

# Poland

## Health system summary 2024

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**This Health System Summary is based on the *Poland: Health System Review (HiT)* published in 2019 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) ([www.hspm.org](http://www.hspm.org)). For this edition of the Health System Summary, key data have been updated to those available in September 2024 unless otherwise stated. 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.**

## Main sources:

Sowada C, Sagan A, Kowalska-Bobko I, Badora-Musiał K, Bochenek T, Domagała A, Dubas-Jakóbczyk K, Kocot E, Mrozek-Gąsiorowska M, Sitko S, Szetela A, Szetela P, Tambor M, Więckowska B, Zabdyr-Jamróz M, van Ginneken E (2019). Poland: Health system review. *Health Systems in Transition*, 21(1):1–235.

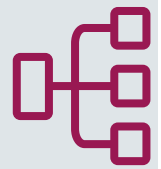
Health Systems and Policy Monitor (HSPM) – Poland (2024). European Observatory on Health Systems and Policies (<https://eurohealthobservatory.who.int/monitors/health-systems-monitor>).

**Please cite this publication as:** Sowada C, Richardson E, Kowalska-Bobko I. *Poland: Health System Summary, 2024*. Copenhagen: European Observatory on Health Systems and Policies, WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

ISSN 2958-9193 (online)

ISBN 9789289014526 (PDF)

# How is the health system organized?



Core governance functions are fairly centralized but coordinating activities between the health system's administrative levels is difficult to achieve

## 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 (Narodowy Fundusz Zdrowia, 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 (voivodeships) own the regional hospitals while counties own smaller county hospitals. Municipalities own some primary care

practices although most 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 hinders coordination of care and other activities. The regional branches of the NFZ are charged with the purchasing of services in their respective territories, and contracts are open to both public and private providers. The package 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. 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* 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 priority setting in the system, but do not always lead to real changes in contracting (see also Box 1).

### Box 1 Capacity for policy development and implementation

The publication of the *National Strategic Framework – Policy Paper for health protection for 2014–2020*, which set out priorities for the health system with support from EU structural funds, paved the way for more holistic planning that encompasses the entire health system. A new strategic framework adopted in 2021, *Healthy Future. A Strategic Framework for the Development of the Health Care System for 2021–2027, with a perspective until 2030*, extended this beyond the EU funds. However, strategic planning has so far been directed by the Ministry of Health and subordinate institutions, with little input from other stakeholders. This lack of comprehensive stakeholder involvement is visible in the approach to policymaking through pilot programmes, which often have been difficult to implement in practice, requiring adaptations to respond to realities on the ground.

## Providers

Most 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. Most 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 regions. 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?



Health spending has increased over the years, but remains comparatively low and out-of-pocket spending on medicines is high

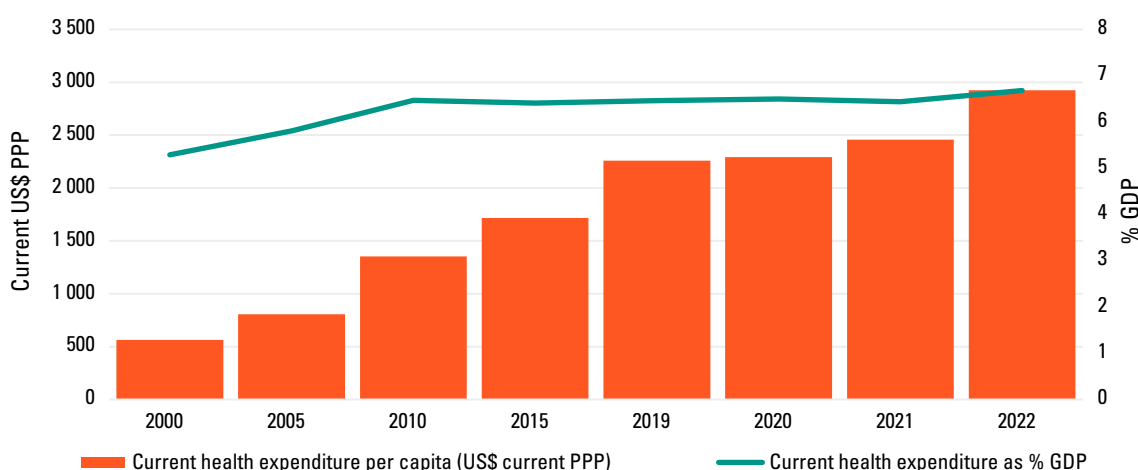
## Health expenditure

In 2022, health expenditure accounted for 6.7% of GDP (Fig. 1), compared to the averages in the EU (8.5%) and the WHO European Region (8.7%). Current health spending has increased considerably over the last two decades, reaching US\$ 2925 per capita (adjusted for differences in purchasing power) in 2022. Despite this, health spending was considerably lower in Poland than the EU/EEA/UK average, although higher than

the average for the WHO European Region (Fig. 2).

In 2018, the government pledged to progressively increase public spending on health as a percentage of GDP. However, in defining its commitment, the government reinterpreted how the share of public health expenditure in GDP should be calculated, which means that national data diverge significantly from international sources.

