State of Health in the EU

POLAND

Country Health Profile 2025

European Commission

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European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profiles series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and knowledge transfer. The 2025 edition of the Country Health Profiles includes a special section dedicated to pharmaceutical policy.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Observatory's Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys, the Survey of Health, Ageing and Retirement in Europe (SHARE), the European Cancer Information System (ECIS) and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2025, based on data that were accessible as of the first half of September 2025.

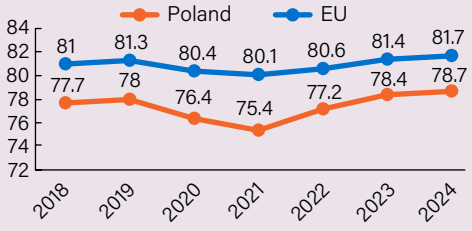
Demographic and socioeconomic context in POLAND, 2024

Demographic factors	Poland	EU
Population size	36 620 970	449 306 184
Share of population over age 65	21 %	22 %
Fertility rate 2023[1]	1.2	1.4
Socioeconomic factors		
GDP per capita (EUR PPP)[2]	31 362	39 675
At risk of poverty or social exclusion rate[3]	16.0 %	20.9 %

1. Number of children born per woman aged 15-49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. At risk of poverty or social exclusion (AROPE) is the percentage of people who are either at risk of poverty, severely materially and socially deprived, or living in a household with very low work intensity.

Source: Eurostat Database.

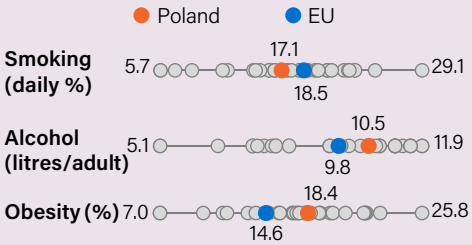
1 Highlights



Life expectancy at birth

Health Status

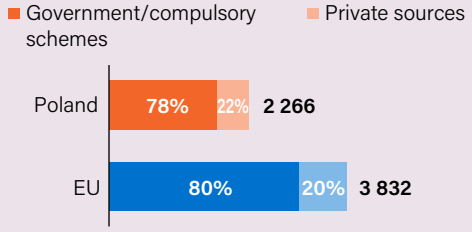
Life expectancy at birth fell by 2.6 years in Poland between 2019 and 2021, but in 2024 it reached its highest ever level, at 78.7 years. The gap between life expectancy for men and women was comparatively high, at 7.5 years in favour of women in 2023. Mirroring trends across Europe, cardiovascular diseases and cancer were the leading causes of death and ill health.



Adults, 2022 (or nearest year)

Risk Factors

Tobacco use in Poland has been falling since 2001. However, smoking rates among adolescents have remained persistently high, and – as elsewhere in the EU – use of e-cigarettes is increasing. This has prompted policy makers to regulate nicotine-containing products in the same way as tobacco products. Alcohol use also remains an important risk factor that has prompted greater regulation of the alcohol market.



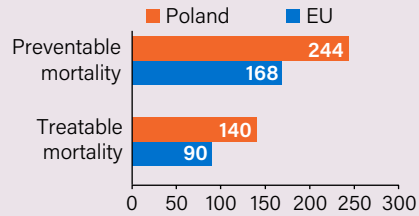
Health spending per capita (EUR PPP), 2023

The Health System

Overall health spending per capita in Poland in 2023 was EUR 2 266, which was 40 % lower than the EU average of EUR 3 832. Of this, 78 % came from prepaid public sources, but 22 % came from private spending – most directly out-of-pocket. The majority of out-of-pocket spending was on outpatient pharmaceuticals and dental care.

Health System Performance

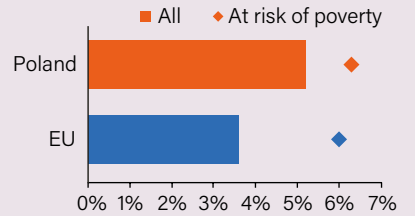
Effectiveness



Age-standardised rate per 100 000 population, 2022

The overall preventable mortality rate in Poland was falling prior to the COVID-19 pandemic, but it has been persistently higher than the EU average. In 2022 it was 244 per 100 000 population, compared to 168 per 100 000 across the EU. Alcohol and tobacco consumption play a key role. Mortality from treatable causes was similarly high.

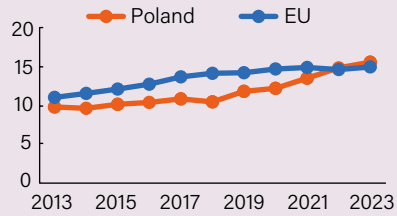
Accessibility



% reporting unmet medical care needs, 2024

In Poland, 5.2 % of people who specifically expressed a need for medical care could not access it due to cost, waiting times or distance to travel in 2024, compared to the EU average of 3.6 %. Unmet medical care needs among the general population have come down as waiting times have fallen, despite disruption caused by the COVID-19 pandemic.

Resilience



Medical graduates per 100 000 population

The sustainability of Poland's health workforce is a key challenge in building resilience. Until very recently, the numbers of medical and nursing graduates have been lower than the EU averages. A data-driven planning process for health workforce development has been instigated across Poland, and the number of medical students almost doubled between 2012 and 2023.

Spotlight: pharmaceuticals

In 2023, on a per capita basis, Poland spent one third less (EUR 352) than the EU average (EUR 510) on retail pharmaceuticals. However, most out-of-pocket health spending in Poland was on pharmaceuticals (63 %, compared to the EU average of 36 %) because statutory coverage is limited by complex copayment criteria. All medicines prescribed and administered in hospitals are free of charge for patients. High-cost inpatient pharmaceuticals are funded under various national schemes, with tightly defined inclusion and exclusion criteria, and close monitoring.

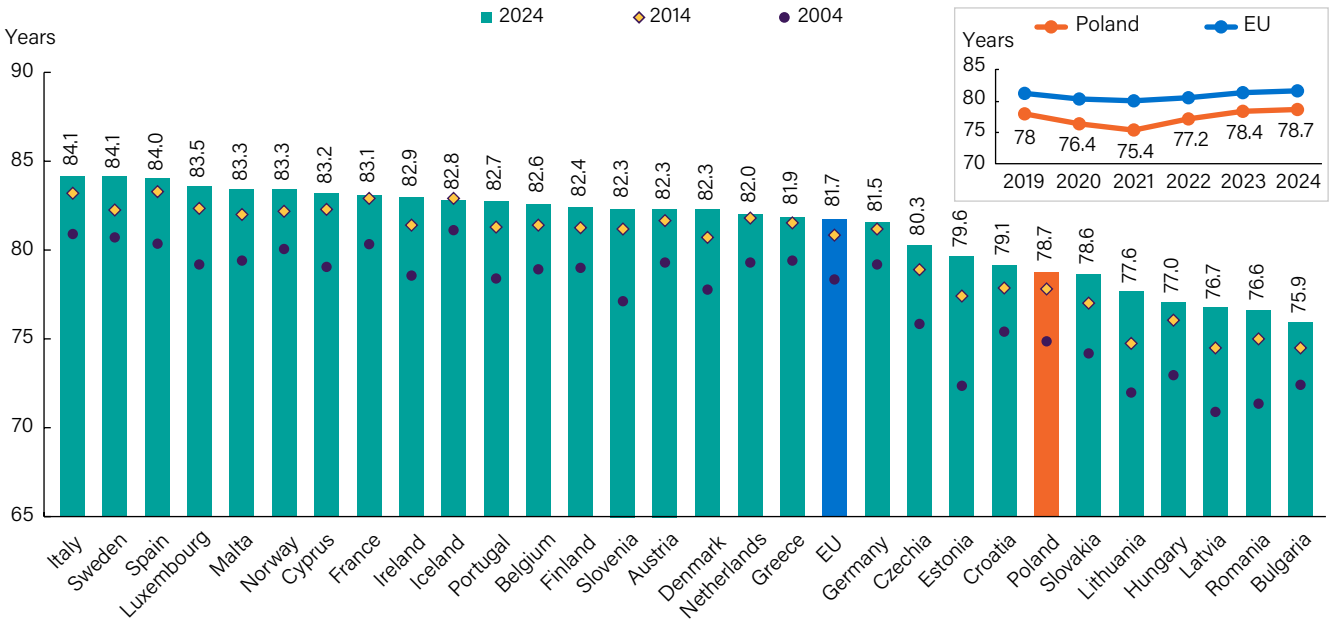
2 Health in Poland

Life expectancy at birth in Poland remains much lower than the EU average

In 2024, life expectancy at birth in Poland was 78.7 years – 3 years lower than the EU average. Following a very large reduction during the COVID-19 pandemic, life expectancy recovered and exceeded its pre-pandemic level in 2023 (Figure 1).

As in other EU countries, Polish men tend to have shorter lifespans than women. In 2024, the life expectancy of men was 7.5 years shorter than women – a gender gap greater than the EU average gap of 5.2 years. However, these numbers have been improving steadily since 2010, when Poland's gender gap was 8.5 years. This disparity is largely due to men's greater exposure to risk factors (see Section 3).

Figure 1. Life expectancy at birth in Poland is three years below the EU average



Notes: The EU average is weighted. 2024 data for Ireland pertain to 2023.
Source: Eurostat (demo_mlexpec).

Cardiovascular diseases and cancer are by far the leading causes of death in Poland

In 2023, the leading causes of death in Poland were cardiovascular diseases (including ischaemic heart disease and stroke) and cancer, which together accounted for 61.2 % of all deaths (Figure 2). Respiratory diseases also accounted for a large number of deaths in 2023. Although the share of deaths attributed to COVID-19 was much lower than in 2020-2022, it was still 1.1 % in 2023.

Most Poles report being in good health, but there are substantial disparities by income level

In 2024, 64 % of Polish people reported being in good health – slightly lower than the EU average of 68 %. As in other EU countries, there is a significant gender gap: 67.5 % of men reported being in good health compared to 61.6 % of women (Figure 3). The gap by income level is much greater: 49.3 % of Polish women in the lowest income group reported being in good health compared to 76.4 % of those in the highest income group. This income gap is greater than the EU average.

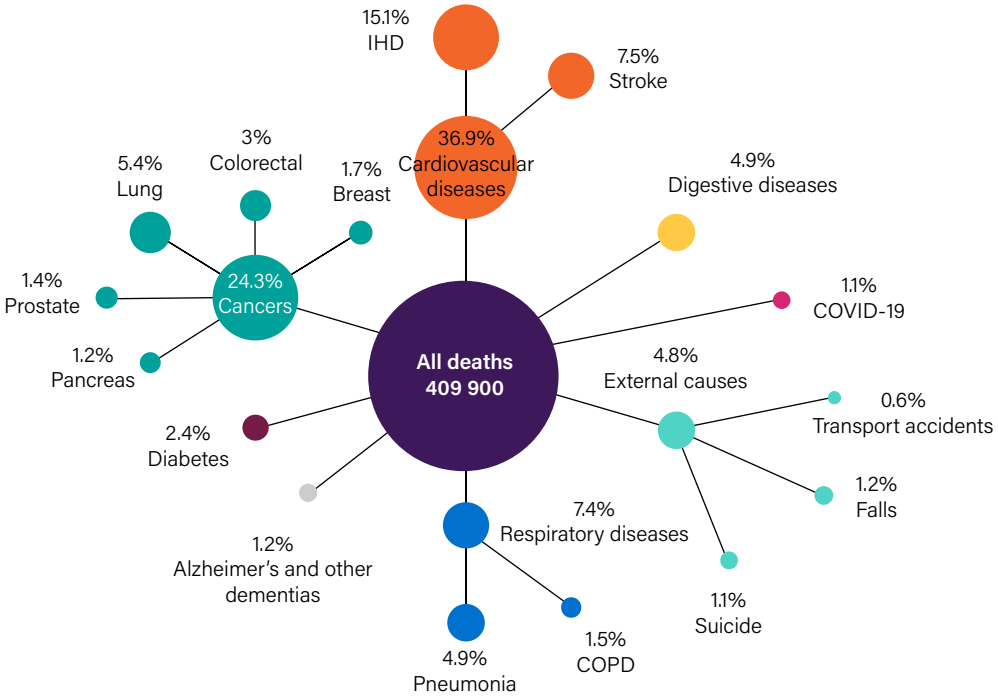
Older people have shorter lifespans and a higher prevalence of chronic conditions

As in other EU countries, Poland has experienced a demographic shift towards an older population over the past two decades, with the proportion of people aged 65 and over rising from 12 % in 2000 to 21 % in 2024. This share is projected to increase further to 30 % by 2050. The effects of population ageing on a shrinking labour force are also exacerbated by relatively high mortality at working ages.

In 2022, 65-year-old women in Poland could expect to live another 19.6 years, while men could expect to live another 15.4 years. However, there was almost no gender gap in healthy life years (8.6 years for women and 7.8 years for men) as women could expect to live a smaller proportion of their lives after age 65 with no activity limitations (Figure 4).

