, elements of P4P (e.g., for prophylaxis or effective management of chronic diseases such as diabetes)</td>
<td>Per visit (based on DRGs); elements of P4P (for coordinated care)</td>
<td>Lump sum (based on DRGs), which is meant to cover both outpatient and inpatient care; elements of P4P (for coordinated care) and quality-based funding (higher lump sums for quality certificates)</td>
<td>Lump sum (based on DRGs), which is meant to cover both outpatient and inpatient care; fee-for-service; elements of P4P (for coordinated care) and quality-based funding (higher lump sums for quality certificates)</td>
<td>Fee-for-service</td>
<td>Paid per product (reimbursed pharmaceuticals)</td>
</tr>
</tbody>
</table>

Note: ¹Hospitals that are not included in the hospital network participate, as before, in tender procedures and their contracts are based on DRGs.
What resources are available for the health system?

HEALTH PROFESSIONALS

According to Eurostat data, the number of practicing doctors in Poland is 238 per 100 000 population, the lowest in the EU, and the number of nurses is also among the lowest (510 per 100 000 population), with both these numbers remaining fairly constant over several years (Figs. 5A and 5B). While national data report higher numbers, shortages of health workers still have been reported across the country, particularly in small counties around large cities and in rural areas. Financial incentives have been introduced to attract more doctors to these areas.

FIG 5A  NUMBER OF PHYSICIANS PER 100 000 POPULATION IN POLAND AND SELECTED COUNTRIES, 2000–2020 (OR NEAREST YEAR)

Note: Data for Poland is from 2017.

FIG 5B  NUMBER OF NURSES PER 100 000 POPULATION IN POLAND AND SELECTED COUNTRIES, 2000–2020 (OR NEAREST YEAR)

Note: Data for Poland is from 2017.
HEALTH INFRASTRUCTURE

The number of hospital beds is comparatively high, at 435 beds per 100,000 population in 2019, compared to an EU average of 387, although it appears to have declined slightly over the past few years (Fig. 6). Rather than reducing the overall number of hospital beds, current reform plans foresee transforming some acute care beds into other types of beds, to respond to deficits in other areas of care, such as long-term and geriatric care.

The availability of expensive medical equipment is lower in Poland than the EU average (Fig. 7). The majority of equipment is located in hospitals. Investments in medical equipment are funded by the hospitals themselves, including from external sources (for example, EU funds) and donations, or by hospital owners, as funding from NFZ contracts is usually not enough. Due to the fragmentation of hospital ownership, there is little coordination of investments.

**FIG. 6** BEDS IN ACUTE HOSPITALS PER 100,000 POPULATION IN POLAND AND SELECTED COUNTRIES, 2000–2019


**FIG. 7** MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) SCANNERS IN POLAND PER 100,000 POPULATION, 2020

<table>
<thead>
<tr>
<th>Country</th>
<th>MRI Scanners per 100,000 Population</th>
<th>CT Scanners per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>1.05</td>
<td>2.01</td>
</tr>
<tr>
<td>Lowest and highest in EU (range)</td>
<td>0.49 (Hungary) to 3.45 (Germany)</td>
<td>0.96 (Hungary) to 4.64 (Iceland)</td>
</tr>
</tbody>
</table>

Note: In 2016, there were 926 hospitals, of which 600 were public. Close to 80% of CT scanners and 60% of MRI scanners are located in hospitals.

DISTRIBUTION OF HEALTH RESOURCES
Access to primary care is generally good, but patients living in rural areas have worse access compared with urban patients. Despite the overcapacity in the hospital sector, access to hospitals may also be limited by their uneven geographical distribution, which is determined more by historical factors than by current population needs. Since medical equipment is mostly located in hospitals, access to diagnostics is also uneven. For example, there were 24 CT scanners in the country in 2017, but 10 of them were located in only two regions and two regions had none. The use of teleconsultations was high during the first two years of the COVID-19 pandemic; they have since remained widely used for initial consultations and patient triage within primary care. Since late 2021, they have been mandatory in certain situations, for example, when renewing prescriptions.