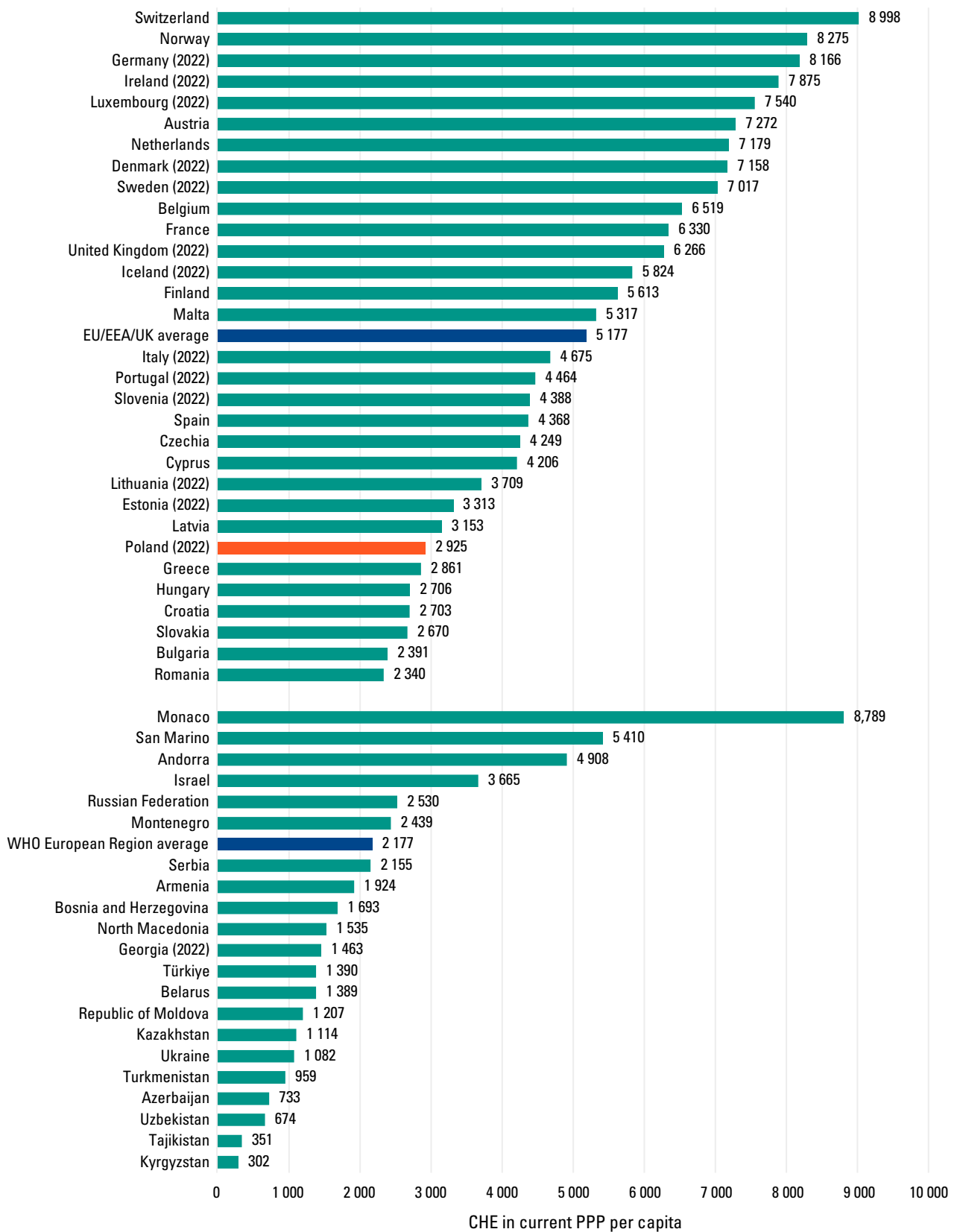
**Fig. 1** Trends in health expenditure, 2000–2022 (selected years)



**Notes:** GDP: gross domestic product; PPP: purchasing power parity.

**Source:** WHO, 2024.

**Fig. 2** Current health expenditure (US\$ PPP) per capita in WHO European Region countries, 2021 or latest available year



**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity.

**Source:** WHO, 2024.

## Funding mechanisms

Health insurance contributions (mostly an earmarked payroll tax) are the main source of public health care funding (90% of current health spending from public sources). Allocation takes into account the number and risk profile of inhabitants as well as the distribution of physical and human resources. Since 2022 the NFZ has also covered spending on some services for population

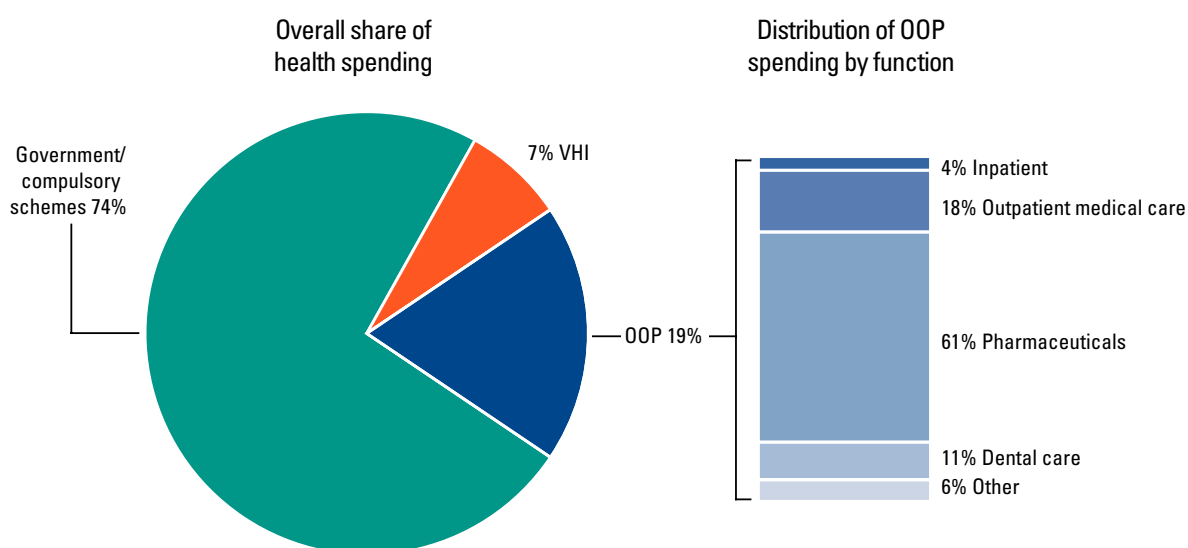
groups exempt from paying SHI contributions, and from 2023 the full cost of emergency care. Budgetary contributions from general taxation are used to finance public health programmes, among other things. Spending on voluntary health insurance (VHI) accounts for 7.5% of current health spending and its role as supplementary and complementary insurance has grown.