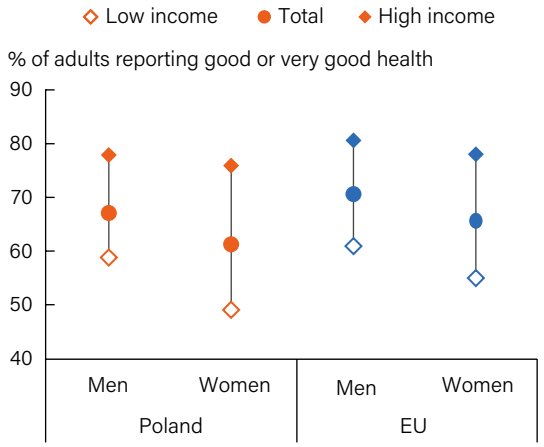
Among Poles aged 65 and over, 47 % of men and 56 % of women reported having multiple chronic conditions, which were among the highest proportions across EU countries. The proportion of Polish women aged over 65 reporting limitations in activities of daily living was also much greater than the proportion of men, as in other EU countries.

Figure 2. Cardiovascular diseases and cancer account for over 60 % of all deaths in Poland



Notes: IHD = ischaemic heart disease; COPD = chronic obstructive pulmonary disease.
Source: Eurostat (hlth_cd_aro); Data refer to 2023.

Figure 3. Inequalities in self-rated health by gender and income level are large



Note: Low income refers to adults in the bottom 20 % (lowest quintile) of the national equivalised disposable income distribution, while high income refers to adults in the top 20 % (highest quintile).
Source: Eurostat based on EU-SILC (hlth_silc_10); data refer to 2024.

In 2021, 4.3 million people in Poland were living with a cardiovascular disease

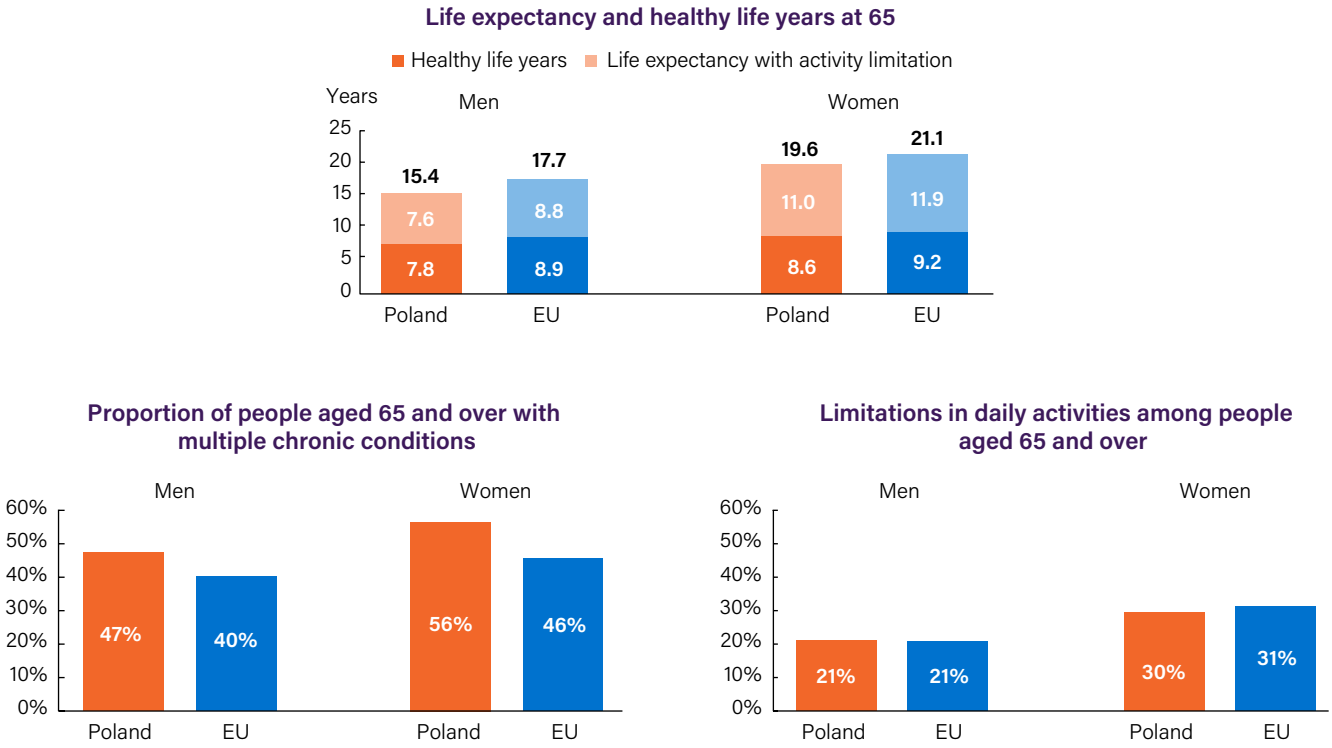
According to estimates from the Institute for Health Metrics and Evaluation (IHME), about 386 000 new cases of cardiovascular disease (CVD) occurred in 2021 in Poland, and 4.3 million people were living with a CVD in 2021. This corresponds to an age-standardised incidence rate of 1 046 per 100 000 population and an age-standardised prevalence rate of 11 702 per 100 000 population – slightly below the EU averages (Figure 5). Over 14 % of all hospital discharges in 2022 were related to CVDs. As in many other EU countries, incidence and prevalence of CVDs in Poland are much greater among men than women.

In 2022, 1.1 million people in Poland were living with a cancer diagnosis

About 202 000 new cases of cancer are estimated for 2022 in Poland, and 1.1 million people were estimated to be living with cancer in 2020, according to the European Cancer Information System (ECIS) (Figure 6). Compared to the EU averages, both the age-standardised incidence and prevalence rates of cancer in Poland are estimated to be lower, but this should be interpreted with care as cancer mortality rates are higher than the EU average (OECD/European Commission, 2025).

In 2022, the cancer incidence rate was estimated to be 8 % higher among men than women. The most common newly diagnosed cancers among men in 2022 were estimated to be of the prostate, lung and colorectum. Among women, cancers of the breast, colorectum and lung were estimated to be the most common.

Figure 4. A large share of people aged over 65 in Poland live with multiple chronic conditions



Sources: Eurostat for healthy life years (tespm120, tespm130) and SHARE survey (for chronic conditions and limitations in daily activities); data refer to 2022 and 2021-22, respectively.

Figure 5. Incidence and prevalence of cardiovascular disease in Poland are lower than the EU averages

386 318
New cases in 2021
Incidence rate (age-standardised), 1 046 per 100 000 population (1 157 in the EU)

4.3 MILLION
Living with the condition in 2021
Prevalence rate (age-standardised), 11 702 per 100 000 population (12 965 in the EU)

Source: IHME, Global Health Data Exchange; estimates refer to 2021.

Figure 6. The incidence and prevalence of cancers in Poland is lower than the EU averages

202 037
New cases in 2022
Incidence rate (age-standardised), 548 per 100 000 population (572 in the EU)

1.1 MILLION
Living with the condition in 2020
Prevalence rate (age-standardised), 3 138 per 100 000 population (4 767 in the EU)

Notes: These are estimates that may differ from national data. Cancer data include all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System; estimates refer to 2022 for incidence data and 2020 for prevalence.

3 Risk factors

Behavioural and environmental risk factors account for 35 % of all deaths

According to estimates from IHME, about 146 00 deaths in Poland in 2021 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Poor diet (including low fruit and vegetable intake, and high sugar and salt consumption) was the leading cause of deaths from behavioural risk

factors in 2021. Another 34 000 deaths can be attributed to air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone. Together, these behavioural and environmental risk factors accounted for 35 % of all deaths in Poland in 2021, which was higher than the EU average of 29 %.

Smoking among adults has decreased but remains above the EU average

Smoking rates among adults have fallen considerably over the past two decades, from 28 % smoking daily in 2001 to 17 % in 2019, which was slightly lower than the EU average (18.5 %) (see also Figure 7). This has been driven by a steep reduction in smoking among men, although Polish men still smoke more than women. National data also show a downward trend but much higher rates of tobacco use. In 2018, 35.8 % of men and 20.5 % of women reported regular use of nicotine products; in 2025, the figures were 28.8 % among men and 20.3 % among women (Wojtyniak & Smaga, 2025).

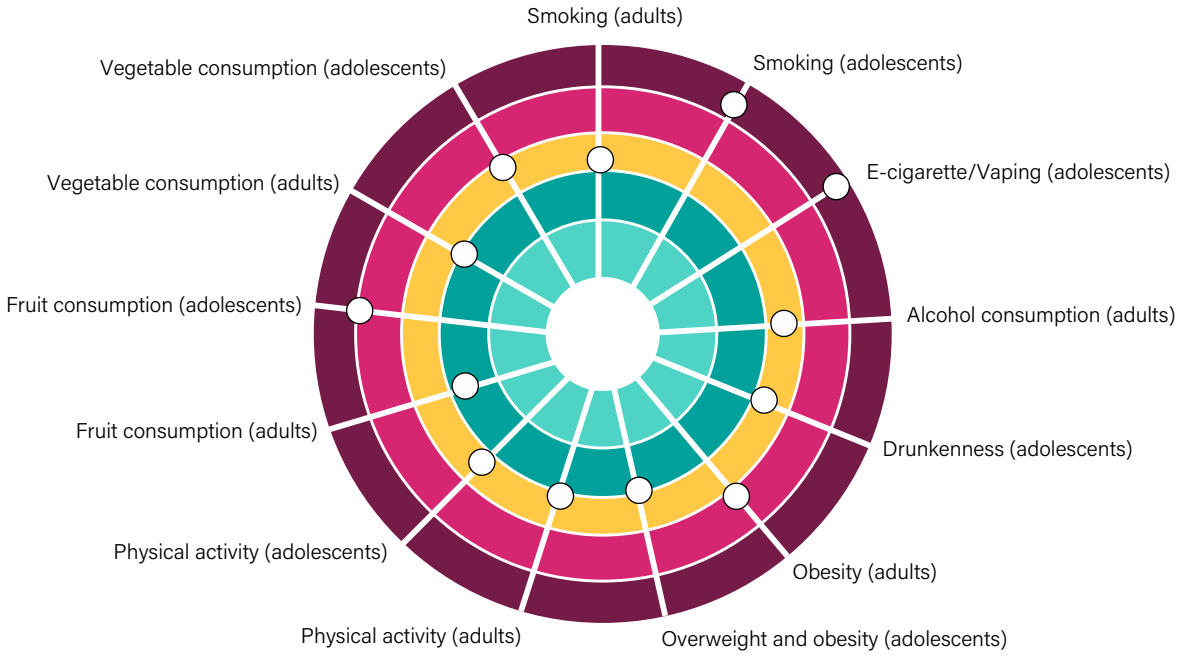
Cigarette smoking among 15-year-olds has not decreased as much. It remained relatively high in 2022, with 22 % of adolescents reporting having smoked regular cigarettes in the past month – a higher proportion than the EU average (18 %). As in many other EU countries, use of vapes or e-cigarettes has become more popular among adolescents in Poland: 31 % of 15-year-olds reported smoking e-cigarettes in the past month in 2022 – a much higher share than the EU average of 21 %. This has prompted policy makers to regulate the supply of e-cigarettes in similar ways to tobacco products (see Section 5.1).

Excessive alcohol consumption is declining

The average alcohol consumption among adults in Poland was equivalent to 10 litres of alcohol per person in 2023. This was only slightly above the EU average of 9.8 litres in 2022.

While the proportion of 15-year-olds in Poland who reported having been drunk more than once in their life (22 %) was slightly lower than the EU average (23 %) in 2022, it increased between 2018 and 2022, particularly among boys. This highlights the need to sustain efforts to curb heavy drinking among adolescents.

Figure 7. Many health risk factors are more prevalent in Poland than in most other EU countries



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; Eurostat based on EU-SILC 2022 and OECD Data Explorer for adult indicators (2022 or nearest available year).

Obesity rates have been growing slowly but steadily, especially among adolescent boys

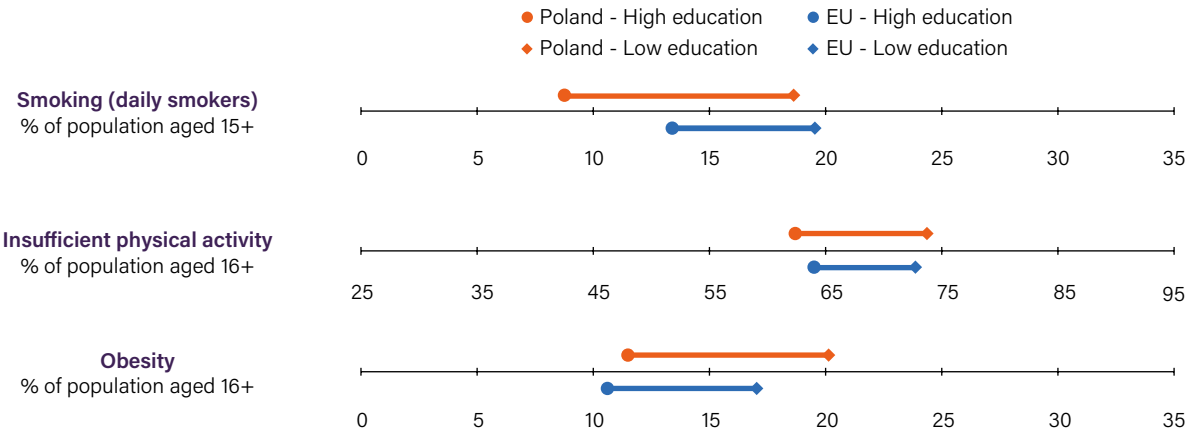
About 18 % of adults in Poland were obese in 2022 – a higher proportion than the EU average (15 %). Men (20 %) were more likely to be obese than women (17 %). Other national surveys show much lower rates: in 2025, 14 % of adults were obese (15 % of men and 12 % of women) according to national data (Wojtyniak & Smaga, 2025).

