



# State of Health in the EU

# Poland

Country Health Profile 2023

## The Country Health Profile 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 voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

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 Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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## 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

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 2023, based on data that were accessible as of the first half of September 2023.

## Demographic and socioeconomic context in Poland, 2022

### Demographic factors

	Poland	EU
Population size	37 654 247	446 735 291
Share of population over age 65 (%)	19.1	21.1
Fertility rate <sup>1</sup> (2021)	1.3	1.5

### Socioeconomic factors

GDP per capita (EUR PPP <sup>2</sup> )	28 044	35 219
Relative poverty rate <sup>3</sup> (%)	13.7	16.5
Unemployment rate (%)	2.9	6.2

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. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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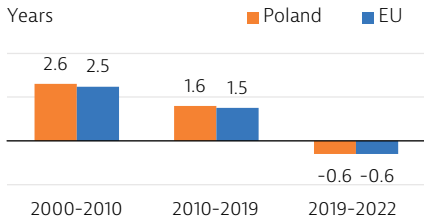
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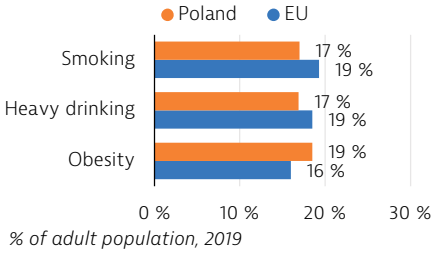
# 1 Highlights



Changes in life expectancy at birth

## Health Status

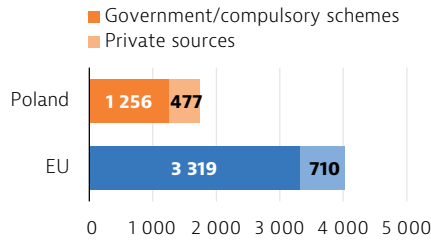
Life expectancy at birth in Poland fell by 0.6 years between 2019 and 2022, and at 77.4 years it was 3.3 years below the EU average in 2022. Circulatory diseases and cancers accounted for more than half of all deaths in 2021, followed by COVID-19. However, COVID-19 deaths may have been underreported in 2020 and 2021.



% of adult population, 2019

## Risk Factors

Smoking rates among adults are close to the EU average, but there is relatively high use of e-cigarettes among young people. Alcohol consumption levels are quite high, but heavy drinking is less prevalent than on average in the EU. Obesity rates have been growing slowly but steadily, including among adolescents. Tobacco smoking and poor diet are the major contributors to mortality.



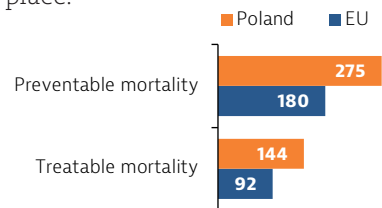
EUR PPP per capita, 2021

## Health System

While Poland's health expenditure is well below the EU average, it provides universal coverage and a broad package of benefits. The share of private spending is relatively high, at 28% compared to 19% across the EU. The majority of this spending is in the form of out-of-pocket payments (20%), and nearly two thirds of it is spent on medicines.

## Effectiveness

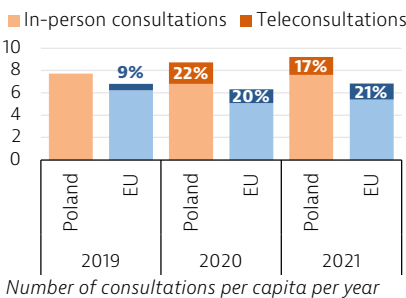
Both preventable and treatable mortality rates are higher in Poland than in the EU, and progress in reducing mortality from treatable causes has stagnated or even regressed slightly since 2014. This has been attributed to the increase in mortality from ischaemic heart disease, even though this disease appears to be underreported, with heart failure often reported in its place.



Age-standardised mortality rate per 100 000 population, 2020

## Accessibility

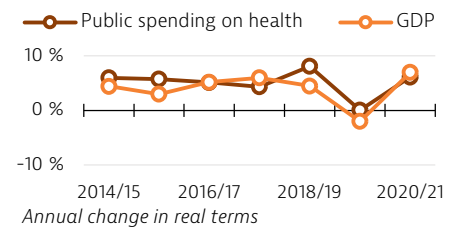
There was an unprecedented increase in teleconsultations during the pandemic; in 2020, these accounted for 22% of all consultations (the same as the EU average). The share fell to 17% in 2021, even though the total number of consultations per capita remains among the highest in the EU.



Number of consultations per capita per year

## Resilience

In 2020, public spending on health in Poland did not increase, while GDP fell. It subsequently rebounded, alongside the recovery in GDP. The national Recovery and Resilience Plan has earmarked significant investment for the health system, focusing on hospital reform and restructuring, development of digital health and health workforce strengthening.



## Mental Health

Despite having one of the lowest prevalence rates in the EU, mental health issues may be more common than reported in Poland due to lack of awareness, social stigma and poor access to services. Women in the lowest income quintile are most likely to report depression. Psychiatric hospitals remain the primary sources of mental healthcare, although steps are being taken to move towards a community-based model, and efforts are being made to reduce stigma associated with accessing mental healthcare.

## 2 Health in Poland

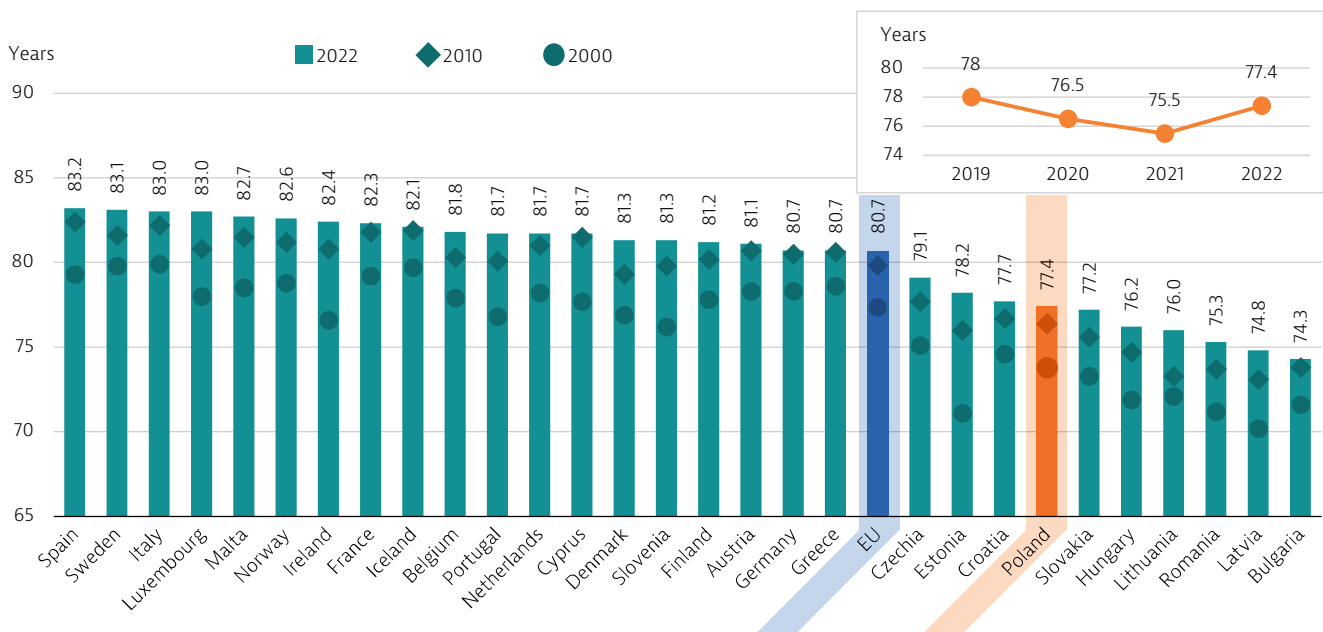
### Life expectancy at birth in Poland declined in two consecutive years during the pandemic

In 2022, life expectancy at birth in Poland was 77.4 years, which is 3.3 years lower than the EU average. In the decade preceding the COVID-19 pandemic, Poland's life expectancy was increasing at a similar rate as the EU, so that life expectancy had risen to 78.0 years by 2019. The pandemic had a greater impact on mortality in Poland than in most other EU countries, with life expectancy falling by 1.5 years in 2020 followed by a further

reduction of 1 year in 2021, but in 2022 the trend was reversed and life expectancy improved (Figure 1).

As in other EU countries, in Poland, men tend to have shorter lifespans than women. In 2022, men were expected to die, on average, 6 years earlier than women. This gender gap in life expectancy, is largely due to men's greater exposure to risk factors – particularly smoking and excessive alcohol consumption (see Section 3).

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



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refers to 2021.

Source: Eurostat Database.

### Circulatory diseases were the leading cause of death in 2021

The broad group of circulatory diseases, including ischaemic heart disease, stroke and other cardiovascular diseases, was the leading cause of death in Poland, accounting for more than one third of all deaths in 2021. Ischaemic heart disease was the main cause of death within that group. Almost one in five deaths in 2021 were due to various types of cancer, with lung cancer remaining the most common cause of cancer death (Figure 2).