## Out-of-pocket payments

In 2022, OOP payments made up 19% 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 many 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).

**Fig. 3** Composition of out-of-pocket payments, 2022



Source: OECD, 2024.

## 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?

The breadth of coverage is relatively good and there are mechanisms in place to ensure people who fail to enrol themselves or (more frequently) their family members into the mandatory insurance scheme have access to retrospective enrolment. Certain groups (for example, pregnant women and children under 18) have access to publicly financed health care irrespective of their insurance status.

The scope of statutory coverage is also comprehensive for primary care services, outpatient specialist services and hospital services. However, access to these services might be limited in practice by long waiting times. Dental services and rehabilitation have only limited cover, although dental care is more comprehensive for certain vulnerable groups, such as children and pregnant women. There is also little public provision of long-term care, which is highly reliant on informal carers.







The key gap is in depth of coverage for outpatient medicines and medical devices as these are subject to substantial co-payments. Spending on outpatient medicines is the main driver of OOP payments and household catastrophic expenditure.

## 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, are widely used, but pay-for-performance (P4P) and quality-based payments are also slowly emerging (Fig. 4).

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

					
GPs	Specialists	Acute hospitals*	Hospital outpatient services	Dentists	Pharmacies
Capitation (age adjusted), fee-for-service, lump sum, elements of P4P	Per visit (based on DRGs); elements of P4P (for coordinated care)	Lump sum (based on DRGs), elements of P4P (for coordinated care) and quality-based funding (higher lump sums for quality certificates)	Lump sum (based on DRGs); fee-for-service; elements of P4P (for coordinated care) and quality-based funding (higher lump sums for quality certificates)	Fee-for-service	OOP; paid per product (reimbursed pharmaceuticals)

**Note:** \*Hospitals that are not included in the hospital network participate in tender procedures and their contracts are based on DRGs, as well as using fee-for-service, per diem, and elements of P4P

# What resources are available for the health system?



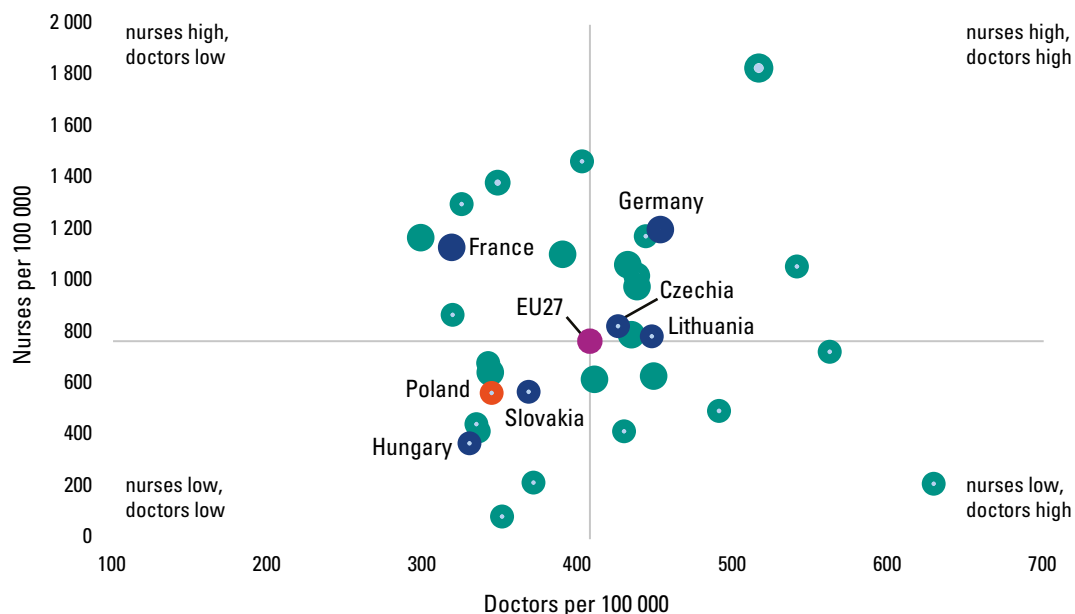
Poland has relatively low numbers of doctors and nurses and the geographical distribution of health resources such as specialist facilities and hospitals is uneven

## Health professionals

According to Eurostat data, the number of practising doctors in Poland was 344 per 100 000 population, lower than the EU average (407 per 100 000 population). The number of nurses is among the lowest among Member States, at 568 per 100 000 population (the EU average is 770 nurses per 100 000

population) (Fig. 5). While national data sources contain 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 underserved areas.