As in many other EU countries, the proportion of 15-year-olds classified as overweight or obese has increased in recent years, from 16 % in 2018 to 20 % in 2022, which is close to the EU average. Adolescent boys are twice as likely (27 %) as girls (13 %) to be overweight or obese. Poor nutrition partly explains the increasing prevalence of overweight and obesity among adolescents in Poland. In 2022, only about 30 % of 15-year-olds reported eating at least one portion of fruit or vegetables daily – a proportion slightly lower than the EU average.

Socioeconomic inequalities in risk factors contribute to inequalities in health status

As in other EU countries, most behavioural risk factors are more frequent among people with lower education levels in Poland. In 2019, 19 % of adults with the lowest level of education reported smoking daily, compared to 9 % among those with the highest level (Figure 8). There was also a significant gap in the prevalence of obesity between people with lower (20 %) and higher (12 %) education levels.

Figure 8. People with lower education levels are more likely to smoke, be obese and be less physically active



Notes: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8). Low physical activity is defined as people doing physical activity three times or fewer per week.
Sources: Eurostat based on EHIS 2019 for smoking (hlth_ehis_sk1e) and EU-SILC 2022 for physical activity and obesity (ilc_hch07b, ilc_hch10).

4 The health system

Almost all residents are covered by the social health insurance system

Poland has a social health insurance (SHI) system that covers approximately 97 % of the population. Most of those who are uninsured live outside the country while still being registered as residents. People who lack SHI coverage who do not belong to protected groups (such as children and pregnant women) can still access outpatient emergency medical care and primary care without paying, but they may subsequently be billed.

The health system is largely centralised, with the Ministry of Health and the National Health Fund in charge of governance, financing and purchasing. However, some key responsibilities have been decentralised – mainly to the 16 regions, which own the larger regional hospitals, and the 314 counties, which own the smaller county hospitals. Medical universities and the Ministry of Health own highly specialised clinics and institutes. About 15 % of hospital beds are private (Sowada, Richardson & Kowalska-Bobko, 2025). Some primary care practices are owned by the 2 477 municipalities, but most are privately owned, as are most specialist outpatient care providers. All private providers can offer services to patients under contracts with the National Health Fund, which ensures that patients can access these services free of charge, or on a private, fee-paying basis.

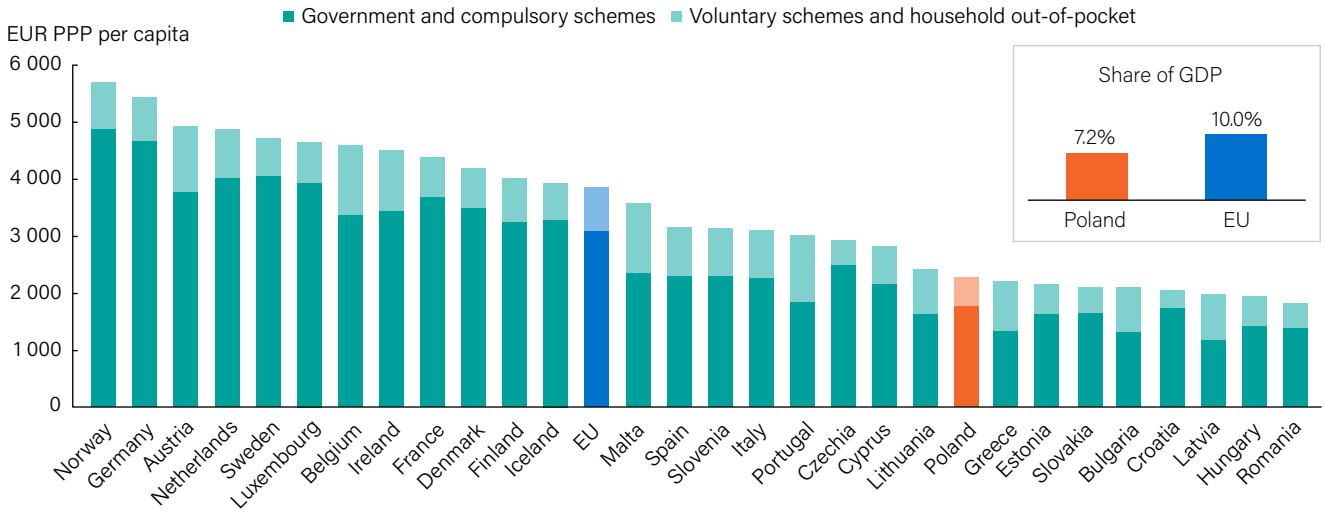
Health expenditure has been growing but the share of private spending remains substantial

Current health spending has increased considerably over the last two decades, reaching EUR 2 266 per capita (adjusted for differences in purchasing power) in 2023. Despite this increase, the level of health spending remains among the lowest in the EU, where the average was EUR 3 832 in 2023. This corresponds to 7.2 % of GDP in Poland – far below the EU average of 10 % (Figure 9).

The share of public financing for health has grown steadily in recent years and amounted to 77.8 % of health spending in 2023. SHI contributions remain the cornerstone of public financing, collected predominantly through earmarked payroll taxes. Private out-of-pocket (OOP) spending by households was the second largest source of funding. Although it fell to 15.7 % of current health spending in 2023, it remained slightly higher than the EU average (15.5 %). Voluntary health insurance plays a supplementary and complementary role, accounting for 6.5 % of health spending in 2023.

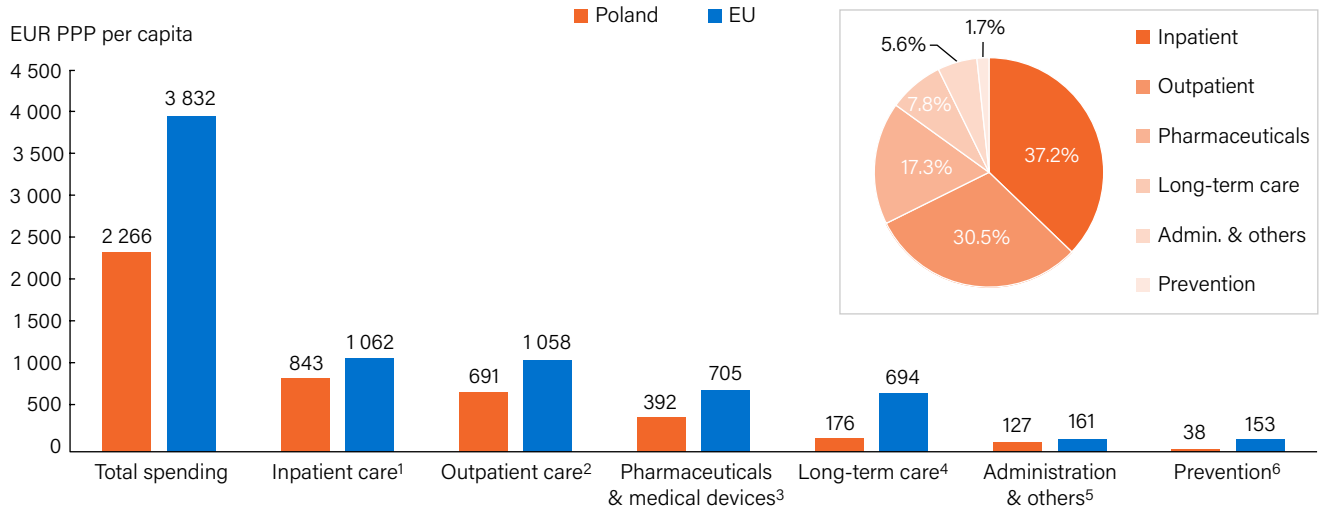
Primary care, outpatient specialist care and hospital care (including inpatient pharmaceuticals) are provided free of charge within the publicly financed health system (see Section 5.2). Private spending on outpatient medicines accounts for the largest share of OOP payments, followed by

Figure 9. Health spending per capita in Poland is far below the EU average



Note: The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA); Eurostat (demo_gind); data refer to 2023.

Figure 10. Poland's share of funding dedicated to inpatient care is relatively high



Notes: 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes health system governance and administration and other spending; 6. Includes only spending for organised prevention programmes; The EU average is weighted (calculated by the OECD).
Sources: OECD Data Explorer (DF_SHA); data refer to 2023.

outpatient medical care and dental care, as many services are excluded from the statutory package of benefits.

Health spending on long-term and preventive care is comparatively low

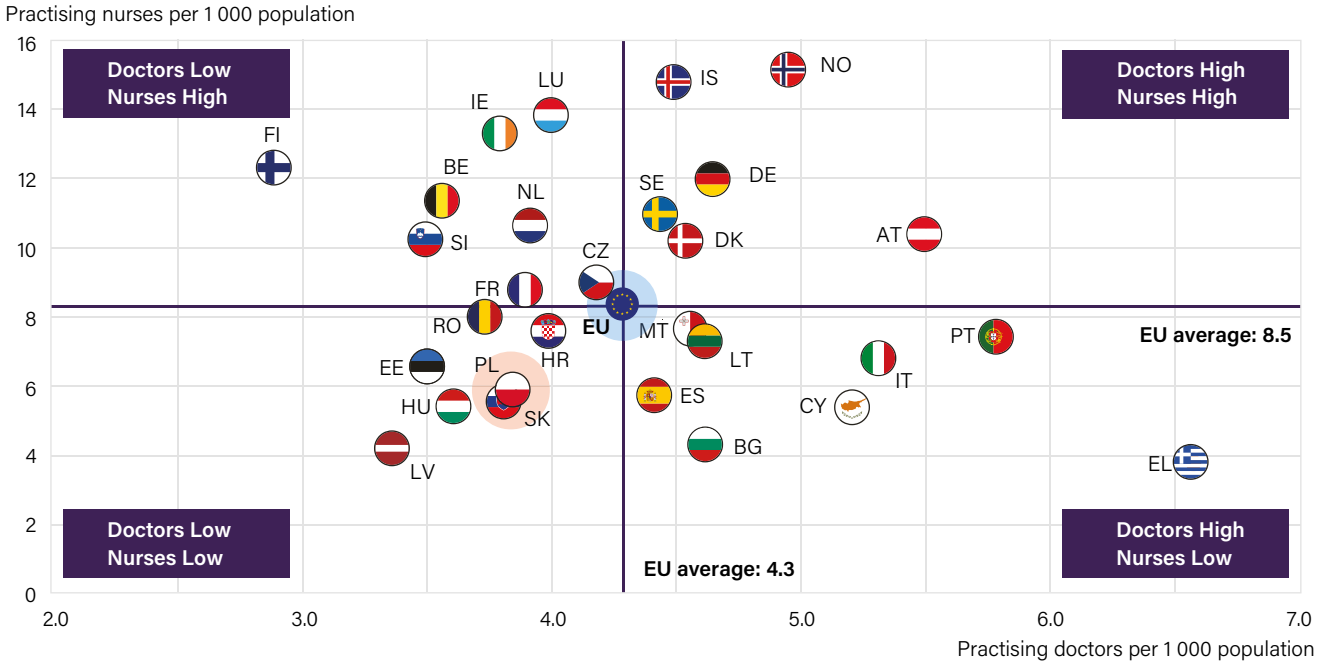
In 2023, 37.2 % of current health spending went on inpatient services, compared to an EU average of 27.7 % (Figure 10). Outpatient services followed, at 30.5 %, which was also higher than the EU average (27.6 %). Pharmaceutical and medical devices spending accounted for 17.3 % of health expenditure, roughly in line with many other EU countries (and below an EU average of 18.4 %). By contrast, only 7.8 % of current spending in Poland was on long-term care – less than half the EU average of 18.1 % – highlighting the continued reliance on unpaid, informal care and a lack of formal long-term care provision. Similarly, spending on preventive care was low, at 1.7 %, compared to the EU average of 4 %.

Poland has relatively low numbers of doctors and nurses, and this is a key capacity constraint

In 2023, there were 3.9 practising physicians per 1 000 population in Poland – lower than the EU average of 4.3 per 1 000 – and 5.9 nurses per 1 000 population compared to 8.5 per 1 000 on average across the EU (Figure 11). Shortages of health workers have been reported in specific specialties and regions, particularly in the small counties around large cities and in rural areas. Salary increases have been implemented to try to boost nursing workforce numbers, but higher salary costs have had collateral effects on the finances of community hospitals.

Poland has one of the lowest levels of general practitioners/family doctors as a share of total physicians in the EU (6.7 % in 2023 compared to an EU average of 19.9 %). General practice or family medicine as a model of primary care provision has not been fully realised in Poland, so primary care services are also still provided by internists and paediatricians working at this level of the system. Furthermore, around a fifth of physicians are aged 55-64, and almost a third of nurses are aged 50-59, raising concerns about the long-term accessibility of health services (European Commission, 2025).

Figure 11. Poland has comparatively low numbers of doctors and nurses



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Data Explorer (DF_PHYS, DF_NURSE); data refer to 2023 or nearest available year.