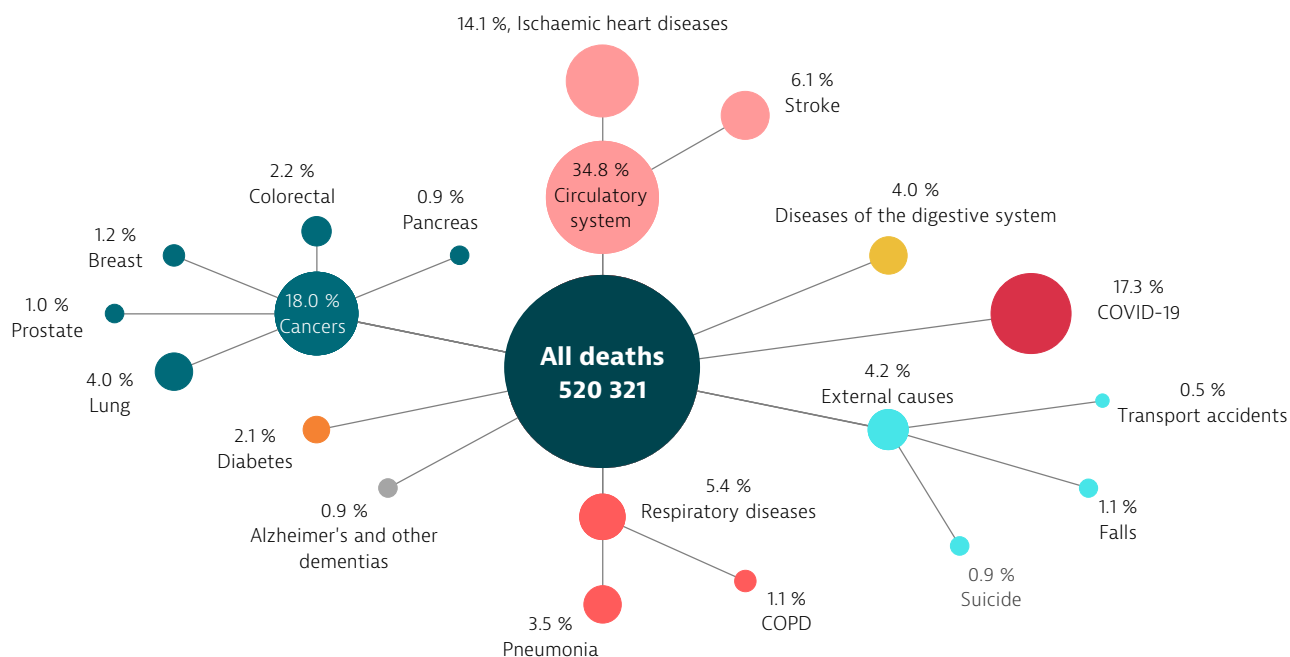
In 2020, the first year of the pandemic, Poland reported about 41 500 deaths due to COVID-19 (8.7 % of total deaths). In 2021, over 90 200 deaths due to COVID-19 were reported (17.3 % of total

deaths). In both years, the majority of these deaths (82 - 84 %) occurred among people aged 65 and over.

### Poland recorded high excess mortality rates in 2020 and 2021

The indicator of excess mortality, defined as deaths that occurred (regardless of their cause) above a baseline derived from pre-pandemic levels, provides a more complete picture of the pandemic's mortality impact. The 245 000 excess deaths that occurred in Poland between 2020 and 2022 accounted for over 20 % of deaths above the historic baseline over the same period, which is much higher than the 12.6 % excess mortality observed on average in the EU for the same period.

**Figure 2. COVID-19 accounted for a large number of deaths in Poland in 2021**



Note: COPD refers to chronic obstructive pulmonary disease.  
Source: Eurostat Database (data refer to 2021).

Like most other central-eastern EU countries, Poland experienced a large increase in excess mortality during 2021. This large increase in excess deaths (of nearly 30 %) can be explained to a large extent by the occurrence of two major COVID-19 waves in 2021: one in the spring and one at the end of that year, against a background of low COVID-19 vaccination uptake (see Section 5.1). Excess mortality in 2022 was calculated to be 11.2 %.

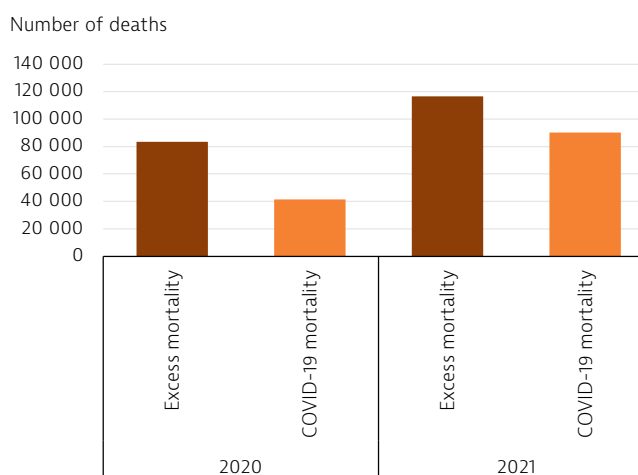
The number of excess deaths in Poland in 2020 and 2021 was significantly higher than reported COVID-19 deaths, suggesting that the direct and indirect mortality impact of the pandemic was higher than the mortality reported as being directly related to the virus, or that the full number of COVID-19 deaths were underreported (Figure 3).

### Older people in Poland have shorter lifespans and a higher prevalence of chronic conditions and disabilities compared to EU averages

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 18 % in 2020 – a lower share than the EU average (21 %). However, this share is projected to increase rapidly to 30 % by 2050 – the same as the EU average.

In 2020, 65-year-old women in Poland could expect to live another 19.2 years, which is nearly 2 years below the EU average, while men could expect to live another 14.6 years, which is nearly 3 years below the EU average. However, the gap in healthy life years between Polish women and men is much

**Figure 3. The number of excess deaths in Poland exceeded COVID-19 mortality in 2020 and 2021**



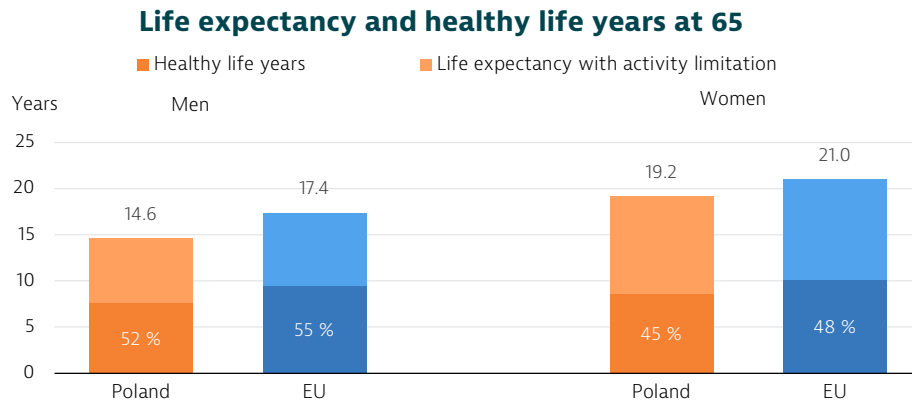
Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the pandemic (2015–19).

Sources: Eurostat Database (for COVID-19 mortality) and OECD Health Statistics based on Eurostat data (for excess mortality).

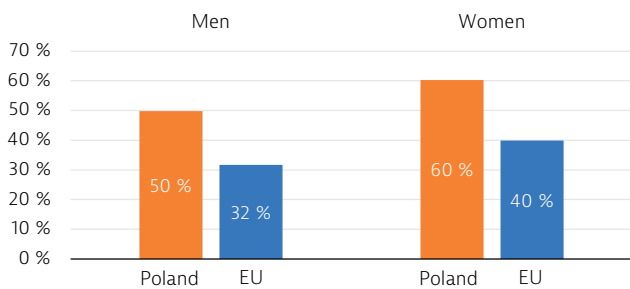
smaller (approximately 1 year) because women tend to spend a greater portion of their remaining life years with some health limitations.

Among Poles aged 65 and over, 50 % of men and 60 % of women report having multiple chronic conditions, which are among the highest proportions across EU countries. The proportions of men and women aged 65 and over in Poland reporting limitations in basic activities of daily living, such as dressing and showering, are higher than the EU averages, particularly for men (Figure 4).