**Fig. 5** Practising nurses and physicians per 100 000 population, 2021 or latest available year



**Note:** Nurse numbers are for practising nurses (with an EU-recognized qualification).

**Source:** Eurostat, 2024.

## Health infrastructure

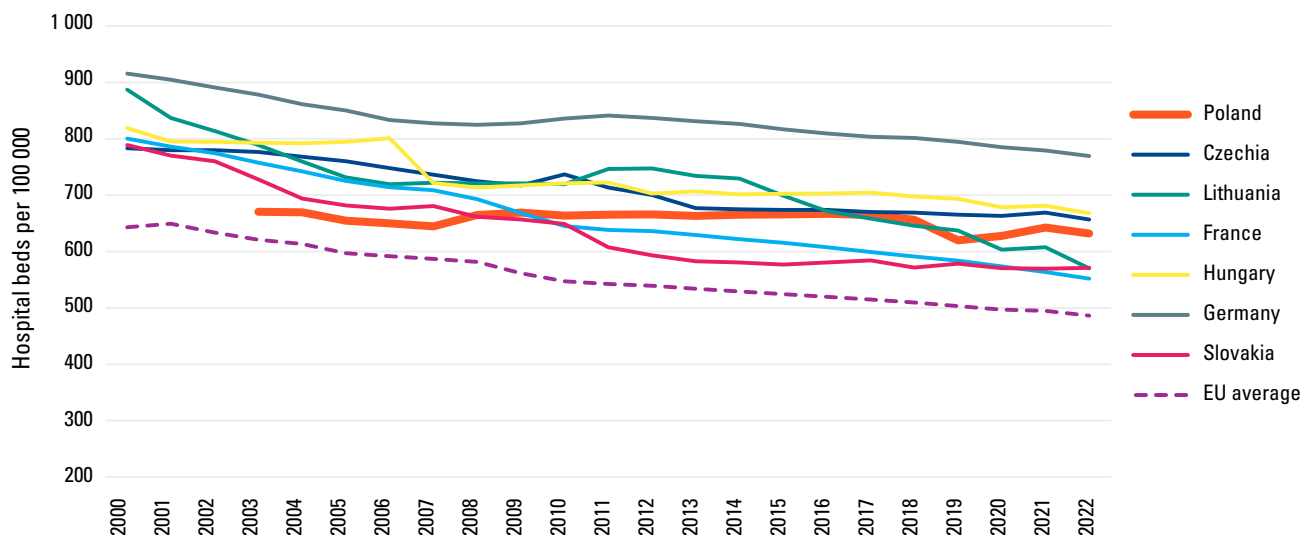
The number of hospital beds is comparatively high in Poland, at 629 beds per 100 000 population in 2022, compared to an EU average of 485 beds per 100 000 population, although it appears to have declined slightly after capacity was expanded in 2020-2021 in response

to the COVID-19 pandemic (Fig. 6). Rather than reducing the overall number of hospital beds, current reform plans foresee reprofiling some acute care beds into other types of beds, to respond to deficits in other areas, such as long-term care and geriatric care.

The availability of expensive medical equipment is lower in Poland than in many other EU countries (Fig. 7). Most equipment is located in large hospitals in big cities. Investments in medical equipment are funded by the hospitals themselves, including from

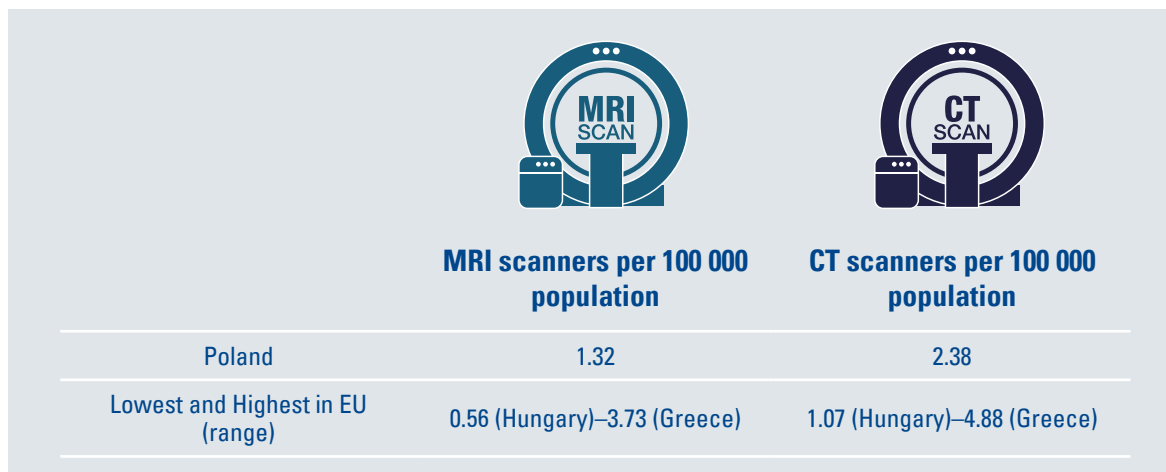
external sources (for example, EU funds) and donations, or by hospital owners, as funding from NFZ contracts is usually not enough. Due to the fragmentation of hospital ownership, there is little coordination of investments.

**Fig. 6** Beds in acute hospitals per 100 000 population in Poland and selected countries, 2000–2022



Source: Eurostat, 2024.

**Fig. 7** Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Poland, per 100 000 population, 2022



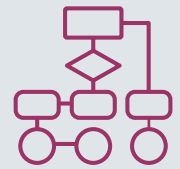
Source: Eurostat, 2024.

## Distribution of health resources

Access to primary care is generally good, but patients living in rural areas have worse access to specialist care compared with patients residing in urban areas. Despite the overcapacity in the hospital sector, geographical 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.

# How are health services delivered?



There are efforts to strengthen public health, primary care and mental health services as well as to move more care into the community

## Public health

The adoption of the Act on Public Health in 2015 has enhanced the status of public health in Poland. The Act has pulled together regulations pertaining to public health in one piece of legislation; it also changed the focus of the National Health Programme to fighting risk factors and, for the first time, allocated separate funding for its implementation. The new edition of the Programme for 2021–25 includes operational goals on: the prevention of overweight and obesity, healthy ageing, mental health promotion, addiction prevention and the reduction of health risks arising from environmental factors and infectious diseases.

Rates of vaccinations are high and incidence of infectious diseases is low. However, anti-vaccination movements have been growing in strength in recent years. This had serious implications for the

COVID-19 response and COVID-19 vaccination coverage remained persistently low, despite Poland experiencing very high rates of excess mortality rates in 2020 and 2021. A number of screening programmes are in place, including a cardiovascular disease prevention programme for people aged 35–65 years old and a programme for the prevention of tobacco-related diseases (including COPD).

For cancer screening programmes, data are very incomplete, making it hard to assess effectiveness in terms of reaching their target populations. Survey data put coverage rates higher than national screening programme data. For cervical cancer, most women appear to access screening tests outside the national screening programme, but for breast cancer, and especially colorectal cancer screening, coverage rates are low in both data sources.