Reforms aim to rebalance the extensive healthcare infrastructure away from hospital care

Although hospital bed numbers have been falling following capacity expansion in response to the COVID-19 pandemic, in 2023, the number of hospital beds in Poland was 6.3 per 1 000 population – higher than the EU average of 5.1 per 1 000. The country's relatively large hospital capacity has historically proved difficult to reduce.

Various initiatives under the national Recovery and Resilience Plan intend to repurpose some excess acute care beds for long-term care services. These initiatives seek to balance overall hospital capacity rather than reduce it, but their impact will depend on sustained coordination across national, regional and local authorities, as well as ongoing investments in workforce training and recruitment.

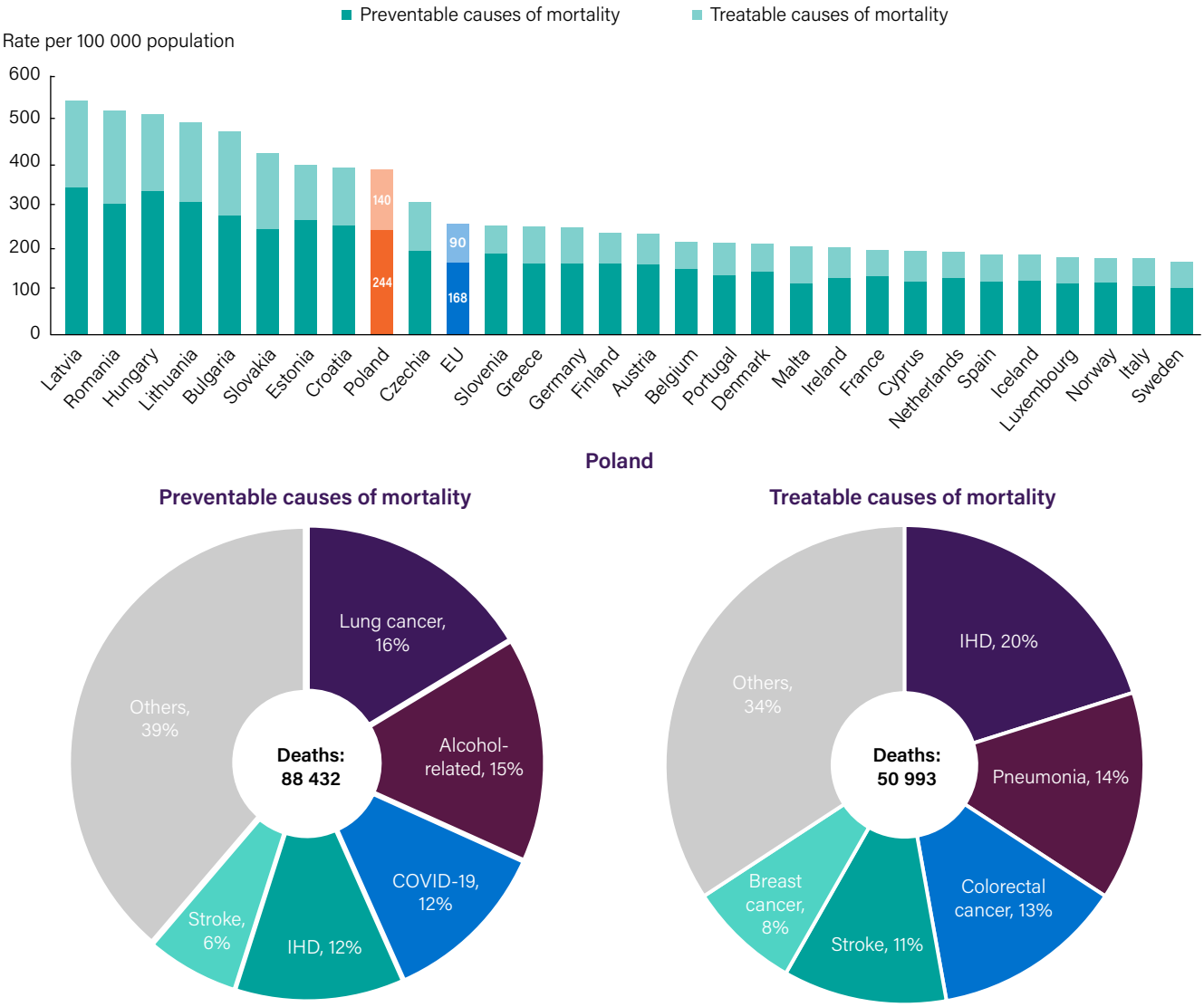
5 Performance of the health system

5.1 Effectiveness

High preventable mortality rates are driven by high alcohol and tobacco consumption levels

Although the overall preventable mortality rate in Poland was falling prior to the COVID-19 pandemic, it has been persistently higher than the EU average (Figure 12). The leading causes of preventable mortality in 2022 were lung cancer (16 %), alcohol-related diseases (15 %) and COVID-19 (12 %). The high prevalence of behavioural risk factors – particularly tobacco smoking and alcohol consumption – among the Polish population (see Section 3) are key drivers of preventable mortality rates. Alcohol and tobacco control policies have been inconsistent (Box 1), and spending on preventive care was relatively low at

Figure 12. Both preventable and treatable mortality rates are relatively high in Poland



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease (IHD), stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat (hlth_cd_apr); data refer to 2022.

approximately 2 %, compared to the EU average of 4 % in 2023 (see Section 4). Deaths from COVID-19, most of which could be prevented through vaccination and other public health measures, were much higher in Poland than on average across the EU, especially in 2022. COVID-19 vaccination rates have remained below the EU average in Poland, partly due to vaccine hesitancy.

Cardiovascular diseases and cancers dominate in mortality from treatable causes

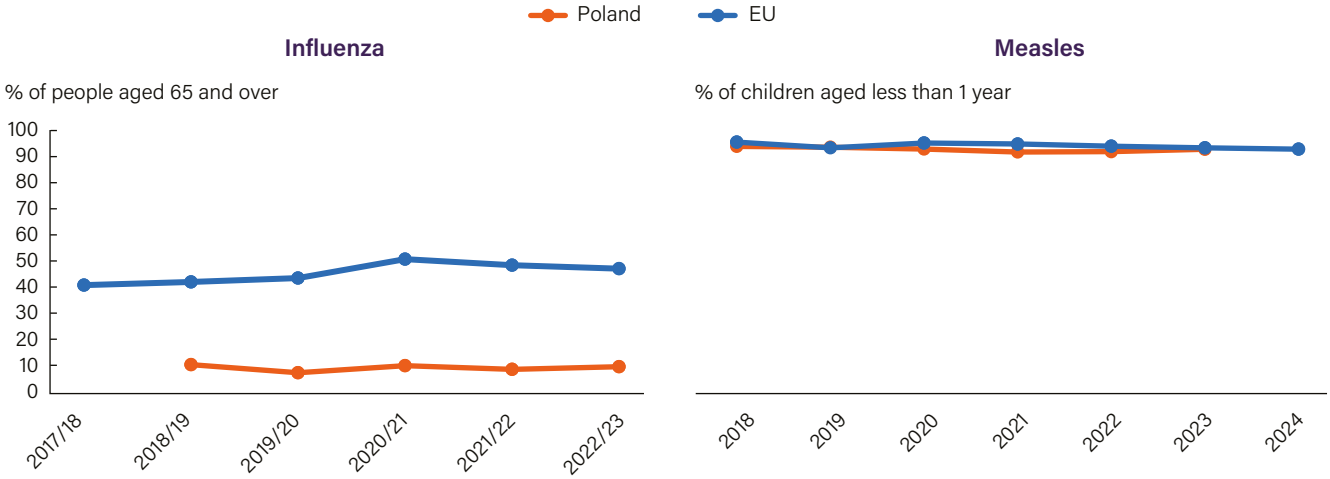
Progress in reducing mortality from treatable causes stalled as a result of the COVID-19 pandemic, and has not yet resumed. Reduced access to routine services during the pandemic could partly explain this increase. Treatable mortality has also been persistently above the EU average: in 2022, the rate was 140 per 100 000 population compared to the EU average of 90 per 100 000. The leading treatable cause of mortality in 2022 was ischaemic heart disease (20 %), followed by pneumonia (14 %), colorectal cancer (13 %), stroke (11 %) and breast cancer (8 %) (Figure 12). The high rates of treatable mortality from pneumonia are multifactorial, but delayed diagnosis, limited access to primary care and diagnostics, and shortages of medical staff – particularly in pulmonology and internal medicine – contribute significantly to this issue. Reforms set out in the Polish Recovery and Resilience Plan aim to improve access to and the quality of oncological and cardiological care by introducing national networks in these areas and standardised care along the entire patient pathway in primary care. They will also establish specialised outpatient healthcare, hospital treatment and rehabilitation. Similarly, the National CVD Programme for 2022-32 aims to reduce morbidity and mortality from CVDs by improving access to prevention and screening.

Box 1. Tobacco and alcohol control policies in Poland have been inconsistent but are now being strengthened

Tobacco control regulations were introduced in Poland in the 1990s, and the prevalence of cigarette smoking decreased. However, in 2015 the National Tobacco Control Programme was discontinued, and tobacco control policies were rolled into the National Health Programme for 2021-25. 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. Vapes or e-cigarettes are legal to purchase without a prescription, with a minimum age restriction of 18. Advertising and promotion of e-cigarettes and vapes are strictly regulated, and manufacturers and importers are prohibited from sponsoring various activities – including sporting and cultural events. There has been a notable shift in the usage patterns and regulatory landscape of vaping devices in Poland in recent years.

Alcohol control measures were weakened at the start of the century: the ban on beer advertising on television was lifted in 2001, and excise taxes on spirits were reduced by 30 % in 2002. Since 2020, however, Poland has strengthened fiscal measures targeting alcohol and tobacco consumption. Excise taxes on tobacco and alcohol, which had previously been frozen or reduced, are now subject to regular annual increases planned through 2027, covering both traditional products and newer categories such as heated tobacco and e-cigarettes.

Figure 13. Vaccination coverage is much higher for children than for adults



Notes: The EU average is weighted for influenza (calculated by Eurostat) and unweighted for measles and HPV.
Sources: Eurostat (hlth_ps_immu) and WHO/UNICEF Joint Reporting Form on Immunization (JRF).

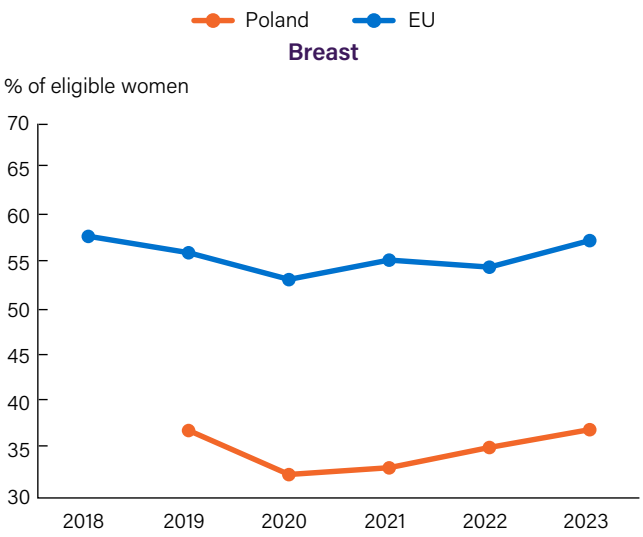
Routine childhood immunisation rates are close to the EU average

Having fallen to 85.6 % in 2021, the share of infants immunised against measles reached 91.8 % in 2023 – slightly below the EU average of 92.6 % and the threshold necessary to sustain measles elimination (95 %) (Figure 13). Although it is universally free of charge and was expanded to cover both boys and girls aged 9-14 in 2024, the human papillomavirus (HPV) vaccine has not been included in the schedule of mandatory vaccinations, and national data sources show that only 13 % of children aged 9-14 were vaccinated in 2023 (CeZ, 2025a). Some negative trends in immunisation uptake have been observed in recent years, partly due to vaccine hesitancy – particularly for influenza and COVID-19 vaccinations. Only 9.6 % of the population aged 65 and over were vaccinated against influenza in 2022/23 compared to the EU average of 47.1 %. Influenza, pneumococcus, respiratory syncytial virus and shingles vaccinations for people aged over 65 are free of charge. From 25 August 2025, a broad range of vaccinations in community pharmacies are now partially or fully reimbursed.

Breast and cervical cancer screening is largely opportunistic rather than part of national programmes

Uptake of screening through the national programmes is low for breast cancer and cervical cancer (Figure 14). Many women prefer to access cancer screening through their routine gynaecological care. Consequently, screening coverage rates according to survey data are much higher than formal coverage rates through the national screening programme. In 2019 (latest year available), cervical cancer screening rates reported in survey data reached 73 % of women aged 20-69 in the past two years compared to 16 % in national screening programme data. In 2019, reported breast cancer screening rates were 53.7 % of women aged 50-69 in the past two years in survey data and 37.3 % in programme data, while the EU average was 58.5 %.

Figure 14. Uptake of breast cancer screening through the national programme is very low



Notes: All data refer to programme data. The EU average is unweighted.
Sources: OECD Data Explorer (DF_KEY_INDIC) and Eurostat database (hlth_ps_prev).