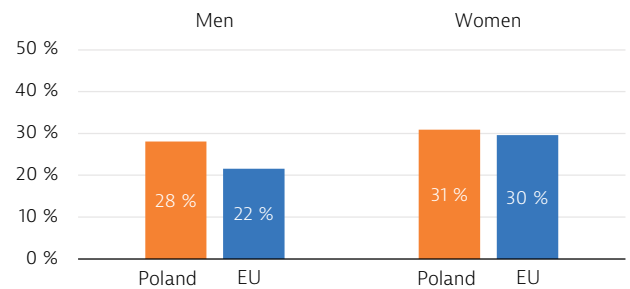
**Figure 4. Rates of multimorbidity in Poles aged 65 years and above are among the highest in the EU**



**Proportion of people aged 65 and over with multiple chronic conditions**



**Limitations in daily activities among people aged 65 and over**



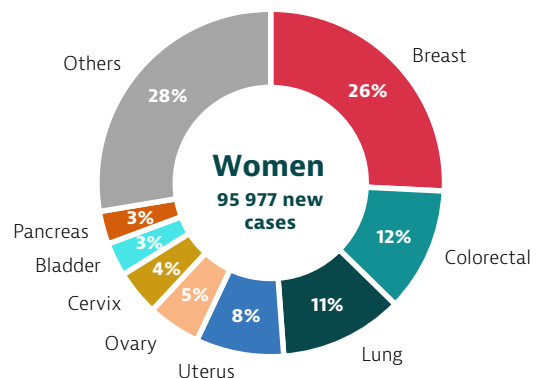
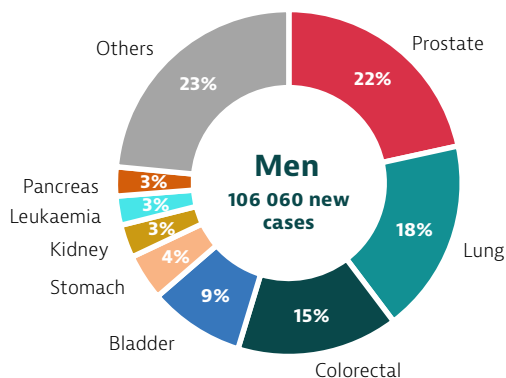
Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for multiple chronic conditions and limitations in daily activities). Data refer to 2020.

**The burden of cancer in Poland is considerable**

According to estimates from the Joint Research Centre, based on incidence trends from previous years, almost 202 000 new cases of cancer were expected in Poland in 2022. Figure 5 shows that the main new cancer sites among men were expected to be prostate (22 %) and lung (18 %), followed by colorectal cancer (15 %). Among women, breast cancer was expected to be the most common cancer (26 %), followed by colorectal (12 %) and lung cancer (11 %). These estimates are very similar to

national estimates of cancer incidence for 2022, which anticipated that the number of cancer cases would increase, and that the cancers most frequently diagnosed in men would be prostate (24 %), lung (14 %) and colorectal cancer (12 %) while for women they would be breast (23 %), lung and colorectal cancer (10 % each) (Wojciechowska et al., 2023). A recent policy initiative from the National Oncology Network aims to improve cancer diagnosis and treatment.

**Figure 5. An estimated 202 000 people in Poland were expected to be diagnosed with cancer in 2022**



**Age-standardised rate (all cancer):** 696 per 100 000 population  
**EU average:** 684 per 100 000 population

**Age-standardised rate (all cancer):** 458 per 100 000 population  
**EU average:** 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.  
 Source: ECIS – European Cancer Information System.

## 3 Risk factors

### Behavioural and environmental risk factors account for 44 % of all deaths

Over two fifths (44 %) of all deaths registered in Poland in 2019 can be attributed to behavioural risk factors, including tobacco smoking, dietary risks, alcohol consumption and low physical activity, which is a higher proportion than the EU average (39 %). Deaths from tobacco consumption and dietary risks were above EU averages (Figure 6). Although the proportion of deaths due to alcohol consumption was the same as the EU average in 2019, trends in mortality attributable to alcohol consumption have shown an increase for all ages since the early 2000s. Air pollution in the form of fine particulate matter (PM<sub>2.5</sub>) and ozone exposure

accounted for an estimated 8 % of all deaths in 2019 (over 30 000 deaths) – twice the proportion estimated for the EU (Figure 6).

The 2015 Act on Public Health shifted the strategic focus of the National Health Programme from the treatment of common diseases to the promotion of healthier lifestyles and the reduction of important risk factors. 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.

**Figure 6. Tobacco smoking, poor diet and air pollution are major contributors to mortality in Poland**



Notes: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components, such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to fine particulate matter (PM<sub>2.5</sub>) and ozone.

Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

### Smoking among adults has decreased but remains above the EU average

Tobacco consumption is a longstanding public health issue in Poland, particularly among men. Smoking prevalence has declined considerably, from 28 % of adults who smoked daily in 2001 to 17 % in 2019, which is slightly lower than the EU average (Figure 7). However, a national survey conducted in 2022 found that 30 % of men and 18 % of women were regular smokers of tobacco or e-cigarettes (Wojtyniak & Goryński, 2022).

Rates of cigarette smoking among adolescents (aged 15 years) have also come down from 24 % of adolescents who reported smoking tobacco

(cigarettes) in the past month in 2014 to 22 % in 2022, but this remains higher than the EU average (18 % in 2022). However, the use of e-cigarettes has become more popular among young people: 30 % of 15- and 16-year-olds in Poland reported smoking e-cigarettes in 2019 – a rate more than twice the EU average of 14 %.

### Alcohol consumption among adults has grown but heavy drinking is lower than the EU average

Average alcohol consumption among adults in Poland was about 11 litres of pure alcohol per person in 2021, an increase from a decade earlier (10.3 litres in 2011). One in six adults reported regular heavy drinking in 2019 (16.9 %),

a proportion that is lower than the EU average (18.5 %), and which remained fairly stable between 2014 and 2019.<sup>1</sup> As in many other EU countries, heavy drinking in Poland is more prevalent among men (28.1 %) than women (8.4 %). The proportion of 15-year-olds in Poland who reported having been drunk more than once in their life fell from 26 % in 2014 to 19 % in 2018, which was below the EU average (22 %), but in 2022 it had increased to 22 % while the EU average had fallen to 18 %.

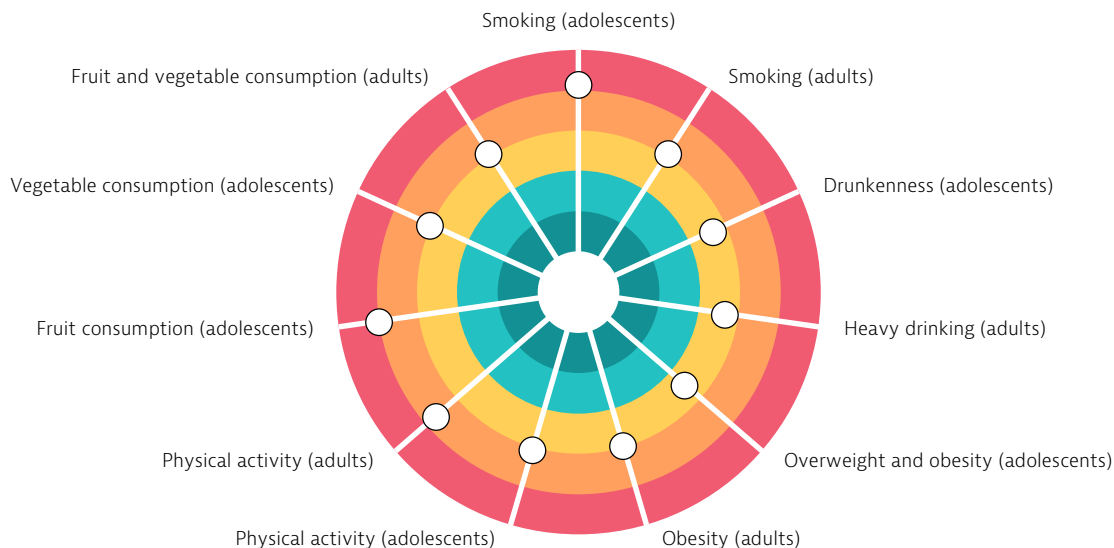
### Obesity rates have been growing slowly but steadily

About 18.5 % of adults in Poland were obese in 2019, which is a higher proportion than the EU average (16 %) and has increased from 16.7 % in 2014. Compared to the period before COVID-19, in 2022, the share of overweight men increased by 3 percentage points, with the strongest increases

seen in men with higher levels of education and those living in urban areas (Wojtyniak & Goryński, 2022). There was a small increase in obesity rates among women (0.5 percentage points).

Poor nutrition partly explains the increasing prevalence of obesity. In 2019, only 9 % of adults in Poland reported consuming five portions of fruit and vegetables every day, which is a decrease from 10 % in 2014 and below the EU average of 12 %. Also, only 20 % of adults in Poland reported doing the recommended 150 minutes of exercise per week in 2019, a lower share than the EU average (33 %). Overweight and obesity rates among adolescents have also increased over the past two decades, but more slowly than in many other EU countries. The proportion of 15-year-olds in Poland who reported being overweight or obese in 2022 was below the EU average (20 % compared to 21 %).

**Figure 7. Many risk factors to health 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; and EHIS 2019 for adults indicators.

### Socioeconomic inequalities contribute to inequalities in life expectancy

As in other EU countries, the prevalence of several behavioural risk factors tends to follow a socioeconomic gradient in Poland. In 2019, 26 % of adults in the lowest income group reported smoking daily, compared to 16 % among those in the top income quintile. There is also a significant gap in the prevalence of obesity between people with lower (22 %) and higher (17 %) incomes.

The gradient is the other way around when it comes to heavy drinking, as also seen in nearly all other EU countries: a higher proportion of people in the highest income group (20 %) report heavy drinking compared to those in the lowest income group (11 %).

<sup>1</sup> Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.