## Primary and ambulatory care

Primary care is the main entry point to the Polish health care system. 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 many patients are referred to more specialist care, contributing to long waiting times for specialist consultations. Since 2022, primary care doctors have been permitted to order a larger range of diagnostic tests, but because 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 to contain costs (Box 3). Since 2015, nurses have been allowed to

prescribe certain medicines and medical devices and refer patients for diagnostic tests.

The Primary Healthcare 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 practices were mandated to hire care coordinators. None of the other solutions has been implemented so far, mainly due to their high cost.

### Box 3 What are the key strengths and weaknesses of primary care?

Access to primary health care is good and patients can usually be seen on the same day in smaller, private GP practices, although this may not be the case in large public facilities where waiting times may be very long. Opening hours of GP practices are long (50 hours a week) and primary health care is also easily accessible out-of-hours, on weekends and during public holidays. Primary care doctors can be consulted in person, on the phone or at the patient's home. Physical access is a key strength of primary care in Poland and is only limited by shortages of doctors willing to specialize in family medicine. Consequently, there are some inequalities in access, with patients living in rural areas having worse access than those in urban areas.

Key weaknesses in primary care stem from the limited funding allocated to this level of the health system. This introduces inappropriate incentives, for example, to limit the use of diagnostic services, but also prevents the full implementation of reforms to strengthen primary care services such as those indicated by the Primary Healthcare PLUS pilot.

## 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 (Box 4). 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 low. Constraints in the health budget and the availability of health workers reduce access to hospital care and waiting times for elective care can be long. Most hospitals are public and operate as "independent public healthcare units", but greater financial autonomy has led to the accumulation of debts in the hospital sector.

### 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 mostly 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 conditions, 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 recognized 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. Integration of health and social care remains weak.

## Pharmaceutical care

The network of community pharmacies is well developed and is among the densest in Europe. 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

Efforts are being made to shift mental health care to the community and reduce mental health stigma. Poland's mental health care system has traditionally relied heavily on inpatient care in psychiatric hospitals, with limited development of community-based services. Community mental health centres across all regions were piloted as part of Poland's second National Mental Health Protection Programme, which ran from 2017 to 2022. The number of these centres doubled from 40 in 2018 to about 80 in 2023. Community mental health centres employ multidisciplinary teams including new types of mental health professionals, such as recovery assistants (recruited

among recovered patients) and mental health coordinators. The new model also involves closer collaboration with social services and a shift towards budget financing.

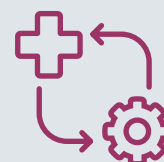
The Programme for 2023–2030 seeks to further popularize the community care model, and to reduce mental health stigma through educational activities. There has also been a strong focus on addressing the specific mental health needs of children and young people. Limited funding for mental health services and staffing shortages have been among the key barriers to reaching the target number of 250–300 centres across Poland by 2027.

## 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 dental 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?



**Increased financing responsibilities for the NFZ could challenge the sustainability of health financing**

Many reforms since 2015 have focused on improving the organization of care for some of the key health problems, including cancer, heart disease 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 implementation of e-health solutions, to some extent accelerated by the COVID-19 pandemic, have supported these efforts.

While strengthening coordination of care is one of the current strategic goals, there is no holistic plan encompassing all the initiatives.

A draft law has been in preparation since 2021 to restructure and improve the efficiency of the hospital sector. As of October 2024, the bill was still being heavily debated and revised, with several issues, such as dealing with accrued debts and low-volume wards, proving to be controversial. The latest draft legislation proposes voluntary measures for the merger of

hospitals, improving quality and better use of staff and resources. Another ongoing reform initiative (started in 2021) focuses on improving quality of inpatient care and seeks to comprehensively regulate issues such as authorization and accreditation of health care providers, monitoring of adverse events and patient compensation. Another goal is the creation of medical registers.

In 2024, the NFZ was given responsibility for the financing of emergency medical services; medicines for people over 75, pregnant women and those provided under the health policy programmes of the Ministry of Health; highly specialized services;

compulsory vaccinations; haemophilia treatment; antiretroviral treatment for people living with HIV; antiviral treatment for hepatitis C for prisoners; as well as insurance contributions for students, soldiers and the unemployed. This was previously financed from the state budget but no additional financial resources for the NFZ have been guaranteed. The NFZ had a budget surplus from 2021 due to unused health services, initially due to COVID-19 and later due to a shortage of health professionals. A new tax reform also increased the health care contributions of self-employed people with higher incomes, thereby increasing NFZ revenues.

### Box 5 Key health system reforms over the last 10 years

- **Introduction of a hospital network with lump sum financing for included hospitals (2017):** to improve provision of specialist care by incentivizing coordination between inpatient care and ambulatory care in hospital outpatient departments.
- **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, introduction of care coordinators became mandatory in all primary care practices (2021) and primary care doctors were permitted to order a broader range of diagnostic tests (2022).
- **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 standardized 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.
- **NFZ tasked with financing all health care services (2024):** a wide range of non-insurance-based services, which were previously financed from the state budget and guaranteed to all people in Poland, regardless of their statutory insurance status, are now the financial responsibility of the NFZ, but without the NFZ being guaranteed additional financial resources.

# How is the health system performing?



Monitoring of health system performance could be improved to better assess access and quality of care

## Health system performance monitoring and information systems

The Polish health system is primarily supervised by the Ministry of Health, with specific tasks delegated to supporting institutions. Monitoring is focused on selected indicators, such as mortality rates or the number of provided services, rather than 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.

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 health workforce numbers and the numbers reported to international databases. However, much progress has been made in the implementation of e-health tools (see Box 5), which can support performance monitoring.

## Accessibility and financial protection

Although patients are not required to pay for primary and inpatient care, access may still be constrained by waiting times. This is due to acute health workforce shortages and budget constraints at the NFZ, which puts limits on the volume of contracted services. 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 cost-sharing exemption mechanisms, 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. In 2023, 3.6% of the Polish population reported unmet needs for medical examinations due to either costs, distance or waiting times (the EU average was 2.4%) (Fig. 8).