How are health services delivered?

PRIMARY AND AMBULATORY CARE
Primary care doctors generally serve as gatekeepers to more specialized care, although a referral is not needed to see certain specialists such as gynaecologists, obstetricians, oncologists, psychiatrists and dentists. Limited access to diagnostics within primary care has meant that patients have often been referred up to more specialist care, contributing to long waiting times to specialist consultations. Since mid-2022, primary care doctors have been permitted to order a larger range of diagnostic tests. However, since the capitation fee paid to them per patient is expected to cover the cost of diagnostics, primary care doctors sometimes limit the number of diagnostic services they provide in order to limit costs. Illness prevention and health promotion have so far been largely neglected within primary care. This was addressed in the new primary care model (PHC PLUS) piloted between 2018 and 2021, which is now being rolled out in a piecemeal and partly voluntary fashion (Box 3).

HOSPITAL CARE
Overreliance on hospital care relative to other forms of care and weak coordination between hospital and non-hospital care have been longstanding features of the Polish health system. Efforts to improve coordination of care have so far largely focused on specialist care (Box 4), with the PHC PLUS pilot being a notable exception. The introduction of the hospital network in 2017 aimed to improve coordination between specialist outpatient and specialist inpatient care, and so far about two thirds of patients have their post-hospitalization services arranged by the hospital in which they were hospitalized. Recent implementation of e-health tools, such as electronic health records (implemented in 2019), e-prescriptions (2020) and e-referrals (2021) can further support coordination of health services across providers and levels of care. Although the number of procedures performed in day-care settings has been increasing, the share of one-day hospitalizations within the total number of hospitalizations remains much lower than the OECD average.

PHARMACEUTICAL CARE
The number of new medicines covered under SHI has increased significantly in recent years, but it can still take several years for a new active substance to be included in the benefits package. Parallel exports, which gave rise to shortages of some drugs in the past, have been curtailed, but the problem of illegal exports remains. To counter this problem, in 2019, the government introduced criminal liability for illegal export of medicines and improved monitoring of the trade in medicines and their availability. The high level of cost sharing for pharmaceuticals poses a major accessibility problem.
MENTAL HEALTH CARE

Financing of mental health care is very low and is mostly allocated to residential care in psychiatric hospitals. Despite the commitment, over a decade ago, to shift provision of mental care to the community, little progress has been made. Since mid-2018, mental health care centres have been piloted across Poland and have shown positive results in terms of improved access to non-stationary care and reduced hospitalizations. Nevertheless, the underdevelopment of community infrastructure means that many of these centres have been located in psychiatric wards of general hospitals or in psychiatric hospitals, rather than in the community, which may be associated with worse access and stigmatization. Acute workforce shortages constitute a major threat to the pilot but innovations such as the introduction of recovery assistants recruited from patients who have recovered can mitigate it to some extent.

BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

Family medicine has not traditionally been a popular specialisation in Poland, but this appears to be changing thanks to financial and other incentives implemented over the past few years (for example, since 2019 young physicians who passed the state medical exam can practice in primary care facilities before starting their specialization). Nevertheless, shortages of primary care physicians continue to constitute a major weakness. To compensate for these shortages, specialists in internal medicine and paediatrics are also allowed to work as primary care doctors, but they have limited competencies in family medicine.

In 2015, nurses were allowed to prescribe certain medicines and medical devices and refer patients for diagnostic tests, which should have alleviated some pressure on primary care doctors. The competencies of primary care doctors in cancer detection were also extended in the same year and they were tasked with identifying patients with suspected cancer for faster diagnostics and treatment. However, this new competency was not accompanied by provision of any additional training in this area.