# 4 The health system

## The health system remains fairly centralised and offers universal coverage for the resident population

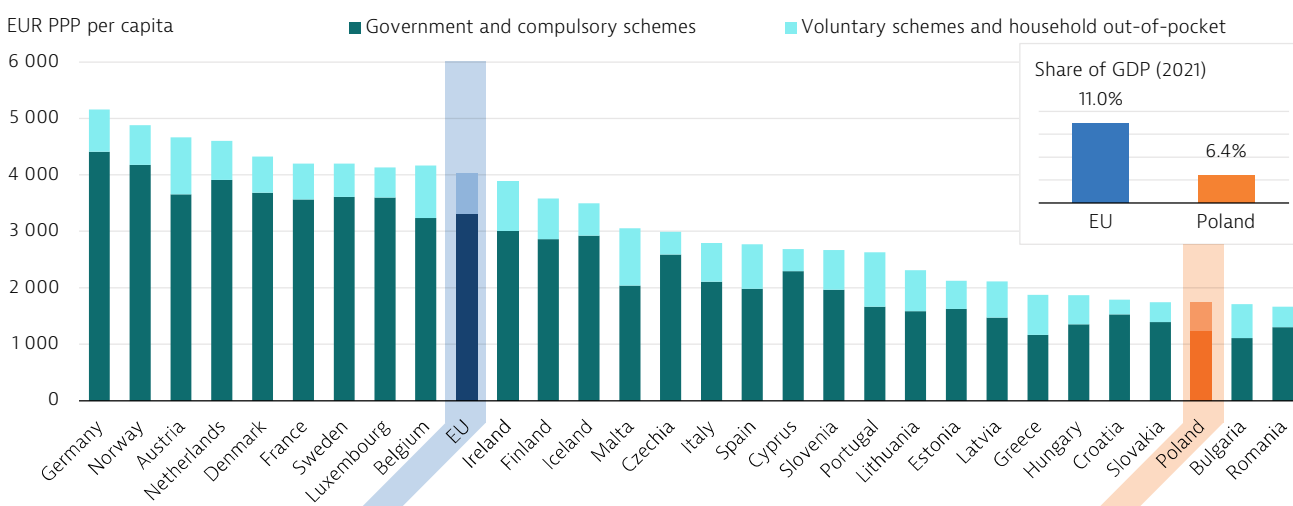
The Polish health system is based on social health insurance (SHI). Although SHI formally covers only 91 % of the population, it is considered nearly universal, as most of those who are uninsured live outside the country while still being registered as residents. People who lack SHI coverage are able to obtain outpatient emergency medical care and primary care. The system is largely centralised, with the Ministry of Health and the National Health Fund (NFZ) 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. Only about 15 % of hospital beds are private. Some primary care practices are owned by municipalities, but the vast majority are privately owned as is the bulk of specialist outpatient care providers. All private providers can offer services to patients under contracts with the NFZ, or on a private, fee-paying basis.

## Health expenditure is low and the share of private spending is substantial

In 2021, Poland's health spending was among the lowest in Europe, both in per capita terms (EUR 1 733, adjusted for differences in purchasing power) and as a share of GDP (6.4 %) (Figure 8). Overall, current health expenditure declined by 0.7 % in 2020, but then grew by 5.8 % in 2021, as part of the response to the COVID-19 pandemic.

The share of public financing for health has grown slightly in recent years and amounts to approximately 73 % of all financing, which is around 8 percentage points lower than the EU average in 2021 (81.1 %). Approximately 60 % of this funding comes from SHI contributions, which are collected as an earmarked payroll tax. Household private spending is the second most significant source of funding, representing 28 % of current health spending compared to 19 % in the EU on average. More than two thirds of this private spending (20 % of current expenditure) is in the form of out-of-pocket (OOP) payments – mainly on outpatient pharmaceuticals, outpatient medical care and dental care. Voluntary health insurance (VHI) also plays a significant role, accounting for 8 % of total health spending. It is usually purchased by employers for their employees to cover occupational health and other health services.

**Figure 8. Poland spends less than half the EU average on health**



Note: The EU average is weighted.

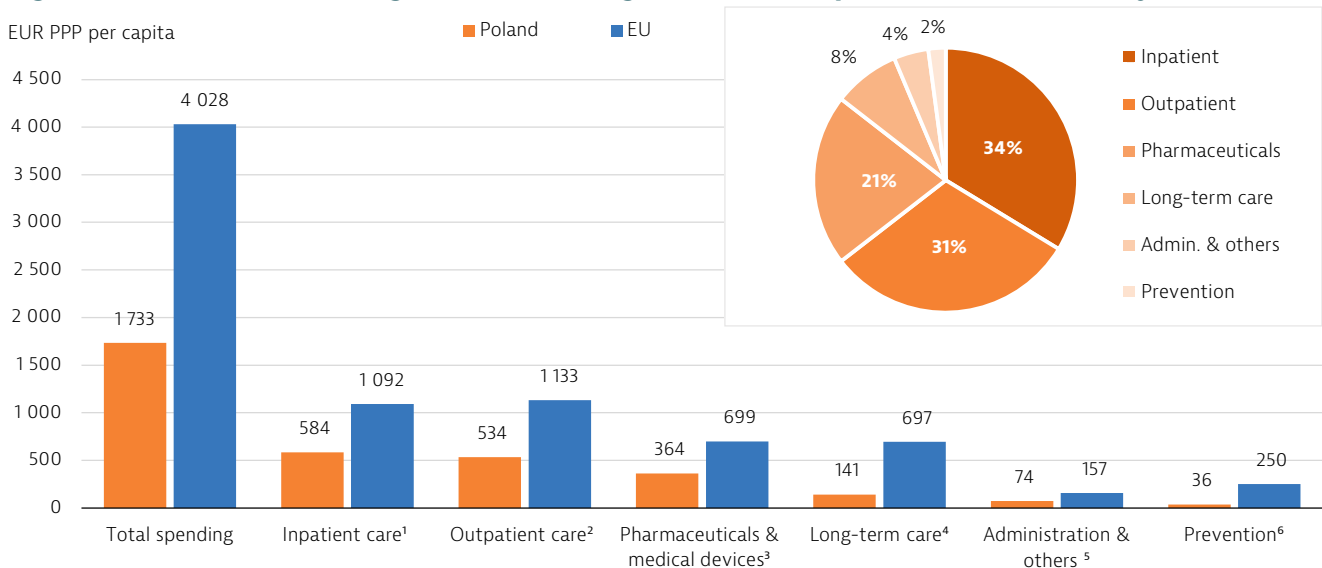
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

## The largest share of health spending is dedicated to inpatient care

Poland spends a higher share of health spending on inpatient care than most EU Member States, at 34 % compared to the EU average of 28 % (Figure 9). Poland's second highest share of health spending is on outpatient care (31 %) followed by pharmaceuticals (21 %), both of which are only slightly higher than the EU averages (28 % for outpatient care and 17 % for pharmaceuticals). Spending on long-term care, at 8 %, is substantially lower than the EU average (16 %). Reliance on

unpaid, informal care means that long-term care is not visible in the OOP spending data (see Section 5.2). Given the high number of hospital beds (6.3 per 1 000 population) and little success thus far in reducing the number of excess beds, the national Recovery and Resilience Plan intends to transform some of these into long-term care and geriatric care beds (Ministerstwo Funduszy i Polityki Regionalnej, 2022). The share spent on prevention (2 %) is also much lower than the EU average (6 %).

**Figure 9. The shares of funding dedicated to long-term care and prevention are relatively low**



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.

Sources: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

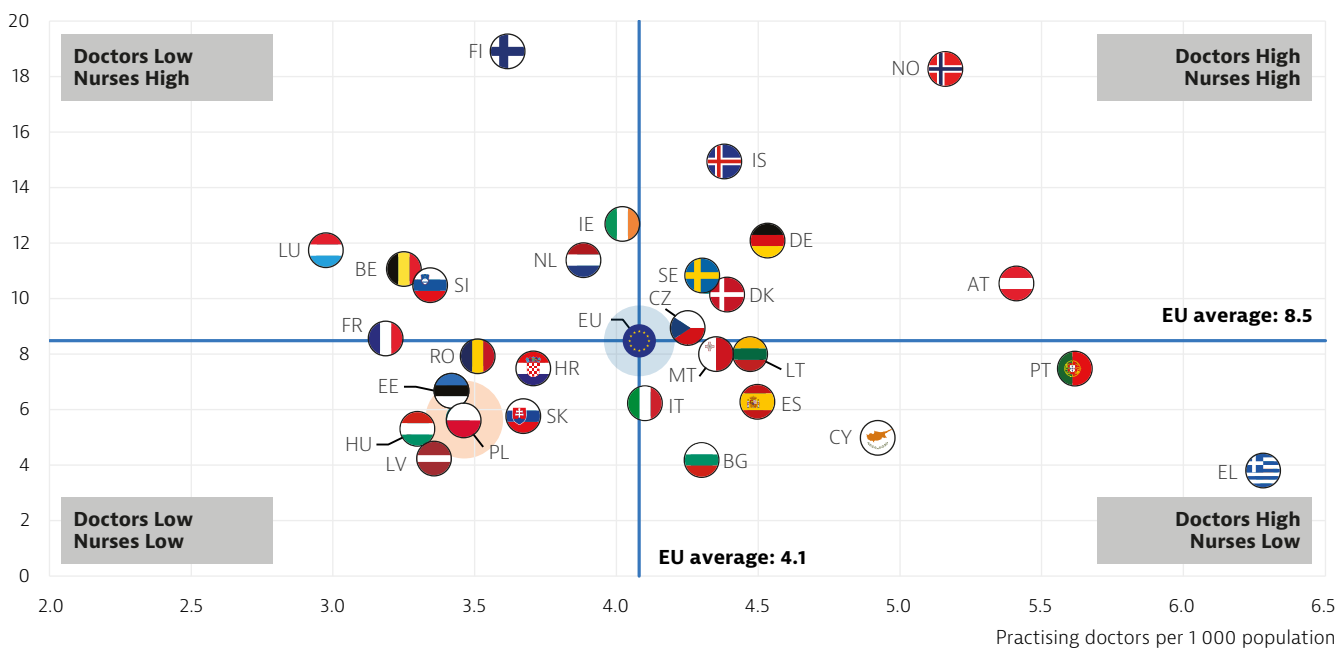
## Poland has among the lowest numbers of health professionals in Europe