## Health care quality

Annual surveys on how satisfied people are with health care services show variable results (Box 6).

Health quality and patient safety are not routinely assessed in Poland, although the planned reform on health care quality may change this. 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 one quarter of hospitals and even fewer primary care

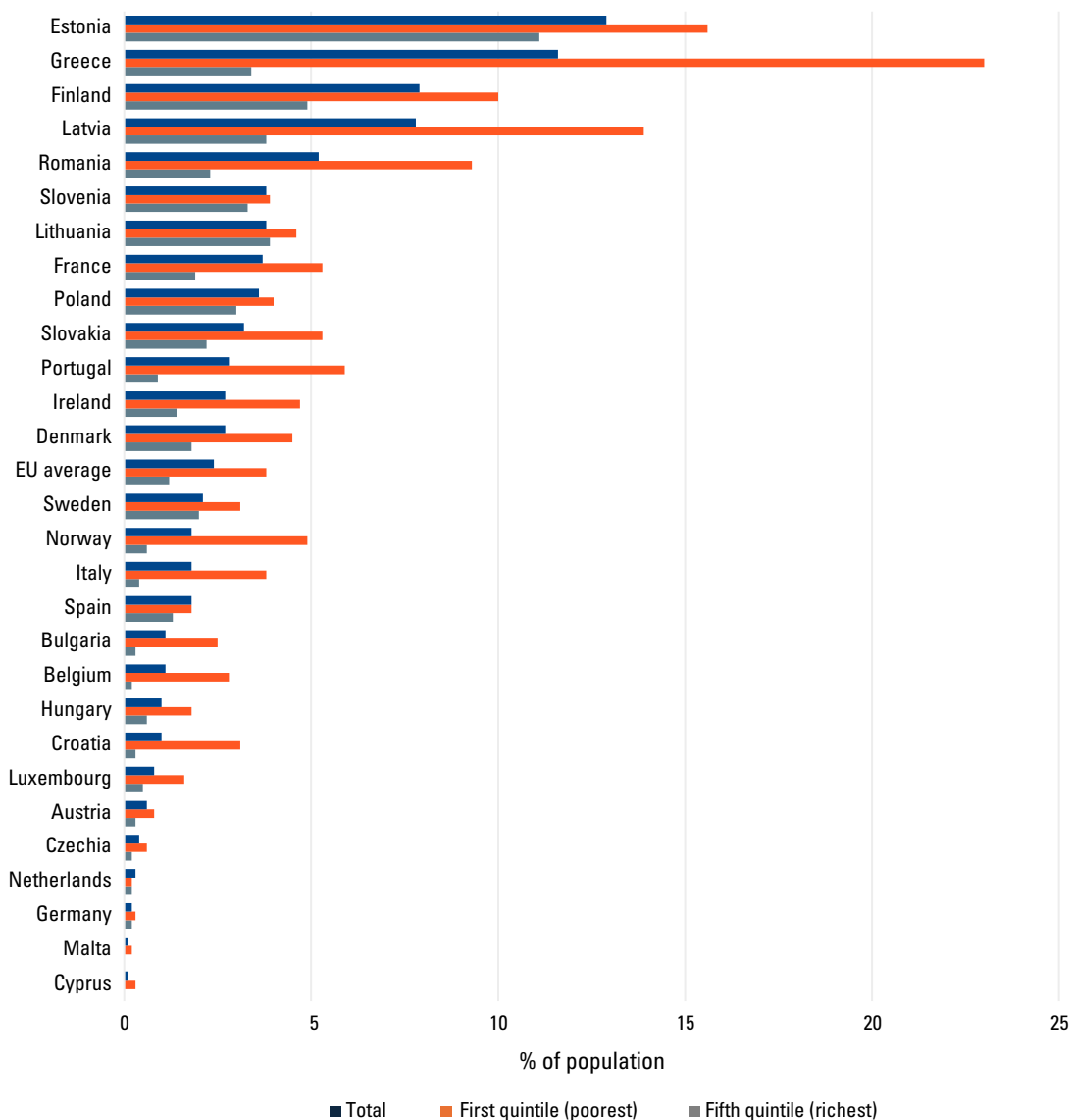
practices have it. Since July 2024, every hospital under contract with the NFZ must have an internal quality management system. As part of this system, all adverse events, including medical errors, must be investigated. However, hospitals themselves decide whether injured parties are allowed to report events.

According to one of the main indicators gauging the quality of primary care, the level of avoidable hospitalizations for conditions that are manageable within primary care or outpatient settings was relatively low

in Poland in 2021 (Fig. 9). Some areas of care, such as cardiology care, have had much investment, and Poland fares more favourably than some other countries in Europe. In terms of indicators for inpatient care,

in-hospital mortality rates after admission for acute myocardial infarction are relatively low in Poland, but there is scope for further reduction (Fig. 10).