The PHC PLUS pilot was a major attempt to strengthen the role of primary care, introducing periodic health check-ups and individual health plans to strengthen disease prevention and health promotion, establishing disease management programmes for common chronic conditions, and shifting their management to newly established multidisciplinary primary care teams, supported by care coordinators and with improved access to specialist consultations. After the pilot was concluded in September 2021, all primary health care practitioners were mandated to hire care coordinators and since July 2022 they were allowed to order a larger range of diagnostic tests. Since October 2022, care coordination was introduced on a voluntary basis in four areas (cardiology, diabetology, pulmonology, and endocrinology), with improved access to diagnostics and specialist consultations and strengthened disease prevention and health promotion.

BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?

A number of initiatives to improve coordination of care has been implemented over the past two decades. These have usually focused on specific groups of patients or conditions, usually encompassing various types of specialist care, with only a few initiatives including a wider range of health services or sectors, such as the social assistance sector. Existing programmes cover people with suspected or diagnosed cancer, patients after myocardial infarction and people with mental health disorders, among others. It is not always clear if these initiatives have led to real improvements, partly because their implementation is not properly monitored and assessed. In 2021, improving coordination of care was recognised as a strategic objective of the Polish health system. This is to be achieved by establishing new models of coordinated care, including for older people and for people with mental health conditions, and new structures, such as the National Oncology Network and the National Cardiology Network, which are currently being piloted.
DENTAL CARE

Most dental care is provided in solo private dental practices and paid for privately since the scope of statutory dental benefits is very narrow. The number of dental practices contracted by the NFZ has been decreasing in recent years. Fluoride prophylaxis is available for primary school pupils in grades 1 to 6 but incidence of dental caries in children is very high. Mobile detail clinics (known as dentobuses) were introduced in 2017, one in each region, to improve access to dental care for children.

What reforms are being pursued?

Much of the focus of recent reforms has been on improving the organization of care for some of the key health problems, including cancer, cardiological diseases and mental health conditions (Box 5). This included skill-mix changes among health professionals and strengthening of care coordination, including within primary care, but some of the solutions have only been piloted and not yet widely introduced. The recent implementation of e-health solutions, to some extent accelerated by the COVID-19 pandemic, can support these efforts. While strengthening coordination of care is one of the current strategic goals, there is no holistic plan encompassing all the initiatives. Indebtedness of public hospitals remains a major issue but the attempt to transform them into Commercial Code Companies, initiated in 2011, was too controversial and eventually abandoned. A new draft law has been in preparation since 2021 to restructure and improve efficiency of the hospital sector, which proposes the creation of a dedicated agency charged with restructuring of hospitals that are in the worst financial shape. Another ongoing reform initiative (started in 2021) focuses on improving quality of inpatient care and seeks to comprehensively regulate issues such as authorisation and accreditation of health care providers, monitoring of adverse events and patient compensation. Another goal is the creation of medical registers.

How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

The Polish health system is primarily supervised by the Minister of Health, with specific tasks delegated to supporting institutions. The focus of this supervision is mainly on monitoring of selected indicators, such as mortality or the number of provided services, rather than on explicitly assessing aspects of health system performance, such as quality or efficiency. Public institutions such as the Supreme Audit Office and the nongovernmental sector carry out periodic evaluations of the functioning of the various areas of the health system. Another source
of evaluations is the nongovernmental sector and the academic community.

Data collection is dispersed across several institutions and collected data may not always be coherent (for example, there are large discrepancies in the nationally reported number of human resources in health and the numbers reported to international databases) or accurate (for example, Poland stands out in Europe in terms of the very high number of so-called garbage codes in mortality data). Much progress has been made in recent years in terms of the implementation of e-health tools (see above), which can support performance monitoring.

**BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS**

- **Transformation of public hospitals into companies under the Commercial Companies Code (2011):** to improve financial management in the hospital sector and reduce debts. Few hospitals were transformed and a change in policy in 2016 essentially halted this process.

- **Introduction of nurse prescribing and nurse referrals (2015):** to reduce waiting times and improve access to care.

- **Introduction of a fast cancer pathway with unlimited financing of services covered (2015):** to ensure fast access to diagnostics and treatment for patients with suspected and diagnosed cancer.