Poland has a lower density of doctors than most EU countries, with 3.4 doctors per 1 000 population compared to 4.1 per 1 000 across the EU (Figure 10), and there are shortages of doctors in some areas – especially rural ones. Nevertheless, according to national data, the number of doctors with a right to practise in Poland in 2023 was 4.0 per 1 000 population. The density of nurses in Poland is also one of the lowest in the EU, at 5.7 per 1 000 population compared to 8.5 per 1 000 across the EU. The nursing workforce is generally older, with almost a third of nurses aged 50-59 compared to a fifth of doctors. Virtually all nurses (97.5 %) are women, and 59 % of doctors are women (GUS, 2022).

Salary increases have been implemented to try to boost nursing workforce numbers, but these have had collateral effects on the finances of community hospitals (see Section 5.3).

**Figure 10. The number of nurses in Poland is a third lower than the EU average**

Practising nurses per 1 000 population



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 (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals. Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

## 5 Performance of the health system

### 5.1 Effectiveness

#### Preventable mortality in Poland has been persistently higher than the EU average

The preventable mortality rate has been falling over the past decade but remains persistently high and, as in most other European countries, a sharp increase was recorded in 2020 (an increase of 26 % in Poland compared to 17 % in the EU as a whole). In 2020, COVID-19 deaths, most of which could be prevented through vaccination and other public health measures, accounted for the highest share of preventable mortality (18 % in Poland compared to 15 % in the EU) (Figure 11). The high prevalence of behavioural risk factors, such as tobacco smoking, poor diet and alcohol consumption, among the Polish population (see Section 3) are also key drivers of the preventable mortality rates.

#### Progress in reducing mortality from treatable causes has stagnated since 2014

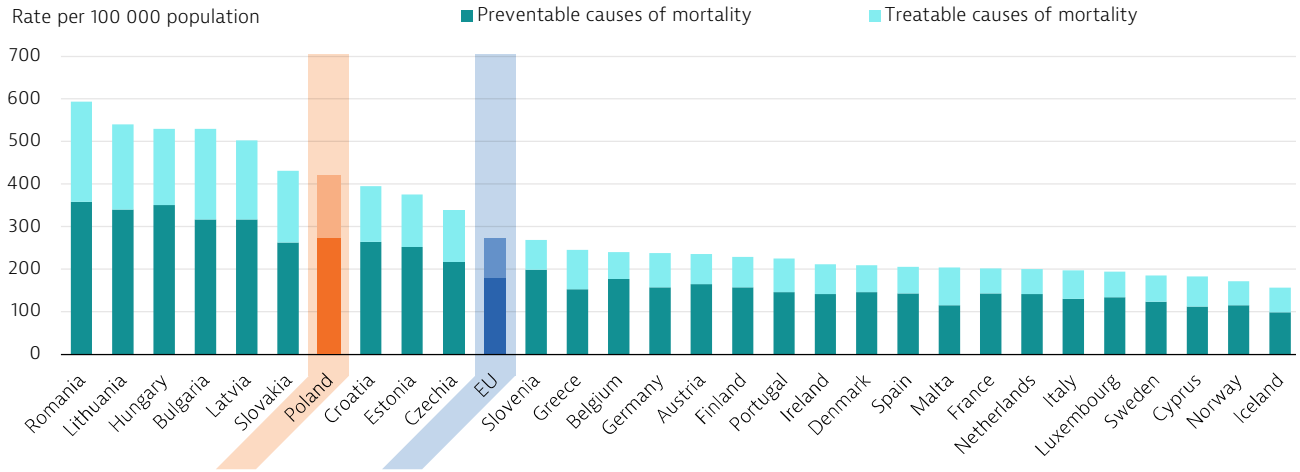
Mortality from treatable causes has also been persistently high compared to the EU average; the rate stagnated between 2014 and 2019, before slightly increasing between 2019 and 2020.

In 2020, the treatable mortality rate reached 144 per 100 000 population compared to 92 per 100 000 across the EU. The increase in the treatable mortality rate in Poland (7 %) was more substantial than in the EU (3 %) in 2020, which could in part be due to the impact of the COVID-19 pandemic on access to services. Another leading cause is ischaemic heart disease, which accounted for 20 % of treatable causes of mortality in 2020 (Figure 11). However, this is likely to be an underestimate: ischaemic heart disease appears to be consistently underreported as a cause of death in Poland, with heart failure reported in its place, as heart failure has the potential of attracting larger payments in the Polish diagnosis-related group system and consequently distorts the coding of deaths (Sagan et al., 2022a).

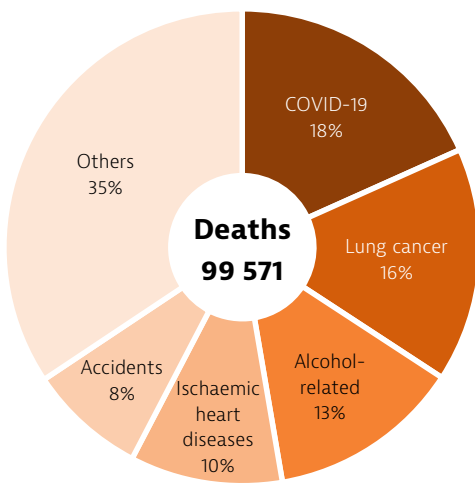
#### Immunisation data are patchy, but vaccination rates appear to have worsened in some areas

Childhood immunisation data are generally more complete than data for adult vaccinations, and coverage rates are also higher. However, some negative trends have been observed in recent years, partly due to vaccine hesitancy, which has

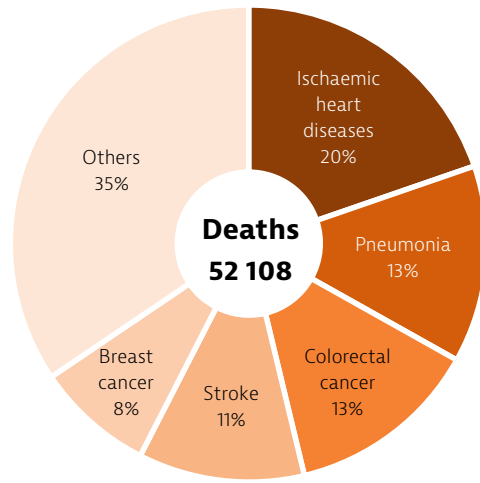
**Figure 11. COVID-19 accounted for the highest share of preventable deaths in 2020**



**Preventable causes of mortality**



**Treatable causes of mortality**



**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, 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. COPD refers to chronic obstructive pulmonary disease.  
Source: Eurostat Database (data refer to 2020).

also affected uptake of the COVID-19 vaccines (see Section 5.3). For example, the rate for diphtheria, tetanus and pertussis vaccination declined from over 96 % in 2017 to 90 % in 2020. Data on human papillomavirus (HPV) vaccinations are not available. Only 10 % of the population aged 65 and over were vaccinated against influenza in 2019 compared to the EU average of 42 %. This rate increased to 51 % across the EU in 2021 but remained at 10 % for older people in Poland.

**Cancer screening data are incomplete, with much variation in screening rates for different cancers**

Data on cancer screening are incomplete, and most of the data are taken from surveys rather than national screening programmes. The rates vary

widely, with a relatively high screening rate for cervical cancer reported in survey data (73 %) in 2019, compared to 16 % from national screening programme data in the same year. Breast cancer screening rates in 2019 were between 37.2 % for programme data and 53.7 % for survey data, which asked women aged 50-69 if they had been screened in the past two years, while the EU average in 2019 was 60 %. Survey data show that reported screening rates are much lower among those with lower incomes and lower levels of education.