Survey data also show that reported screening rates are much lower among those with lower incomes and lower levels of education. To increase participation in screening, the age range for both programmes was expanded in November 2023. Currently, mammography is available to women aged 45-74, and cytology is available to women aged 25-64.

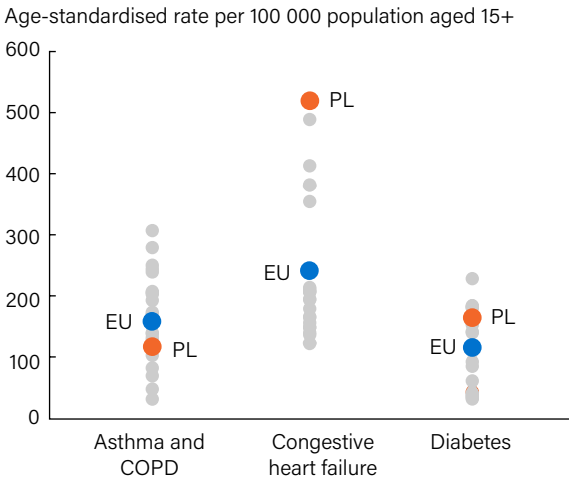
In 2021, a pilot lung cancer screening programme started, and in 2024 pilot studies for early detection of prostate cancer began (OECD/European Commission, 2025).

Strengthening the quality of cardiology care in primary care and hospital settings has been an important focus of recent policy initiatives

Between 2017 and 2021, a new model of primary healthcare provision was piloted in Poland that shifted management of the most common chronic conditions to primary healthcare, strengthening health promotion and disease prevention at this level. Avoidable hospital admissions for asthma and chronic obstructive pulmonary disease (COPD) were relatively low in Poland in 2023, showing that people with these chronic conditions can now access high-quality care at the primary care level. However, avoidable admissions for congestive heart failure were high (Figure 15).

The National Cardiology Network was piloted in 2021-24 and rolled out nationwide in July 2025 to improve co-operation between primary, outpatient and inpatient care in cardiology. The priority is ensuring that every patient, wherever they live, receives cardiology care based on uniformly defined "patient pathways", and that the system responds flexibly to their needs.

Figure 15. Avoidable hospital admissions for congestive heart failure point to weaknesses in care



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Data Explorer (DF_HCQO); data refer to 2023.

5.2 Accessibility

Unmet needs for dental care are low in Poland, despite limited statutory coverage

In 2024, 5.2 % of people in Poland who expressed a need for medical care could not access it due to cost, waiting times or distance to travel (Figure 16). This was higher than the average across the EU (3.6 % in 2023). Trend data for this specific indicator are not yet available, but unmet medical care needs among the general population (not only those with an expressed need for care) have come down as waiting times have fallen, despite the disruption to elective care caused by the COVID-19 pandemic (see Section 5.3).

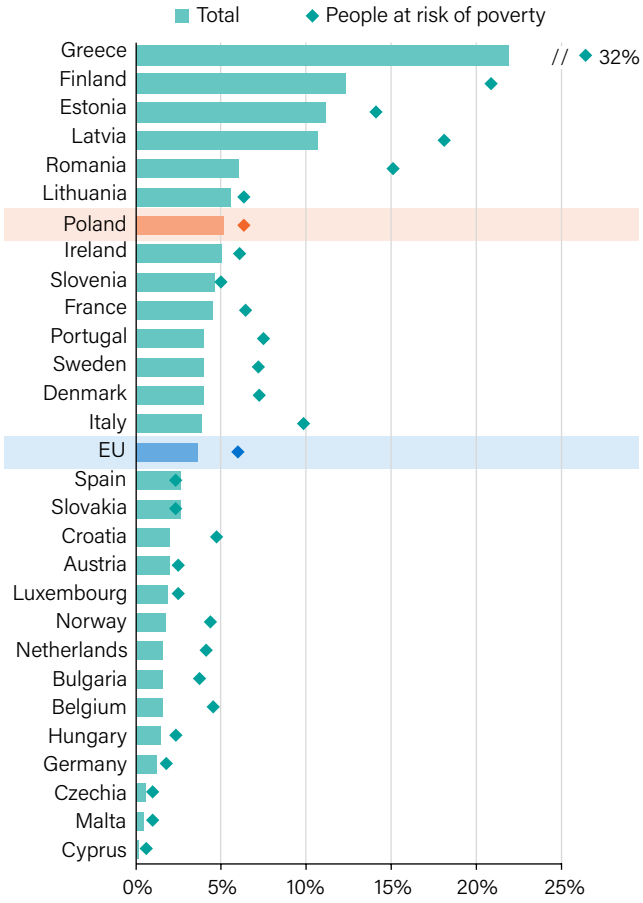
Across the EU, access to dental care is often more limited than access to other medical care due to benefits package design, but in Poland just 3.1 % of people who expressed a need for dental care reported not being able to access services in 2024; the EU average was 6.3 %. This is despite dental care having only limited statutory coverage in Poland, meaning that most services are purchased privately. The reasons behind this are multifactorial and complex, but the relative affordability of dental care in Poland is reflected in high numbers of health tourists travelling to the country for treatment.

Population coverage is almost universal

In 2023, 96.9 % of the population of Poland were formally enrolled in the SHI scheme (see Section 4). Certain population groups, such as pregnant women and children under 18, are entitled to publicly funded healthcare regardless of their insurance status. Special coverage provisions have been implemented since 2022 to extend SHI coverage to Ukrainian citizens fleeing war. As of February 2025, almost 1 million Ukrainian citizens were under temporary protection in Poland, but this number had been as high as 2 million in earlier years.

It is difficult to estimate the size of the population that is not entitled to the full range of publicly financed healthcare. Nearly all residents not enrolled in the SHI scheme are no longer living and working in Poland, are people not required to enrol, or are family members who are entitled to benefits but who have not yet registered (they can be registered

Figure 16. Among those needing care, self-reported unmet needs for medical examination due to financial reasons, long waiting times or distance are relatively high in Poland



Notes: The EU average is weighted. Data refer only to individuals who reported having medical care needs. People at risk of poverty are defined as those with an equivalised disposable income below 60 % of the national median disposable income.
Source: Eurostat (hlth_silc_08b); data refer to 2024.

retroactively for up to 30 days following use of healthcare). Some unregistered people are also more vulnerable, such as unemployed people, homeless people, people working informally and undocumented migrants.

The benefits package offers comprehensive cover for hospital care, but benefits for outpatient medicines and dental care are more limited

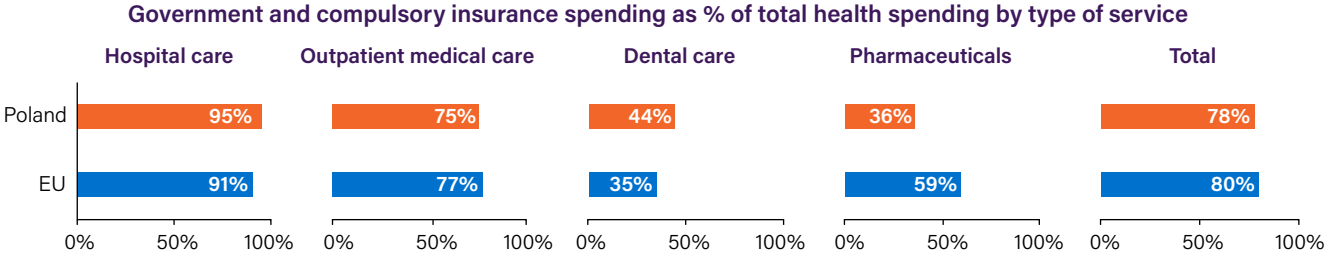
Under the SHI system in Poland, public financing covers 78 % of the costs of medical goods and services (compared to 80 % across the EU), but some access problems may arise. Although access to primary care is free at the point of use, only 36 % of the costs of pharmaceuticals and medical non-durables are covered (see Section 6). In contrast, public financing of inpatient care is broader (95 % of costs covered compared to the 91 % EU average), which means that there are virtually no cost-sharing requirements for inpatient care (Figure 17).

Benefits are very narrowly defined for dental care, outpatient pharmaceuticals, therapeutic appliances and rehabilitation. The list of covered dental care only includes the most essential services and materials, and it is subject to volume and frequency limits – for example, dentures are only covered once every five years. Rehabilitation is limited to outpatient settings up to a maximum of 40 days a year for a given problem. User charges are also applied to outpatient prescription medicines, and OOP spending in this area is high (Figure 18; see also Section 6). Long-term care provision relies heavily on informal caregivers.

The affordability of healthcare has been improving, but catastrophic spending levels remain broadly unchanged

The share of OOP payments in health spending has been decreasing steadily since 2005, reaching 15.7 % in 2023, almost the same as the EU average of 15.5 % (Figure 18). Most OOP spending in Poland is on pharmaceuticals (63.0 %), and the level has remained elevated despite the broadening of exemption mechanisms for outpatient prescriptions (see Section 6). Outlays on medicines are also the main driver of catastrophic spending,[1] accounting for 44.0 % of health spending among affected households. In 2021, 9.4 % of households experienced catastrophic health spending, and the levels of catastrophic health spending have fluctuated around this point for the past decade. Catastrophic health

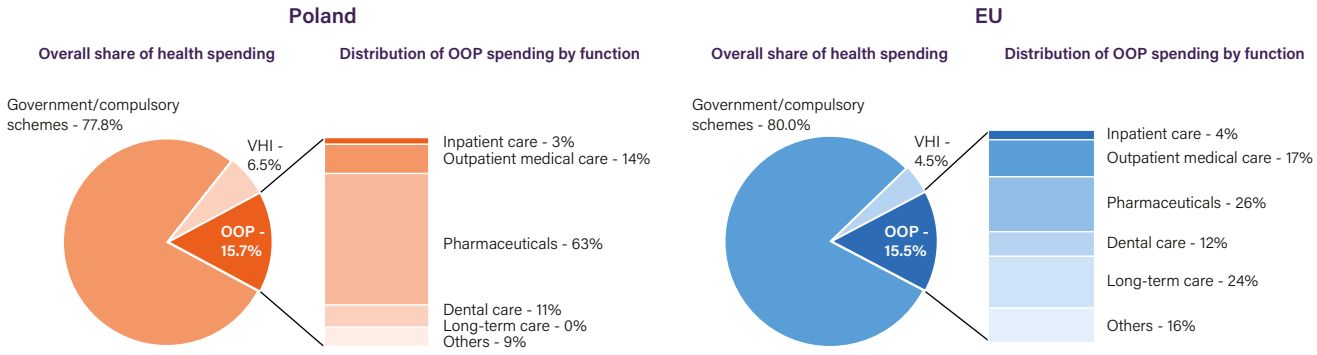
Figure 17. Healthcare coverage is much lower in Poland for pharmaceuticals than across the EU



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. N/A means data not available. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

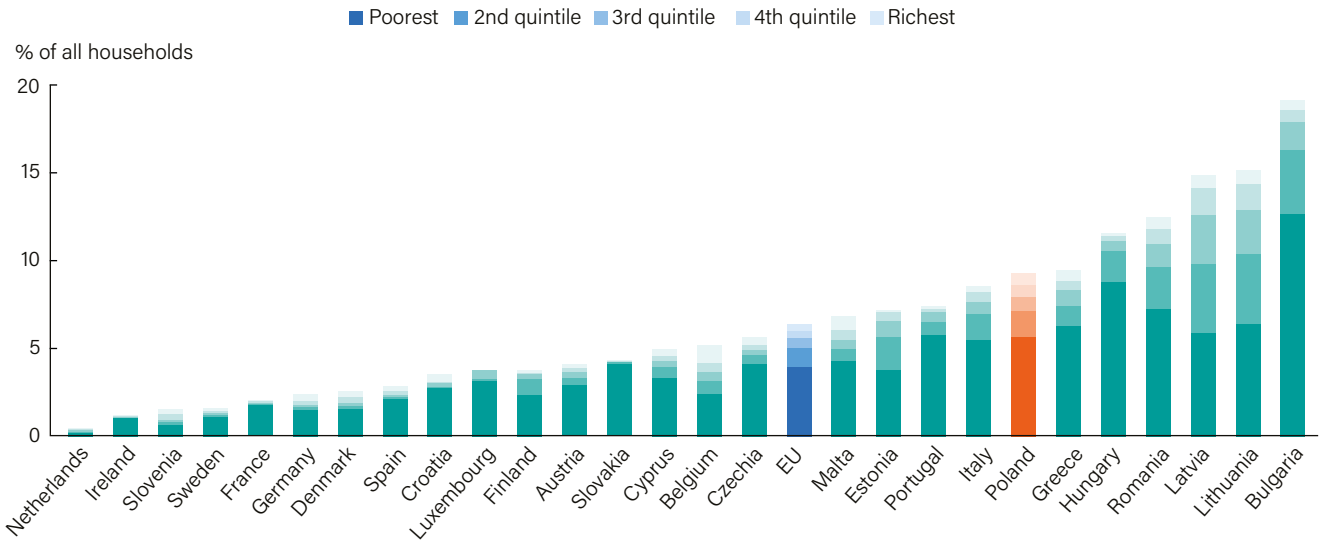
[1] Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

Figure 18. Out-of-pocket payments are dominated by spending on outpatient medicines



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023.