- **Introduction of a hospital network with lump sum financing (2017):** to improve provision of specialist care by incentivizing coordination between inpatient care and ambulatory care in hospital outpatient departments.

- **Increase of public spending on health (2018):** to increase public spending on health to 6% of GDP by 2024. In 2021, it was decided that this target should be met by 2023 and a new target of 7% should be reached by 2027.

- **Extension of competencies of physiotherapists (2019):** to allow physiotherapists to independently plan therapy and decline therapy deemed inappropriate, except for referrals from medical rehabilitation specialists.

- **Piloting of mental health centres (2018–2022):** to shift provision of mental care to the community.

- **Piloting of a new model of primary care provision (2018–2021):** to strengthen provision and chronic care coordination at the level of primary care. After the pilot ended, a piecemeal and partly voluntary roll-out has been pursued (Box 3).

- **Implementation of e-health tools (2019–2021):** to implement the Electronic Platform for Collection, Analysis and Sharing of Digital Medical Records (P1), which was initially planned for 2014. Electronic health records were implemented in 2019, e-prescriptions in 2020, and e-referrals in 2021.

- **Piloting of the National Oncology Network (2019–2022):** to improve the organization of the cancer care system, with standardised patient pathways, concentration of expertise in highly specialized procedures, and quality monitoring.

- **Piloting of the National Cardiology Network (2021–2024):** to improve cooperation between primary care, and ambulatory care and inpatient care in cardiology.

- **Allowing pharmacists, nurses, and physiotherapists to give vaccinations (2021–2022):** to improve access to COVID-19 vaccines (new competencies granted in 2021) and flu vaccines (2022).
ACCESSIBILITY

Although patients are not required to pay for primary and inpatient care, their access to these services may still be constrained in practice. This is due to acute health workforce shortages and the limited financial resources of the NHF, which puts limits on the volume of contracted services. However, some of these limits have been abolished in recent years, such as in oncology since 2015 and in other areas of care with long waiting times (for example, cataract surgery) and diagnostics (such as CT and MRI scans).

No waiting-time guarantees are in place. Problems with accessing outpatient services may encourage those who can afford it to use private care providers and may be one reason behind the high share of non-prescription medicines in OOP spending on pharmaceuticals. Despite the introduction of exemption mechanisms for outpatient prescription, including for older people (2016) and pregnant women (2020), spending on outpatient medicines remains particularly high among pensioners, people with disabilities and households in rural areas, and may lead to unmet need. In 2020, 1.9% of the Polish population reported unmet needs for medical examinations due to either costs, distance or waiting times (the EU average was 1.8%) (Fig. 8).

FIG. 8 UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME, OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2020

HEALTH CARE QUALITY

Health quality and patient safety are not routinely assessed in Poland, although the planned reform on health care quality may change this. So far, the focus of policy initiatives in this area, including in the planned reform, has been on hospital care, with few evaluations targeting primary care. Quality accreditation is financially incentivized but is not mandatory and few hospitals and even fewer primary practices have it. Medical errors are only recorded in accredited hospitals and there is no obligatory reporting of medical errors for other providers.

The level of avoidable hospitalizations for conditions manageable within primary care or outpatient settings is one of the highest across EU countries (Fig. 9), pointing to deficiencies in the provision of primary and outpatient specialist care. The new model of primary care provision piloted between 2018 and 2021 offered an opportunity to strengthen the management of chronic conditions within primary care, including through disease management programmes, and the tested solutions are being gradually implemented (Box 3). The high (albeit falling) amenable mortality rate (see Health System Outcomes and Fig. 11) and low cancer survival rates are further indicators of deficiencies in the quality of care, including late detection. However, there are areas of care, such as cardiology care, where there has been much investment, and where Poland fares more favourably than some other countries in Europe, particularly for in-hospital mortality rates after admission for acute myocardial infarction (Fig. 10). The main reasons for patient dissatisfaction with health care appear to be linked to issues of long waiting times and accessibility (Box 6).