Participation in cancer screening programmes decreased during the pandemic, and has not yet returned to pre-pandemic levels for either breast or cervical cancer screening. At the end of 2022, the lowest yearly participation rate in the public cervical cancer early-detection screening

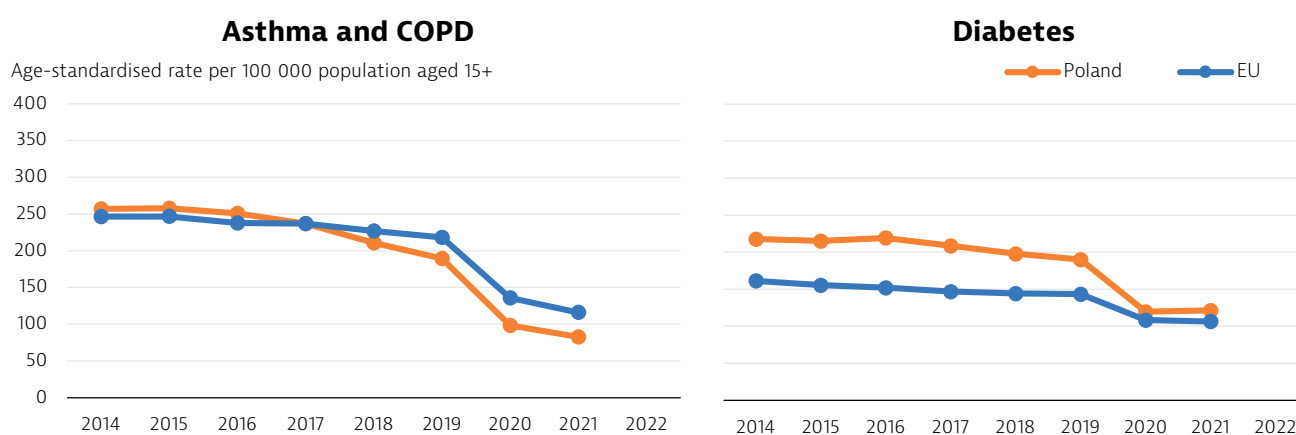
programme (11 %) was recorded. (DNA testing is currently being piloted, and should replace use of cytology in the future for HPV screening.) Survey data show that uptake of colorectal cancer screening was low, at 7.7 % in 2019. Uptake fell during the pandemic but returned to pre-pandemic levels in early 2021, although in 2022 procedural difficulties brought the colorectal screening programme to a complete halt (Wojtyniak & Goryński, 2022).

### Avoidable hospitalisation rates for common chronic conditions are high but improving

Poland has relatively high hospitalisation rates for conditions that could have been effectively treated

in outpatient settings, suggesting weaknesses in primary and outpatient specialist care. Between 2017 and 2021, a new model of primary healthcare provision was piloted that shifted management of the most common chronic conditions to primary healthcare, and strengthened health promotion and disease prevention at this level. Certainly, the rapid decline in unnecessary hospital admissions for asthma and COPD and for diabetes in 2020 needs to be interpreted in the context of disruption caused by COVID-19, which severely affected the capacity of hospitals in Europe to provide acute care and modified patient health-seeking behaviour (Figure 12).

**Figure 12. Stronger primary healthcare could help prevent many hospitalisations**



Note: Admission rates are not adjusted for differences in disease prevalence across countries.

Source: OECD Health Statistics 2023.

## 5.2 Accessibility

### More Poles reported unmet medical needs during the pandemic compared to the EU average

In 2022, according to the EU-SILC survey, 2.3 % of the Polish population reported unmet needs for medical examinations due to either costs, distance or waiting times (the EU average was 2.2 %). There were differences across income groups, but these were marginal (Figure 13). Conversely, only 1 % of the Polish population reported having experienced unmet needs for dental care, which is below the EU average of 3.4 %, despite limited public coverage of dental care services (only 27 % of the costs were publicly covered compared to 34 % across the EU in 2020). The reasons behind this are multifactorial and complex. However, the relative affordability of dental care in Poland is reflected in the high levels of health tourists travelling to Poland for treatment from Germany and Scandinavia. The gap in reported unmet needs for dental care by income

was also much narrower (0.5 percentage points in Poland compared to 5.2 percentage points across the EU).

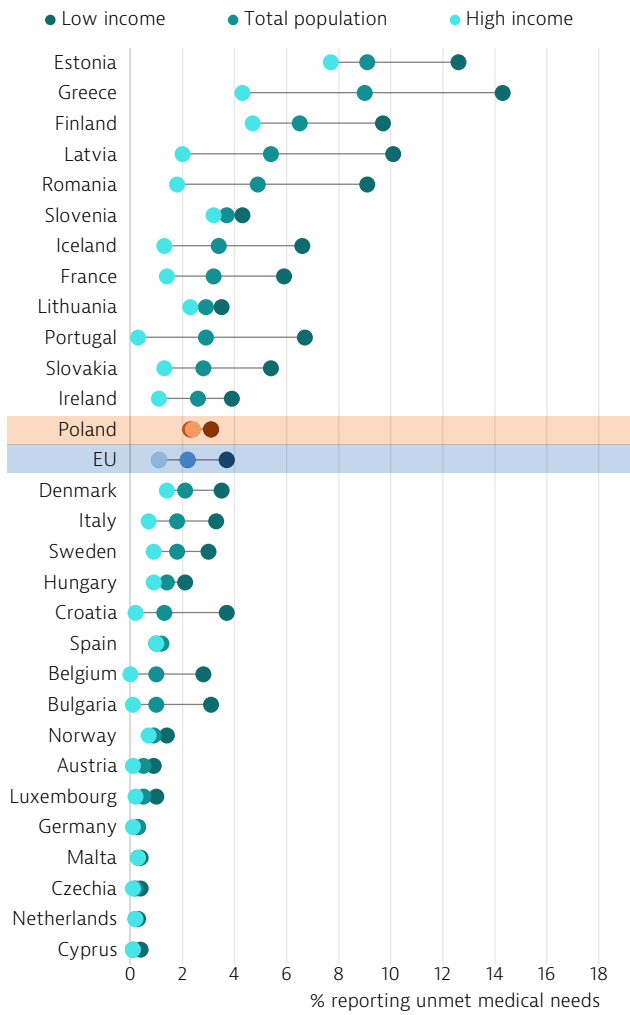
A Eurofound survey<sup>2</sup> during the pandemic found that 31 % of Polish respondents in spring 2021 and 30 % in spring 2022 reported having unmet healthcare needs (Eurofound, 2021; 2022). These figures were among the highest shares recorded in the EU.

### The share of adults using teleconsultations is among the highest in the EU

Despite these reported high levels of unmet needs during the pandemic, the number of medical consultations that an average Pole attends in a year (7.7 in 2019) is typically higher than in most EU countries for which data are available. In 2020, this number rose to 8.7 consultations, of which, 22 % were conducted remotely, although this fell back to 17 % in 2021 (Figure 14). According to the Eurofound (2022) survey, 62 % of adults

<sup>2</sup> The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.

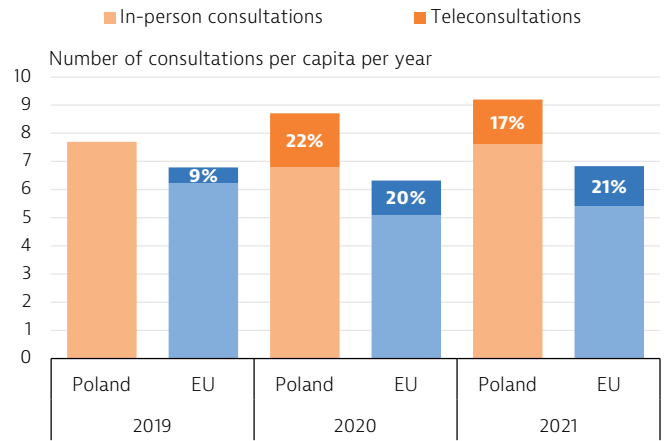
**Figure 13. The gap between income groups for unmet medical care needs is narrower than in many countries**



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.  
Sources: Eurostat Database, based on EU-SILC (data refer to 2022, except Slovakia and Norway (2020), and Iceland (2018)).

in Poland reported in February/March 2021 that they had had a teleconsultation since the start of the pandemic, which is among the highest shares in the EU. In 2020, national data show that the share of teleconsultations was 28 % in primary healthcare and 15 % in specialist outpatient care. In 2021, these figures declined to 24 % in primary healthcare and 11 % in specialist outpatient care, but these shares have been rising since the end of 2021 (Ministry of Health, 2023). There is wide variation in the use of teleconsultations among regions; for example, in 2021, the share of teleconsultations ranged from 19 % in Lubuskie (in the west) to 30 % in Mazowieckie (the capital region).

**Figure 14. The total number of consultations per person remains among the highest in the EU**



Sources: OECD Health Statistics 2022 (for in-person consultations) and national sources (for teleconsultations); Eurostat Database. Coverage provisions have been adapted to provide for the inflow of Ukrainian refugees

**Coverage provisions have been adapted to provide for the inflow of Ukrainian refugees**

Population healthcare coverage is almost universal (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. All residents – even those without SHI coverage – can receive outpatient emergency medical care and primary care. Special coverage provisions have been implemented since 2022 to extend SHI coverage to Ukrainian refugees (Box 1). An estimated 1.4-2.0 million Ukrainian refugees are currently staying in Poland, which puts pressure on the health system (Pędzwiatr et al., 2022).

**The range of social health insurance benefits is broad, but there is little scope to tailor them to local needs**

A broad range of services is covered under SHI and includes primary care, outpatient specialist care and hospital services. However, since public financing covers only 72 % of the costs of medical goods and services (compared to 76 % across the EU), access problems may arise. For example, although access to primary care is free at the point of use, only 35 % of the costs of outpatient pharmaceuticals and 41 % of the costs of therapeutic appliances are covered. In contrast, public financing of inpatient care is extensive (94 % of costs covered compared to the 91 % EU average), which means that there are virtually no cost-sharing requirements for inpatient care. Some vulnerable groups have access to extra benefits, such as dental care for young children, but there are still significant coverage gaps for outpatient medications, medical devices and dental care.