Figure 19. Catastrophic health spending in Poland is highest among the poorest households



Note: The EU average is unweighted. The data for Poland refer to 2021.
Source: WHO Barcelona Office for Health Systems Financing.

spending is concentrated among the lowest-income households (Figure 19).

Shortages of funding and health workers have led to long waiting times that are the main barrier to accessing healthcare

Chronic resource constraints – such as limited fiscal resources allocated to the health system and shortages of health workers – underpin access barriers (see Section 4). There are also large disparities in the geographical distribution of health workers and infrastructure, which may result in variable access to services. However, a main barrier is waiting times, which can be very long (see Section 5.3). Waiting times are mainly an issue for outpatient specialist services, some specialist inpatient elective care and rehabilitation services. They have been particularly long for some highly specialised services and specialties such as endocrinology (WHO Regional Office for Europe, 2025).

The National Health Fund has used various strategies to reduce waiting times. In 2015, it started removing annual volume caps for outpatient care providers; in 2021, all were removed. However, due to a lack of funds, it was unable to pay for all the services provided; consequently, many providers accrued budget deficits. New cost-based tariff setting aims to increase payments and match them better to costs, to encourage provision of care with long waiting times and to reward attainment of waiting time targets where these are in place. In 2018, the National Health Fund introduced a platform to enable patients to check waiting times for specific services in all contracted facilities. However, the impact of these strategies on reducing waiting times has been limited by a significant shortage of specialist doctors in the statutory system.

5.3 Resilience

Health system resilience – the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks and structural changes – has become central to policy agendas. Key priorities include easing pressures on service delivery,

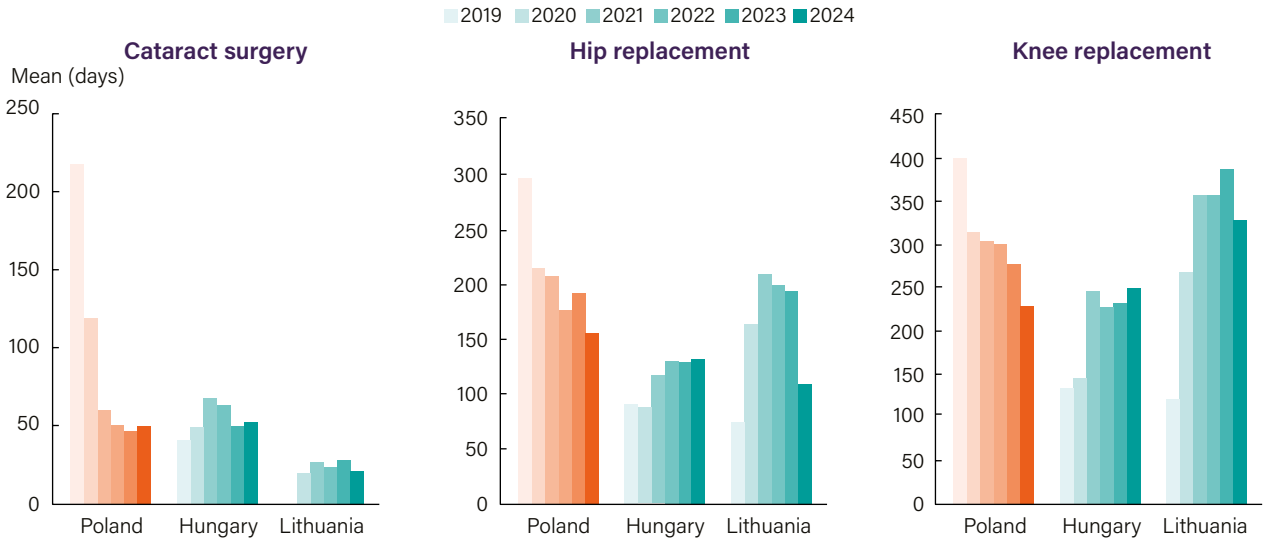
strengthening health infrastructure and workforce capacity, adapting crisis preparedness strategies, supporting digital innovation, and safeguarding long-term sustainability.

In response to the COVID-19 pandemic hospital activity levels fell sharply but waiting times for elective care are now below pre-pandemic levels

Poland has historically had very large hospital capacity – much higher than the average for EU countries – and reducing excess capacity has been a strong focus of policies to improve efficiency in the system. The reduction in hospital bed numbers in 2019 stalled in response to the COVID-19 pandemic, and was 6.3 per 1 000 population in 2023, compared to the EU average of 5.1 per 1 000. Hospital activity levels in Poland fell more sharply than on average across the EU in response to the pandemic, but hospital discharges have risen again since 2020, reaching 22 449 per 100 000 population in 2023.

The volume of elective surgical procedures performed in Polish hospitals is lower than the EU average, and the number of hip replacements, knee replacements and hernia repairs fluctuated widely as the volume of elective surgery was cut in response to the COVID-19 pandemic. Nevertheless, waiting times in Poland have managed to come down from previously very high levels – despite the reductions in the volume of elective care during the pandemic years that caused waiting times to increase elsewhere in Europe (Figure 20). On average, in 2024, people in Poland were waiting 156 days for a hip replacement (down from 298 days in 2019) and 231 days for a knee replacement (down from 403 days in 2019).

Figure 20. Fewer patients are waiting more than three months for elective surgery



Source: OECD Data Explorer (DF_WAITING).

Reduced waiting times have been achieved through investment in the health system to adequately finance the increased volume of care needed. Since 2021, various reform plans have been proposed by the Ministry of Health with the aim of consolidating the health system, reprofiling hospitals and improving coordination to improve efficiency and cut hospital debts.

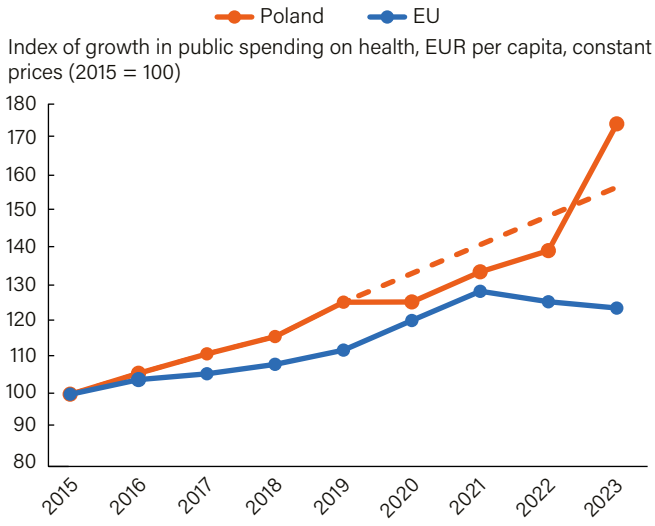
Public spending on the health system is among the lowest in the EU, but increasing investment is a political priority

In late 2017, the government at the time pledged to increase public spending on health in Poland progressively to 6 % of GDP by 2024. The next government continued this prioritisation of health, and health spending accounted for 12.2 % of total government spending in 2023. This is below the EU average of 14.8 % in 2023, but health expenditure as a share of total government spending has been growing more quickly in Poland than across the EU. Health spending did not grow as a share of total government spending in 2020-21 during the COVID-19 pandemic, but preliminary data show it expanded rapidly in the following years, bucking the wider trend across the EU, and surpassing the hypothetical trajectory in per capita expenditure projected from pre-pandemic growth patterns (2015-19) (Figure 21). Considerable investment in the health system is also derived from EU funding instruments (Box 2).

Ensuring the sustainability of the health workforce in Poland is a key challenge in building resilience

The densities of doctors and nurses in Poland are below the EU averages (see Section 4). Until recently, the numbers of medical and nursing graduates were also lower than the EU averages. Poland lacked a reliable planning process for development of the health workforce. In 2021, the Ministry of Health developed a comprehensive online platform to enhance health workforce data collection, reporting, analysis and monitoring. Analyses are provided by region down to the county level, and are part of the Maps of Health Needs, which are co-financed by the EU from the resources of the European Social Fund (Ministry of Health, 2025). Student intakes in medicine and dentistry programmes have increased greatly in recent years in Poland, and student intake numbers almost doubled between 2012 and 2022 – from 5 202 to

Figure 21. Public spending on health has grown rapidly in recent years



Notes: The EU average is weighted (calculated by the OECD). The dashed line represents the projected trend based on pre-pandemic (2015-19) data. The data for Poland are still preliminary and currently being validated.
Source: OECD Data Explorer (DF_SHA).

9 706 students (OECD/European Commission, 2024). The government has been actively incentivising young people to study medicine and then stay in Poland to work, but the rapid expansion of medical school places put pressure on postgraduate internship training capacity (Kupis et al., 2025). It therefore became necessary to redistribute places for specialisation training, considering underserved regions and priority fields, as well as the health needs of the population.

The digital transformation of health is underway but the digital divide between users is considerable

The Polish Government has prioritised investing in the digital transformation of health in policy documents, and investment in health information and communication technology (ICT) per capita more than doubled between 2018 and 2023. However, ICT investment in Poland remains below the EU average (at EUR 0.4 million per 100 000 population in 2023 at 2015 constant prices, compared to an EU average of EUR 2.3 million per 100 000).

The central digital health system provides a range of products and electronic services. An internet patient account allows patients to have access to their treatment history and electronic medical records, choose a primary care physician, apply for a European Health Insurance Card, and consent to the cross-border transfer of e-prescription data, which enables e-prescriptions to be filled abroad. E-prescribing is mandatory (97.4 % of prescriptions were issued electronically in 2024), as are e-referrals for selected medical services.

The Service Provider and Pharmacy Application allows physicians and other healthcare professionals to issue and process e-prescriptions and e-referrals. A survey conducted in 2024 found that most healthcare providers (85.3 %) have electronic medical records in place, and use of e-referrals has been increasing – particularly for hospitals. One third (33.4 %) of health facilities use e-referrals to specialist clinics or for hospital treatment (CeZ, 2025b). The main obstacles to full implementation of digital tools include insufficient financial resources, inadequate digital competencies among healthcare staff and resistance from medical workers.

Use of digital tools by households has been growing. The share of the Polish population that used the internet to search for health information and access health records is similar to the EU average. However, a lower proportion used the internet to make a medical appointment (22 %), and the gap with the EU average (40 %) widened in 2024. Moreover, there was a considerable digital divide in the use of digital tools by age and socioeconomic status. In 2024, Polish adults aged 25-64 were much more likely to use the internet to find health information (59 %) than those aged 65-74 (38 %). Similarly, someone with higher education status was three times more likely to use the internet to search for health information than someone with lower education status, and this difference was much larger (approximately 10 times more likely) for making an appointment or accessing health records (Figure 22).

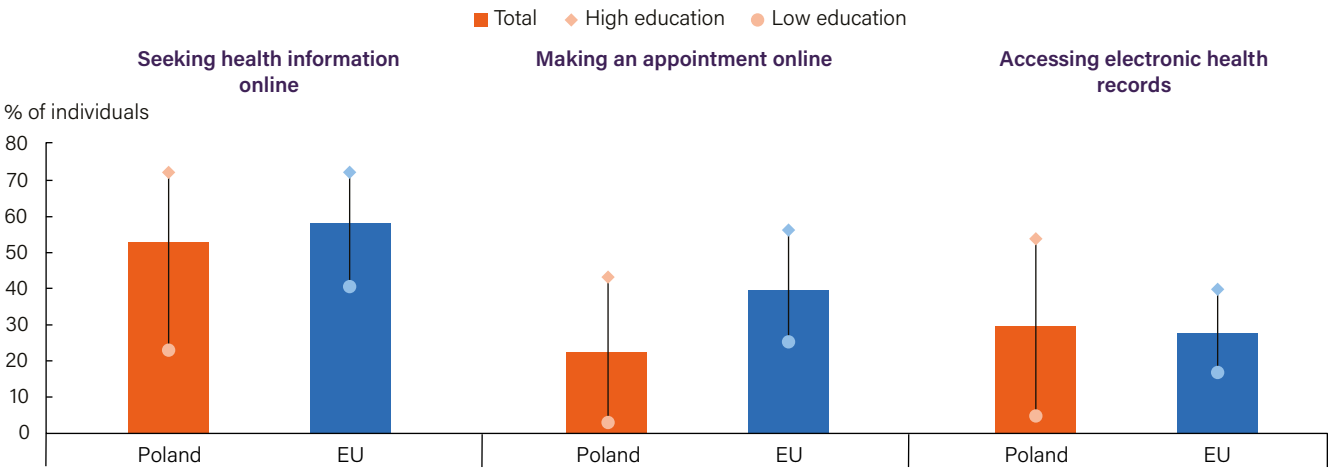
Box 2. Poland is a major beneficiary of EU co-funding for health system strengthening

Poland's health sector is supported by significant EU funding across multiple instruments. Under the Recovery and Resilience Plan (RRP), Poland was allocated around EUR 3 billion (5 % of total RRP funds of almost EUR 60 billion).[2] Poland's plan aims to: support restructuring of the hospital sector; accelerate digitalisation of health services; create more opportunities to allow for more medical staff of good quality; and support the development of research in the critical field of medical sciences. These reforms and investments are being implemented by 2026.