FIG. 9 AVOIDABLE HOSPITAL ADMISSION RATES FOR ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE AND DIABETES, 2019

Note: Data for congestive heart failure is not available in Latvia and Luxembourg. Data for diabetes for Luxembourg is from 2015.

Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).
Both preventable and amenable mortality rates decreased in Poland between 2011 and 2019, but both remain higher than their respective EU averages (Fig. 11). The high prevalence of tobacco smoking and alcohol consumption are key drivers of preventable mortality rates (which could be avoided through public health and primary prevention interventions), but efforts are being made to address these (Box 7). The decline in amenable mortality (which could be avoided through health care interventions, including screening and treatment) appears to have stagnated between 2014 and 2019, which is a trend not seen in other countries in Europe. Moreover, there are signs that the declining trend has even reversed in some regions. Ischaemic heart disease (IHD), cancer and stroke are the major drivers of amenable mortality rates, and the slowdown in amenable mortality in recent years appears to be due mostly to slower progress in reducing deaths from IHD. However, there seems to be a systematic underreporting of IHD as a cause of death in Poland in favour of heart failure, which makes analysis of health system performance using amenable mortality as an indicator less reliable (Sagan et al., 2022).

Assessment of patient experience is done on a voluntary basis, with individual hospitals using different methods and time frames. According to the annual survey conducted by the Public Opinion Research Centre (CBOS), the share of respondents that were satisfied with the public health care system in Poland increased from 23% in 2016 to 30% in 2018. Yet, the majority of respondents remained unsatisfied (in 2018, 27% were “definitely”, and an additional 39% “rather” unsatisfied). The key reasons for dissatisfaction were long waiting times for diagnostic tests and specialist consultations. At the same time, respondents appreciated doctors’ professional skills and work ethics. While satisfaction with the health system increased slightly in 2020, it decreased to pre-pandemic levels in 2021. In 2020, 4360 formal complaints were submitted to the NFZ. Most of them (69%) were related to the issue of access to services, and 20% were focused on issues related to the quality of care. The Patient Rights Ombudsman received over 135 000 complaints in 2020, most of them related to limited access to care, mainly to hospital care (about 60% of confirmed violations of patient rights).
HEALTH SYSTEM EFFICIENCY

Over recent years, measures have been put in place to improve allocative efficiency in the health system, such as through the introduction of health needs maps. However, contracting continues to be largely determined by the available infrastructure and the imbalance between hospital care and outpatient care persists. The number of hospital beds remains relatively high and occupancy rates low compared to other countries in the EU, which point towards overcapacity in the hospital sector. There are now plans to convert some of the hospital beds into other types of beds, such as long-term care beds, where there has been chronic under-provision. In the area of pharmaceuticals, the generics market is well developed, and market shares of generics are among the highest in Europe. However, cost-effectiveness is not a key determinant of pharmaceutical policy (Box 8), perhaps partly because the share of public spending on medicines is not very high.

FIG. 11 MORTALITY FROM PREVENTABLE AND AMENABLE (TREATABLE) CAUSES 2011 AND 2019

Note: Data are for 2011 and 2019 or latest available year. Data for France is from 2017, and from 2018 for Malta and the United Kingdom.
Tobacco and alcohol control policies have been inconsistent and not always very effective over the years. While alcohol consumption has been increasing, smoking rates have been decreasing, including in adolescents (although growing popularity of e-cigarettes among young people is concerning). Obesity rates have also been rising and this increasing prevalence has only become a policy concern in recent years.

Tobacco control regulations were introduced in the 1990s and prevalence of cigarette smoking has decreased in both men and women. However, in 2015 the national tobacco control programme was discontinued. The annual tax increases on tobacco products were suspended and it was only in 2020 that excise duty on tobacco products (including e-cigarettes) was increased.