## Box 1. Ukrainian refugees have been able to access SHI benefits on similar terms to Polish citizens

Ukrainian citizens who arrived in Poland since the Russian invasion of Ukraine on 24 February 2022 have the right to free public healthcare, including mental healthcare and reimbursed medicines, on similar terms to Polish citizens. Rehabilitation, health resort treatment in sanatoria, and cross-border care are excluded. Ukrainian refugees can choose their primary healthcare practice, but they are not included in the patient lists, and are thus not covered by capitation payments – instead, all services they receive are covered on a fee-for-service basis. This means that they do not have access to certain services, such as preventive services and coordinated care programmes.

To obtain medical assistance, it is enough for a Ukrainian citizen to confirm that they meet the conditions set out in the Act on Assistance to Ukrainian Citizens in Connection with the Armed

Conflict in the Territory of that State of 12 March 2022 and their identity. Confirmation of the right to medical care is a personal identification number (PESEL UKR), which also allows Ukrainians to receive social benefits, to work officially and study. Possession of a PESEL UKR has been obligatory since 1 March 2023. A special application has been introduced to facilitate communication between Ukrainian patients and doctors who do not speak Ukrainian or Russian. In addition, the First Contact Teleplatform service (which allows patients to receive medical assistance over the phone by accessing primary healthcare services outside office hours, on holidays and weekends) and the Internet Patient Account (which allows patients to see their medical documentation, e-prescriptions and similar) have been adapted to use the Ukrainian language.

Long-term care provision relies heavily on informal caregivers.

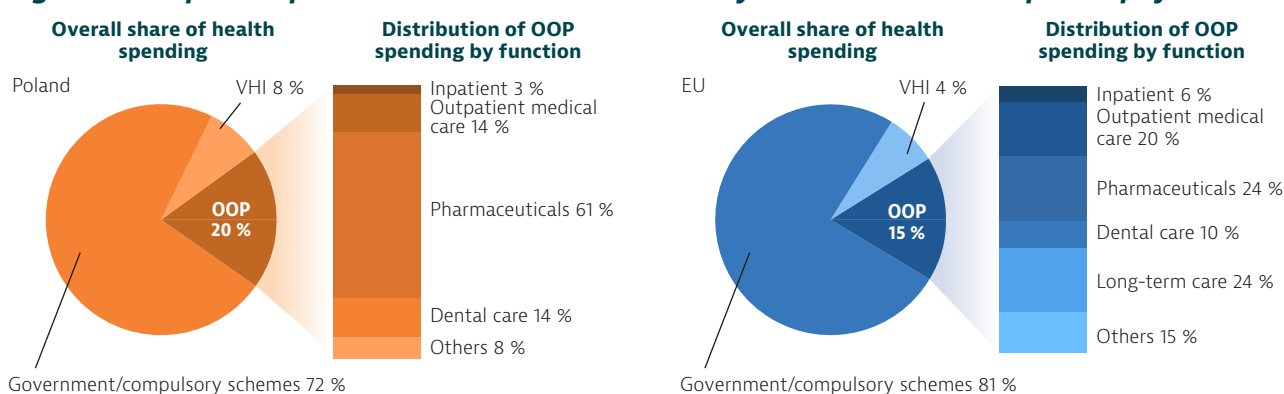
Regional branches of the NFZ create their own plans for purchasing health services on the basis of a centrally defined package of guaranteed benefits, and these branches are responsible for contracting healthcare services in their regions. Since 2015, the voivodes (the regional representatives of the central government) and the Ministry of Health have been charged with developing regional and national health needs maps to improve contracting and to set policy priorities.

### Despite declines in out-of-pocket spending, it remains higher than the EU average

The share of OOP payments in health spending has been decreasing steadily since 2005, standing at 20 % in 2021, which is well above the EU

average of 15 % (Figure 15). Reductions in OOP spending since 2019 may also indirectly reflect disruptions to services. Most OOP spending goes towards outpatient medications, and these payments are also the main driver of catastrophic spending,<sup>3</sup> accounting for 44 % of outlays among households experiencing catastrophic spending on health. In 2021, 9.4 % of households experienced catastrophic health spending; of these, 25 % were at risk of impoverishment and 35 % were actually impoverished. OOP spending on outpatient medicines remains elevated despite the introduction of exemption mechanisms for outpatient prescriptions, including for older people (2016), pregnant women (2020) and children up to the age of 18 (2023). It is particularly high among pensioners, people with disabilities and households in rural areas.

**Figure 15. Outpatient pharmaceuticals account for nearly two thirds of out-of-pocket payments**



Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.

Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

<sup>3</sup> Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).

Chronic constraints, such as the NFZ's limited financial resources and shortages of healthcare workers (see Section 4), are among the key contributors to access barriers. There are large disparities in the geographical distribution of the health workforce, medical equipment and beds (Ministry of Health, 2023), which may result in differences in access to services. Waiting times for specialist consultations can be very long for some services and for elective surgeries (see Section 5.3).

### 5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war in Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,<sup>4</sup> improve critical areas of the health sector, and fortify their preparedness for future shocks.

#### Hospital discharges fell significantly in 2020

Poland's hospital capacity has traditionally been considerably larger than that of most other EU countries. This is a legacy of the hospital-centred Semashko model that was in place during the communist era, and of unsuccessful attempts to reorient the system towards outpatient and community care. Before the pandemic, Poland had over 25 % more hospital beds (6.2 hospital beds per 1 000 population) than the EU average (4.9 per 1 000), but the low occupancy rate (66 % in 2021) points towards overcapacity in the hospital sector (Ministry of Health, 2023).

Despite having such a substantial buffer in terms of hospital beds, Poland chose to secure additional capacity for treating COVID-19 patients in early 2020. This involved suspending all elective care and reserving beds for treating COVID-19 cases, including by designating at least one hospital in each region for the sole use of COVID-19 patients, and implementing other measures, such as building field hospitals. These efforts are reflected in a slight increase in the number of hospital beds and a sharp drop in the hospital discharge rate in 2020 to 25 % (compared to 16 % across the EU).

#### Numbers of elective surgeries fell more sharply than in the EU

With much of elective care suspended after the outbreak of COVID-19, most EU countries saw a substantial reduction in the volumes of non-urgent surgery in 2020 compared to 2019. In Poland, the volumes of elective surgical procedures fell by a larger magnitude than in the other EU countries for which data are available: by 27 % in Poland compared to 23 % in the EU for knee replacements, 22 % compared to 14 % for hip replacements, and 15 % compared to 13 % for breast cancer surgery (Figure 16). This inevitably led to an increase in the number of patients waiting for these procedures for more than 90 days – particularly for hip and knee replacements, which are predominantly performed as inpatient procedures (an increase of 5-6 % of patients waiting over 90 days between 2019 and 2020). Consequently, although some surgical volumes recovered to their previous levels in 2021, this is unlikely to be sufficient to clear the backlog of cases.

#### Low uptake of COVID-19 boosters is concerning, given the high rate of excess mortality

Having experienced very high excess mortality in 2020 and 2021, with deaths among people aged 65 and over accounting for 94 % of total mortality, Poland undertook efforts to ensure a quick rollout of the COVID-19 vaccines. By the end of August 2021, 50 % of the population had received two doses (or equivalent) compared to 54 % across the EU. Since then, uptake of vaccines has slowed, partly due to vaccine hesitancy. In early 2023, only 60 % of the population was fully vaccinated with two doses or equivalent (Serwis Rzeczypospolitej Polskiej, 2023). Poland has also lagged behind most EU countries in terms of second booster vaccination coverage among older age groups (Figure 17).

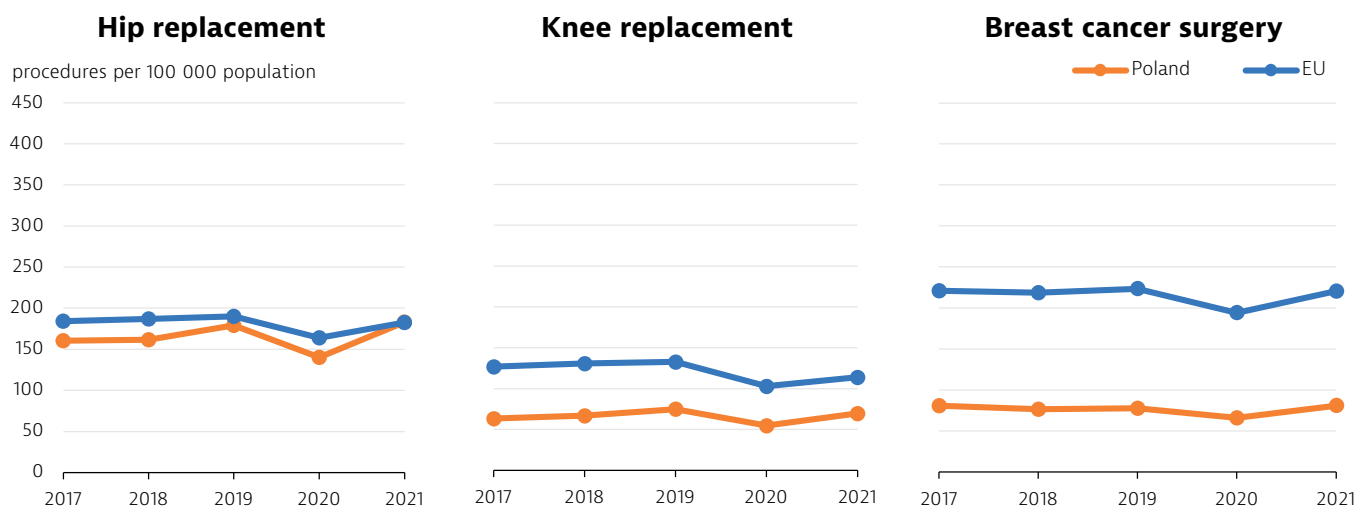
#### Public spending on health in Poland has grown considerably over the past decade

In 2019, public spending on health grew by 7.6 % compared to 2018 – the highest growth rate recorded over the last decade, and higher than the GDP growth rate in that year (4.5 %) (Figure 18). This is in line with the government's pledge, made in late 2017, to increase the share of public expenditure on health to 6 % of GDP by 2024. In 2020, GDP growth turned negative in all countries in the EU, but while most countries managed to maintain positive growth in public health spending – with some recording unprecedented growth rates in order to avert the damaging effects of the

<sup>4</sup> In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessments, 2020).