**Fig. 8 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2023**



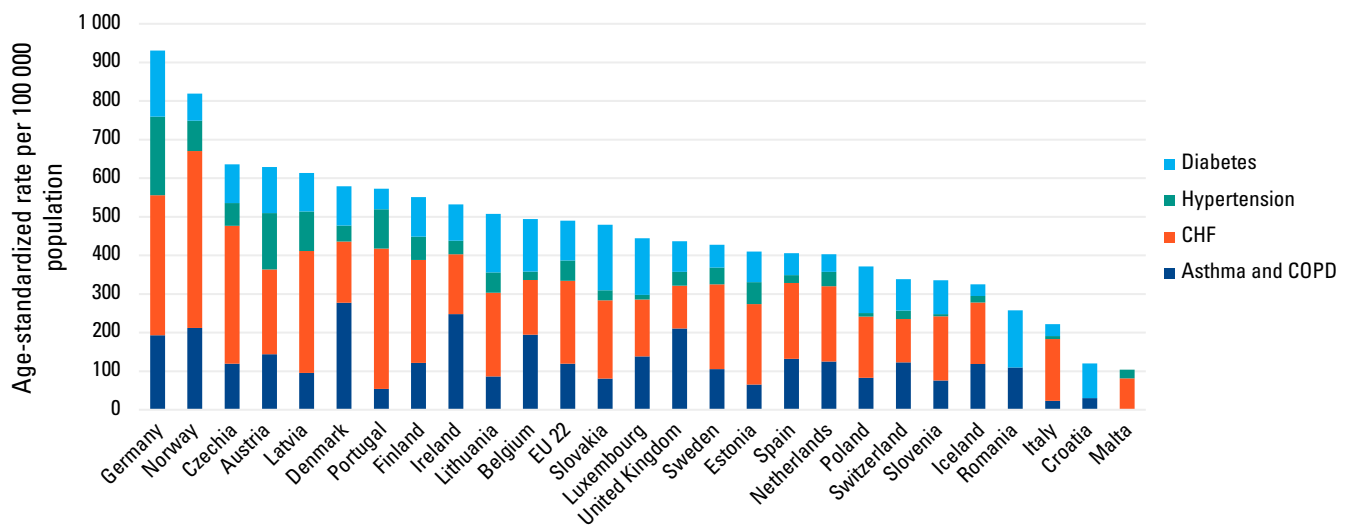
**Notes:** EEA: European Economic Area; EU: European Union.

**Source:** Eurostat, 2024.

### Box 6 What do patients think of the care they receive?

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 who were satisfied with the public health care system in Poland increased from 23% in 2016 to 27% in 2023. Yet most respondents remained unsatisfied (in 2023, 34% were “definitely”, and an additional 36% “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 (70% positive answers) and work ethic (over 50% of positive answers).

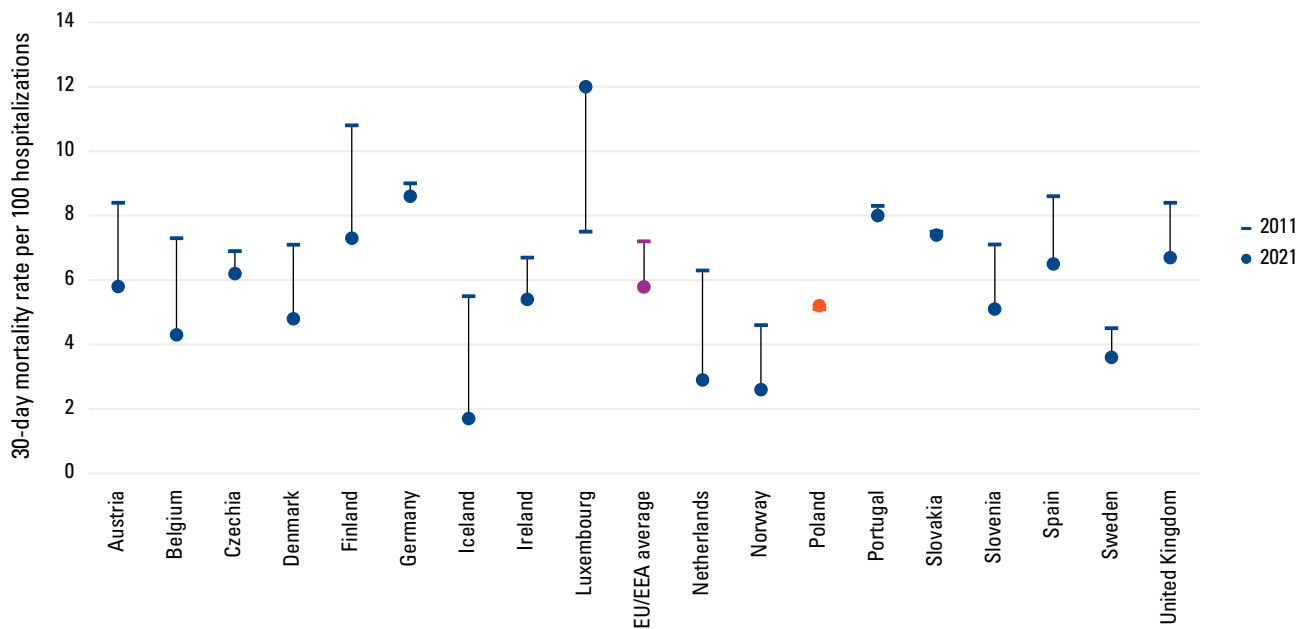
**Fig. 9** Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021