Complementing the RRP is the EU Cohesion Policy (2021-27). Poland is the largest beneficiary, at EUR 75.5 billion overall, of which EUR 2.1 billion is dedicated to healthcare, predominantly for infrastructure and equipment. Additionally, under the EU4Health work programmes (2021-23), Polish beneficiaries received funding via joint actions and direct grants amounting to EUR 28.5 million. It was primarily dedicated to cancer initiatives (39 %), crisis preparedness (26 %), and health promotion and disease prevention (18 %).

[2] Recovery and Resilience Fund data are based on the information available as of 20 September 2025; potential future amendments may affect these figures.

Figure 22. Polish adults with higher education levels were much more likely to use the internet for health-related activities than those with lower levels

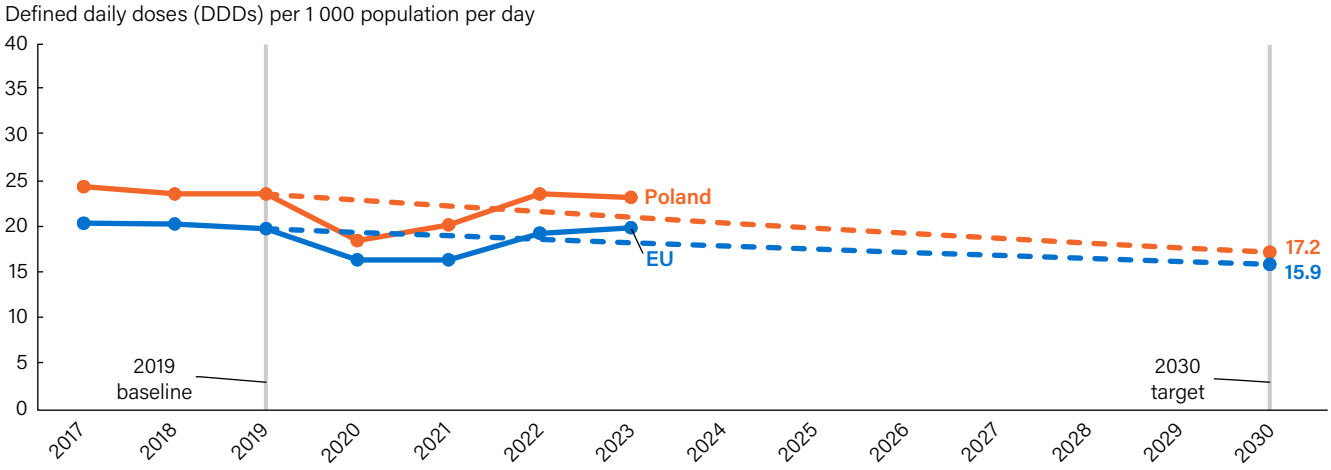


Note: Low education is defined as the population with no more than lower secondary education (ISCED levels 0-2), whereas high education is the population with tertiary education (ISCED levels 5-8).
Source: Eurostat (isoc_ci_ac_i); data refer to 2024.

Antimicrobial resistance has the potential to threaten public health without renewed progress towards meeting stewardship targets

Curbing excessive antibiotic use is critical to addressing antimicrobial resistance (AMR), a priority reinforced by the EU Council's targets for reducing consumption by 2030 that were adopted in 2023.[3] As in most countries, antibiotic consumption in Poland reduced in 2020-21 – largely driven by lower routine use during the COVID-19 pandemic. However, overall antibiotic consumption levels in Poland are high, and rebounded to a higher level with higher hospital activity levels following the pandemic, which will make it harder for Poland to meet its 2030 reduction target (Figure 23). In 2023, antibiotic consumption levels were 23.2 defined daily doses per 1 000 inhabitants per day. The national AMR action plan has been integrated into the National Health Programme 2021-25 under the goal of ensuring environmental health and preventing communicable diseases.

Figure 23. Mirroring the general pattern across the EU, antibiotic consumption trends in Poland have increased since the COVID-19 pandemic



Note: The EU average is weighted. The chart shows antibiotic consumption in hospitals and the community. The dashed line illustrates the policy target pathway to meet the 2030 reduction targets.
Source: ECDC ESAC-Net.

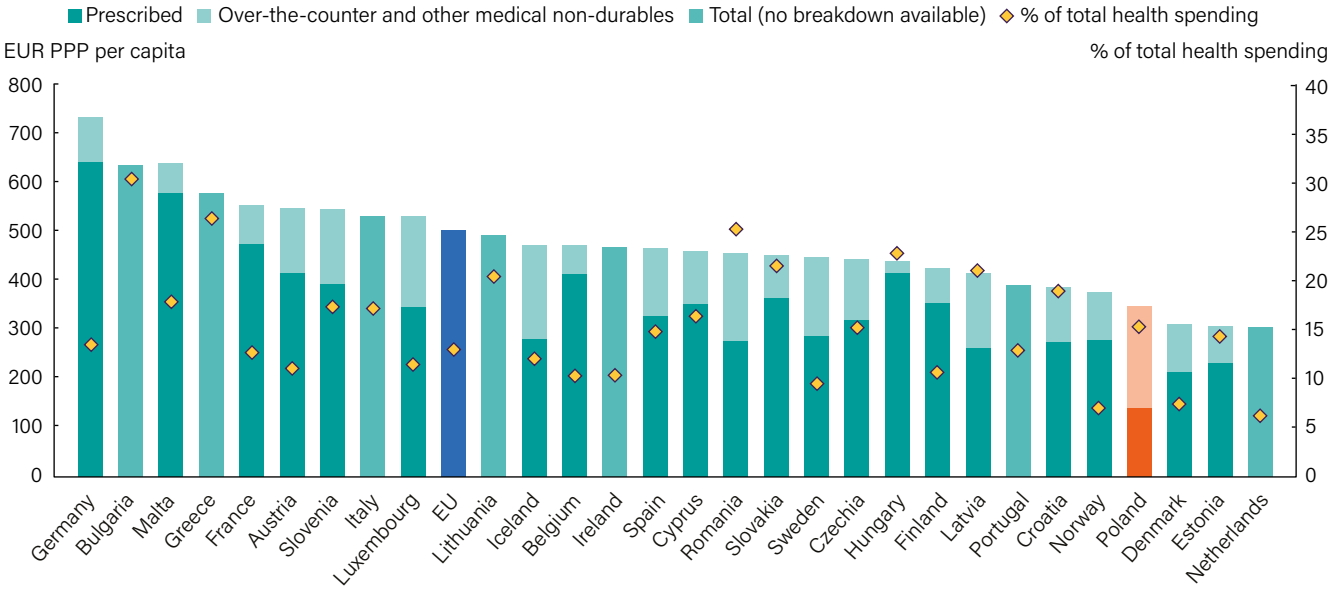
[3] Council Recommendation on stepping up EU actions to combat antimicrobial resistance in a One Health approach, 2023/C 220/01.

6 Spotlight on pharmaceuticals

Poland spends less on retail pharmaceuticals per capita than the EU average, and offers limited coverage for outpatient medicines

In 2023, retail pharmaceutical spending accounted for about 16 % of total health expenditure in Poland – a slightly higher share than the EU average of 13 % (Figure 24). On a per capita basis, Poland spent one third less than the EU average on retail pharmaceuticals (EUR 352 compared to EUR 510, adjusted for differences in purchasing power).

Figure 24. Expenditure on retail pharmaceuticals per capita in Poland is about one third lower than the EU average



Note: This figure represents expenditure on pharmaceuticals dispensed through retail pharmacies for outpatient use only. It excludes medications administered in hospitals, clinics or physician offices.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway (2022).

The statutory system in Poland provides comprehensive coverage for inpatient pharmaceuticals, but coverage of outpatient pharmaceuticals is more restricted. As of 1 September 2023, eligibility for free prescription medicines was expanded from pregnant women and people aged 75 and over to include children under 18 and people aged 65 and over. Military veterans and blood or organ donors are also eligible. However, there are no copayment exemptions for people on low incomes, and there is no overall cap on copayments. For medicines used for up to 30 days, patients copay 50 % or 30 % of the cost, plus the difference between the reference price and the retail price. For longer courses of treatment or more expensive medicines, patients pay a fixed charge of EUR 0.71 per pack of up to 30 defined daily doses plus the difference between the reference price and the retail price.

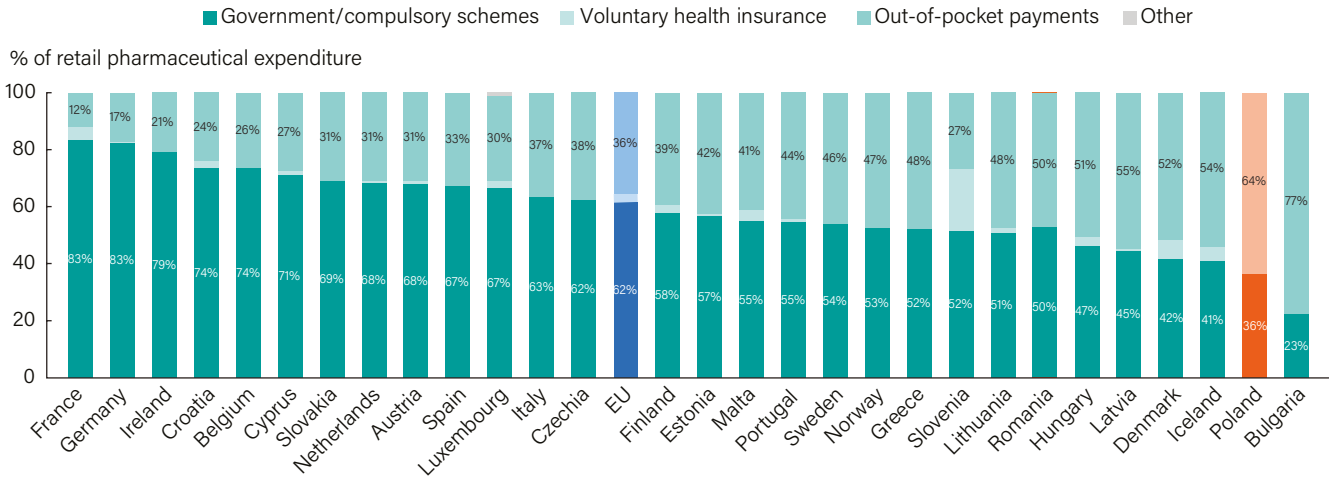
Only one third of retail pharmaceutical expenditure was covered by statutory funds in Poland, and nearly two thirds were paid directly by patients in 2023 (Figure 25). OOP spending was dominated by spending on both prescription and over-the-counter medicines. Financial coverage for pharmaceuticals ranks among the lowest in the EU, and was considerably lower than the EU average of 60 %.

Pharmaceuticals constituted 63 % of household direct OOP healthcare expenditure in Poland, compared to the EU average of 25 % (see Section 5.2).

Financial coverage of inpatient medicines is comprehensive, including high-cost newer treatments and cancer care

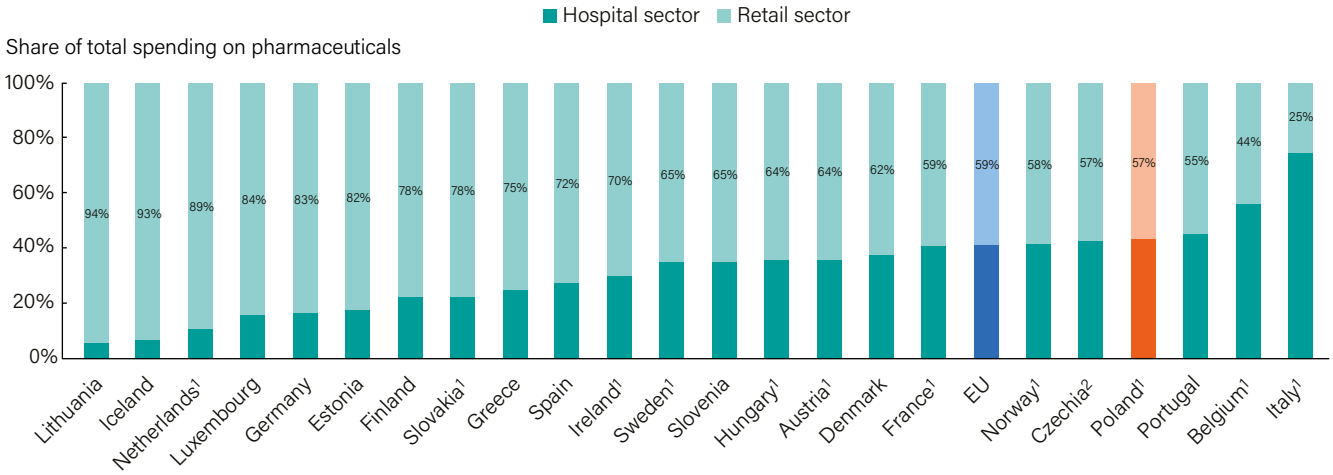
Pharmaceuticals prescribed in hospitals are treated separately, and their costs are mostly reimbursed through diagnosis-related group tariffs. The costs of cancer drugs are funded through a positive list, and a separate positive list of high-cost pharmaceuticals is funded under drug programmes for specific patient groups, with tightly defined inclusion and exclusion criteria and close monitoring. There is also an additional Medical Fund for high-cost innovative therapies and therapies with high clinical value, and for granting emergency access to innovative treatments. All medicines prescribed and administered in hospitals are free of charge for patients. The share of pharmaceutical spending in the hospital setting relative to retail spending was similar to that in other EU countries (43 % in Poland compared to an EU average of 41 %) (Figure 26).