Alcohol control measures have also been weakened over the past 20 years, with the ban on beer advertising on television lifted in 2001 and excise taxes on spirits reduced by 30% in 2002 (Zatoński et al., 2021). In 2020, excise duty was increased by 10% on all alcoholic drinks. To reduce the sales of smaller bottles of vodka, which rose after 2010, in 2021 the government introduced an additional fee on alcohol sold in bottles of up to 300 ml, but producers, in anticipation of this change, switched to 350 ml bottles shortly before the new tax came into force.

Measures aimed at tackling rising obesity rates include mass media campaigns to promote healthy eating, regulation of advertising and sales of certain foods sold in primary and secondary schools. For example, since September 2015, it has been explicitly forbidden to sell products with added sugar or salt, white bread and coffee, certain drinks and fast food on the premises of educational facilities. Economic levers such as taxes and broader sales regulations (similar to the strategies used for limiting alcohol and tobacco consumption) have not been adopted.

Measures aimed at improving cost-effective use of medicines are mainly focused at ensuring that a certain cost–effectiveness threshold is met for new medicines (or new indications) accepted for public reimbursement. Such a threshold has been used since 2012, but cost–effectiveness is only one of the 13 criteria of pharmaceutical pricing and reimbursement decision-making, and it is not obligatory.

There are no officially adopted guidelines for cost–effective prescribing. Prescribing is controlled by the NFZ but mainly for administrative purposes, rather than to influence prescribing behaviour. Pharmacy margins are linked to the price limit established for a particular group of medicines rather than the price of a particular medicine to remove incentives to sell more expensive medicines from the same group.

Polish physicians do not have dispensing budgets and there is no prescribing by active ingredient/International Nonproprietary Name (INN). Nevertheless, pharmacies must inform patients about available substitutes that are publicly reimbursed and be able to supply them to patients. The use of generics is high. According to 2017 data, among the reimbursed prescription medicines the share of generics was 27% by value and 89% by volume in hospitals and, respectively, 66% and 76%, in outpatient pharmacies. Price competition in the generics market has been improved in 2012, but only for medicines that entered the market since that year.
Summing up

The Polish health systems achieves a lot for the little money it spends. However, this low spending means that there are major coverage gaps in the care that is provided (such as pharmaceuticals) and that some types of care, such as long-term care, remain underdeveloped, with patients left to rely on informal care or private provision. It also hampers investments in primary care and development of community care more broadly and means that the historical dominance of acute hospital care remains difficult to reverse. Many patients could be effectively (and more cheaply) treated at lower levels of care and closer to their homes. Recent initiatives to shift provision of care to the community, such as the piloted mental health centres and the gradual roll-out of the PHC reform, are promising. Low levels of financing also means that the heath sector is not a very attractive place to work and partly explains the existing workforce shortages. The recent pledges to increase public sources of health financing are promising and, if fulfilled, offer a chance to implement some of the needed reforms.
### POPULATION HEALTH CONTEXT

### KEY MORTALITY AND HEALTH INDICATORS

<table>
<thead>
<tr>
<th>LIFE EXPECTANCY (YEARS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth, total</td>
</tr>
<tr>
<td>Life expectancy at birth, male</td>
</tr>
<tr>
<td>Life expectancy at birth, female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MORTALITY (PER 100 000)</th>
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</thead>
<tbody>
<tr>
<td>All causes</td>
</tr>
<tr>
<td>Circulatory diseases*</td>
</tr>
<tr>
<td>Malignant neoplasms*</td>
</tr>
<tr>
<td>Communicable diseases*</td>
</tr>
<tr>
<td>External causes of death*</td>
</tr>
<tr>
<td>Infant mortality rate (per 1 000 live births)</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100 000 live births)</td>
</tr>
</tbody>
</table>


**Source:** Eurostat 2022, 2021; World Bank, 2022 for maternal mortality.

**REFERENCES**


Zatoński WA et al. (2021), Alcohol-related deaths in Poland during a period of weakening alcohol control measures. JAMA, 325(11):1108–09.
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