**Notes:** CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for Asthma and COPD or diabetes.

**Source:** OECD, 2024.

**Fig. 10** In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, Poland and selected countries



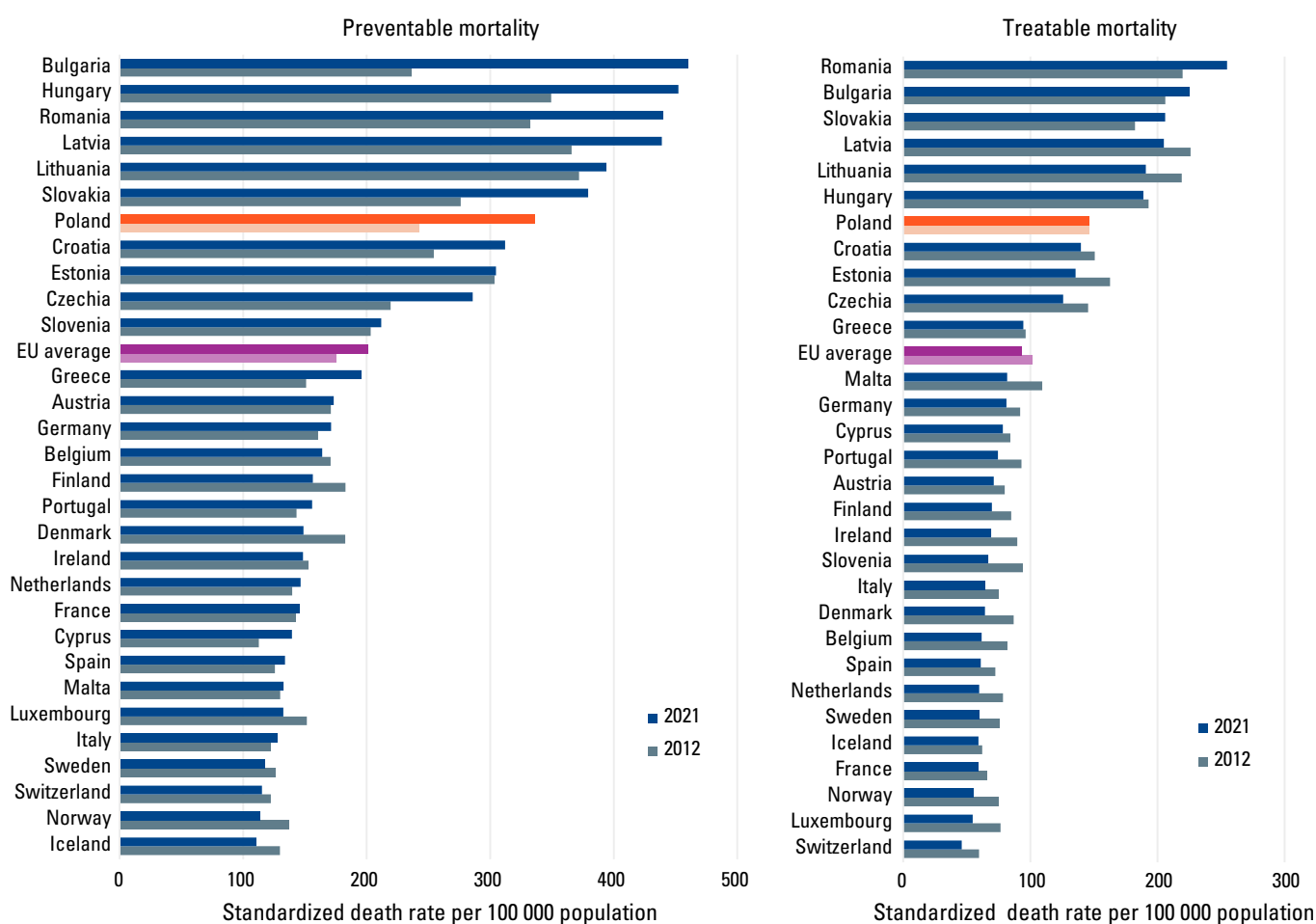
**Source:** OECD, 2024.

## Health system outcomes

The preventable mortality rate increased dramatically in Poland between 2012 and 2021, largely due to the inclusion of COVID-19 deaths as preventable after 2020 (Fig. 11). Before 2019 preventable mortality rates had been falling. The high prevalence of tobacco smoking and alcohol consumption are key drivers of preventable mortality (which could be avoided through public health and primary prevention interventions), but efforts are being made to address these (Box 7). The premature mortality from treatable causes (which could be avoided through health care interventions,

including screening and treatment) had remained more or less the same since 2014 but it also increased during the COVID-19 pandemic, with a rate that was over 50% higher than the EU average in 2021. Ischaemic heart disease (IHD), cancer and stroke are the major drivers of treatable mortality rates. 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 treatable mortality as an indicator less reliable (Sagan et al., 2022).

**Fig. 11** Mortality from preventable and treatable causes, 2012 and 2021



**Notes:** After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

**Source:** Eurostat, 2024.

### Box 7 Are public health interventions making a difference?

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 300ml, but producers, in anticipation of this change, switched to 350ml 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.

## 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 points 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.

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), partly because the share of public spending on medicines is not very high.

### Box 8 Is there waste in pharmaceutical spending?

Measures aimed at improving cost-effective use of medicines are mainly focused on 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. 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 (MZ, 2018). Price competition in the generics market has been improved since 2012, but only for medicines that entered the market since that year.

# Summing up



## Low health financing compounds structural inefficiencies in the health system

The Polish health system achieves a great deal considering its limited budget. However, persistent low spending means that there are major coverage gaps in the care that is provided (such as outpatient medicines) and that some types of care, such as long-term care, remain underdeveloped, with patients left to rely on informal care or private provision. Financial constraints also hamper investments in primary care and the development of community care more broadly and means that the historical dominance of acute hospital care remains difficult to change. 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, are promising. However, the implementation of primary care reform to spearhead community provision has been in limbo ever since its pilot ended in late 2021. Health workforce shortages and low spending have also led to long waiting times for elective surgery and some diagnostic procedures; waiting times more than quality of care are the key public concern.

## Population health context

### Key mortality and health indicators

Life expectancy (years)	2023
Life expectancy at birth, total	78.6
Life expectancy at birth, male	74.8
Life expectancy at birth, female	82.4
Mortality	2021
All causes (SDR per 100 000 population)	1 504.5
Circulatory diseases (SDR per 100 000 population)	541.4
Malignant neoplasms (SDR per 100 000 population)	259.9
Communicable diseases (SDR per 100 000 population)	6.2
External causes (SDR per 100 000 population)	60.1
Infant mortality rate (per 1 000 live births)	3.9
Maternal mortality per 100 000 live births (modelled estimates)*	2

**Note:** \*Maternal mortality data is for 2020.

**Sources:** Eurostat, 2024; WHO Regional Office for Europe, 2024.

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Keywords:  
DELIVERY OF HEALTH CARE  
EVALUATION STUDIES  
FINANCING, HEALTH  
HEALTH CARE REFORM  
HEALTH SYSTEM PLANS – organization and administration  
POLAND

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