Figure 25. Just over one third of retail pharmaceutical expenditure was covered by social health insurance in Poland



Note: The EU average is unweighted.
Source: OECD Data Explorer (DF_SHA); data refer to 2023, except for Norway (2022).

Figure 26. Pharmaceutical spending in hospitals in Poland is similar to the EU average



Notes: The EU average is weighted. Data refer to 2023, except for Norway and Slovenia (2022). Hospital pharmaceutical sales data for the Netherlands are incomplete, leading to an overestimation of the share of retail pharmacy sales in the figure.
Sources: OECD Data Explorer (DF_SHA); [1]IQVIA and Swedish Dental and Pharmaceutical Benefits Agency, 2024; [2]Czech Institute of Health Information and Statistics.

Time to access new medicines varies, but is usually expedited for medicines with high clinical benefit

Poland uses a comprehensive process to determine which new therapies are funded through different Medical Funds and included on the cancer drugs list. This process integrates health technology assessment (particularly the results of cost–effectiveness analysis) to inform both coverage decisions and price negotiations by the Economic Commission of the Ministry of Health. From January 2025, this process will also benefit from the EU Regulation on Health Technology Assessment.

Two of the indicators most commonly used to assess the timelines and breadth of access to new medicines are the average time elapsed between EU marketing authorisation and public reimbursement, and the proportion of centrally (EU) approved medicines available nationally. Both metrics are reported in the European Federation of Pharmaceutical Industries and Associations' Patients WAIT Indicator Survey (Newton et al., 2025). While neither indicator comprehensively measures meaningful patient access to effective treatments, they provide a basis for discussion. For medicines approved by the EU between 2020 and 2023, Poland recorded an average time-to-reimbursement of 723 days (above the EU average of 578 days). However, the waiting time for reimbursement is a combination of the pharmaceutical company's business decisions and the effectiveness of the administrative process conducted in Poland. Currently, the main factor delaying reimbursement for new therapies is the time between EU marketing authorisation and submission of the reimbursement application by pharmaceutical companies.

Of all medicines that received marketing authorisation in the EU between 2020 and 2023, 40 % are available in Poland to various populations. The health technology assessment process identifies those groups of patients who are most likely to benefit from treatment, and coverage is restricted to reflect this. Poland has established specific funding streams – Medical Funds – to expedite swift access to therapies demonstrating high clinical value.

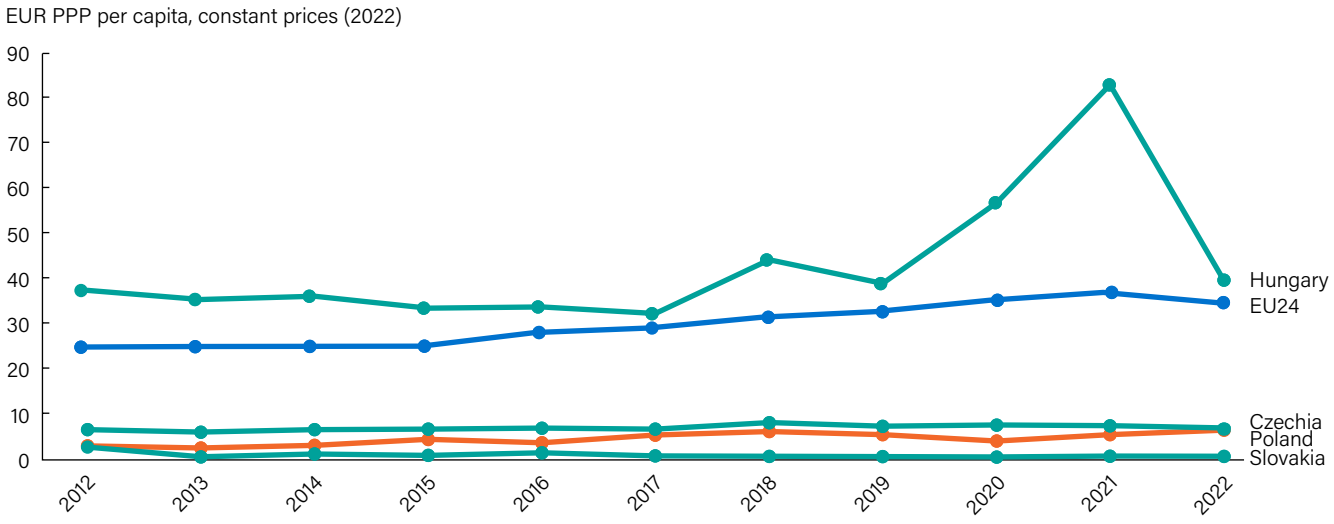
Uptake of generic medicines is well developed in Poland and promoted by pharmacists

Use of generics in Poland is widespread. According to the most recent available data from 2017, for reimbursed prescription medicines, generics accounted for 27 % by value and 89 % by volume in hospitals, and 66 % by value and 76 % by volume in retail pharmacies (Sowada, Richardson & Kowalska-Bobko, 2025). This was achieved despite very limited controls on prescribing behaviour. Polish physicians do not have dispensing budgets, and there is no requirement to prescribe by active ingredient or International Nonproprietary Name. Additionally, there are no officially adopted guidelines for cost-effective prescribing. However, pharmacists are legally obliged to inform patients about the possibility of purchasing a cheaper generic equivalent, and to keep such products in stock.

Pharmaceutical innovation is important for Poland, but the country is a relatively small player in this field

In 2022, pharmaceutical research and development (R&D) investment in Poland was estimated at EUR 240 million (adjusted for differences in purchasing power), representing 1.5 % of total pharmaceutical R&D expenditure across the EU. This is the equivalent of EUR 6.5 per capita in 2022, which is relatively modest compared with the average of EUR 34 for the 24 EU countries that have such data available (Figure 27). Pharmaceutical patent applications serve as a crucial metric for gauging innovation potential within the pharmaceutical sector. According to OECD Intellectual Property Statistics, 35 applications filed under the Patent Co-operation Treaty in 2022 originated from applicants in Poland. This volume accounted for around 2 % of all applications originating from EU countries, positioning Poland as a relatively modest contributor to Europe's pharmaceutical R&D capacity. However, 36 % of new clinical trials in Poland were early phase trials, and Poland has been consistently close to the EU average on this metric. Most clinical trials in Poland are industry-funded (75 %) rather than funded from public sources (25 %). Three quarters are also part of multi-country studies, showing that while local R&D capacity is limited, Poland is well embedded in global pharmaceutical R&D networks.

Figure 27. Pharmaceutical R&D investment per capita in Poland is relatively low



Note: The EU average is weighted (calculated by the OECD).
Source: OECD Data Explorer (DF_ANBERDi4).

7 Key findings

- Although lower than the EU average, in 2024, life expectancy at birth in Poland was 78.7 years – the highest it has ever been. However, 47 % of men and 56 % of women aged 65 and over are living with multiple chronic conditions. This contributes to healthy life expectancy being much lower in Poland than the EU average. At age 65, women in Poland can expect 8.6 years of healthy life expectancy and men 7.8 years, compared to averages of 9.2 years and 8.9 years, respectively, across the EU.
- Tobacco use and alcohol consumption are major contributors to mortality and morbidity in Poland, and the socioeconomic inequalities in exposure to behavioural and environmental risk factors are wide. High smoking rates among adolescents in Poland and the uptake of e-cigarettes, as seen across Europe, are key policy concerns that have prompted policy makers to tighten regulation of the tobacco market and to regulate e-cigarettes in a similar way. The average alcohol consumption among adults in Poland has fallen to 10 litres per capita; just above the EU average of 9.8 litres in 2022. Since 2020, Poland has strengthened fiscal measures targeting alcohol and tobacco consumption.
- High preventable and treatable mortality rates reveal weaknesses in the health system's ability to prevent disease and treat patients. Preventable mortality has been persistently higher than the EU average, and strengthening and developing cancer screening programmes has been a focus for policy makers. Avoidable hospital admissions for some of the most common chronic conditions are among the highest in Europe, indicating shortcomings in the provision of outpatient care.
- Total spending on health remains very low in Poland compared to the EU average, but it has increased over the past two decades. Over three quarters of total health spending comes from public sources, but almost one quarter come from private sources – mostly out-of-pocket spending on medicines. Overall, health spending favours inpatient rather than outpatient care, and the shares of funding allocated to long-term care and prevention are among the lowest in the EU.
- Unmet needs for medical care are relatively high in Poland, and long waiting times have been a key factor. Limited fiscal resources allocated to the health system and shortages of health workers underpin access barriers such as waiting times. There are also large disparities in the geographical distribution of health workers and infrastructure, which may result in variable access to services. Targeted spending increases have enabled hospitals to treat more patients and reduce waiting times, but there is still scope for further reductions. A key policy focus has been on expanding the health workforce to increase capacity in the health system.
- Poland has been a major beneficiary of co-financed EU support for health system strengthening across multiple instruments, and is the largest beneficiary under the EU Cohesion Policy. Poland's Recovery and Resilience Plan aims to support restructuring of the hospital sector, accelerate the digital transformation of health services, increase the health workforce and develop research in medical sciences.
- The statutory system in Poland provides comprehensive coverage for inpatient pharmaceuticals, but coverage of outpatient pharmaceuticals is more restricted. Only one third of retail pharmaceutical expenditure was covered by social health insurance in 2023. Financial coverage of inpatient medicines is comprehensive, including high-cost newer treatments and cancer care. Time to access new medicines varies, but is expedited for medicines with high clinical value. While local pharmaceutical research and development capacity and investment is limited, Poland is well embedded in global pharmaceutical research and development networks, and pharmaceutical innovation is important for the country's economic future.

Key sources

Sowada C, Richardson E, Kowalska-Bobko I (2025), Poland: health system summary, 2024. Copenhagen: European Observatory on Health Systems and Policies, WHO Regional Office for Europe, https://iris.who.int/handle/10665/381445.

OECD/European Commission (2024), Health at a Glance: Europe 2024: State of Health in the EU Cycle, Paris, OECD Publishing, https://doi.org/10.1787/b3704e14-en.

References

CeZ (2025a), Raport o szczepieniach przeciwko wirusowi brodawczaka ludzkiego (HPV) [Human papillomavirus (HPV) vaccination report]. Warsaw, Centrum e-Zdrowia, https://ezdrowie.gov.pl/portal/home/badania-i-dane/raport-o-szczepieniach-przeciwko-wirusowi-brodawczaka-ludzkiego-hpv.

CeZ (2025b), VIII Edycja Badania stopnia informatyzacji podmiotów wykonujących działalność leczniczą [8th edition of the study of the degree of computerisation of entities performing medical activities]. Warsaw, Centrum e-Zdrowia, https://www.cez.gov.pl/pl/page/o-nas/aktualnosci/e-zdrowie-w-polsce-wyniki-viii-edycji-badania-informatyzacji-placowek.

European Commission (2025), Country Report – Poland. Brussels, https://economy-finance.ec.europa.eu/publications/2025-european-semester-country-reports_en.

Kupis R et al. (2025), Medical education in Poland: a descriptive analysis of legislative changes broadening the range of institutions eligible to conduct medical degree programmes. BMC Medical Education 25(444). https://doi.org/10.1186/s12909-025-07031-y

Ministry of Health (2025), System and Implementation Analysis Database Platform, https://basiw.mz.gov.pl/en/2025/.

Newton M et al. (2025), EFPIA Patients WAIT Indicator 2024 Survey. Brussels, European Federation of Pharmaceutical Industries and Associations, efpia-patients-wait-indicator-2024-final-110425.pdf

OECD/European Commission (2025), EU Country Cancer Profile: Poland 2025, EU Country Cancer Profiles, Paris, OECD Publishing, https://doi.org/10.1787/fc2a5e54-en.

WHO Regional Office for Europe (2025), UHC Watch, https://apps.who.int/dhis2/uhcwatch/#/

Wojtyniak B, Smaga A (eds.) (2025), Sytuacja zdrowotna ludności Polski i jej uwarunkowania [Health status of Polish population and its determinants]. Warsaw: National Institute of Public Health and National Research Institute, https://www.pzh.gov.pl/raport-sytuacja-zdrowotna-ludnosci-polski-i-jej-uwarunkowania-2025/.

Country abbreviations

Austria	AT	Czechia	CZ	Germany	DE	Italy	IT	Netherlands	NL	Slovakia	SK
Belgium	BE	Denmark	DK	Greece	EL	Latvia	LV	Norway	NO	Slovenia	SI
Bulgaria	BG	Estonia	EE	Hungary	HU	Lithuania	LT	Poland	PL	Spain	ES
Croatia	HR	Finland	FI	Iceland	IS	Luxembourg	LU	Portugal	PT	Sweden	SE
Cyprus	CY	France	FR	Ireland	IE	Malta	MT	Romania	RO		

State of Health in the EU
Country Health Profiles 2025

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2025 edition of the *Country Health Profiles* provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- an account of the pharmaceutical sector and policies within the country.

Complementing the key findings of the Country Health Profiles is the *Synthesis Report*.

For more information, please refer to: https://health.ec.europa.eu/state-health-eu_en

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2025), *Country Health Profile 2025: Poland*. *State of Health in the EU*, OECD Publishing, Paris/ European Observatory on Health Systems and Policies, Brussels.

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