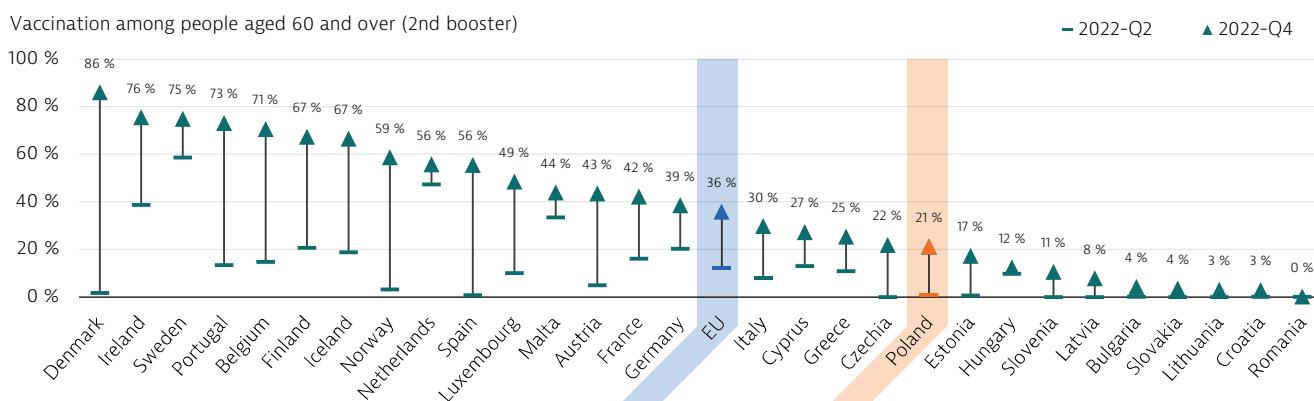


**Figure 16. The volumes of hip and knee replacements and breast surgery were reduced in the first year of the pandemic**



Note: The EU average is unweighted.  
Source: OECD Health Statistics 2023.

**Figure 17. Uptake of COVID-19 booster vaccinations among older people has been lower than in most EU countries**



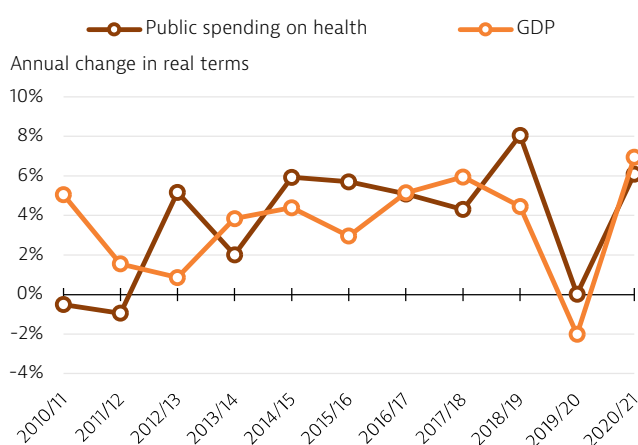
Note: The EU average is unweighted.  
Source: ECDC.

pandemic – in Poland, publicly sourced health spending fell in 2020 (–0.7 %), despite a relatively small fall in GDP that year (–2.0 %). Poland’s GDP recovered in 2021, and public spending on health increased by 5.6 % compared to 2020.

**The national Recovery and Resilience Plan and EU Cohesion Policy have earmarked substantial investment into the health sector**

The Polish health sector is expected to receive a significant financial boost in the coming years, following implementation of Poland’s national Recovery and Resilience Plan (RRP), which is a key pillar of the EU’s response to the COVID-19 crisis. Improving the efficiency, accessibility and quality of the health system is one of the six investment areas specified in the Plan, accounting for 12 % of the national RRP allocation (compared to the EU

**Figure 18. After a decline in 2020 public spending on health grew again in 2021**

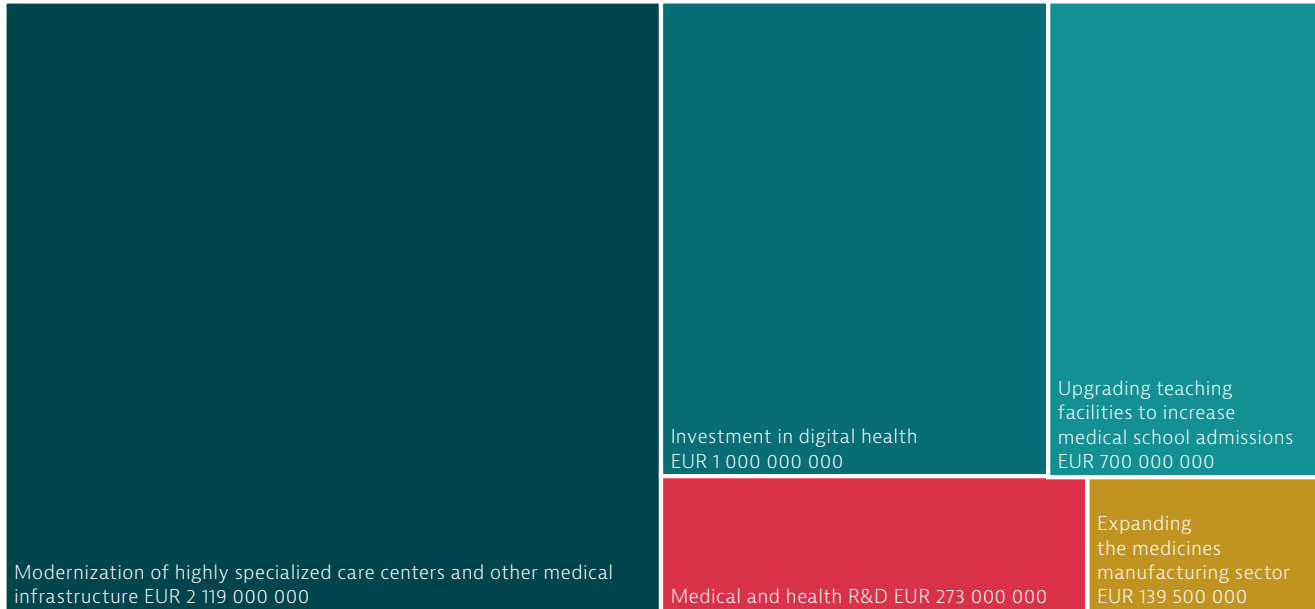


Source: OECD Health Statistics 2023.

average of 8 %). Of this funding, 50 % has been earmarked for modernisation of highly specialised care centres and other medical infrastructure, focusing on hospital restructuring and including the creation of a professionalised system of supervision of hospitals and strengthening of

hospital management (Figure 19). In addition, district hospitals are expected to benefit from targeted support for their partial restructuring into long-term care centres, although funding for this will come from a different investment area of the RRP.

**Figure 19. The Recovery and Resilience Plan prioritises investment in reforming the hospital sector**



Notes: These figures refer to the original Recovery and Resilience Plan. The ongoing revision of the Plan might affect its size and composition. Some elements have been grouped together to improve the chart's readability.  
Source: European Commission – Recovery and Resilience Scoreboard.

These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27 programming, through which Poland is set to invest a total of EUR 2.58 billion in its healthcare system, 81 % of which will be co-financed by the EU.<sup>5</sup> Some EUR 2.15 billion from the European Regional Development Fund (ERDF) will be invested in health infrastructure, health equipment, digital health services, digitisation and mobile health assets. The Polish European Funds for Social Development programme is the second biggest European Social Fund Plus (ESF+) programme in the EU. Priority areas include improving the accessibility, effectiveness and resilience of the health system.

### Poland has taken steps to improve its health workforce capacity

Poland has among the lowest numbers of doctors and nurses in Europe (see Section 4). The numbers of medical and nursing graduates have been persistently and substantially lower than the respective EU averages (Figure 20). Minimum wages in the health sector have been increased regularly since 2017 to improve this situation, with

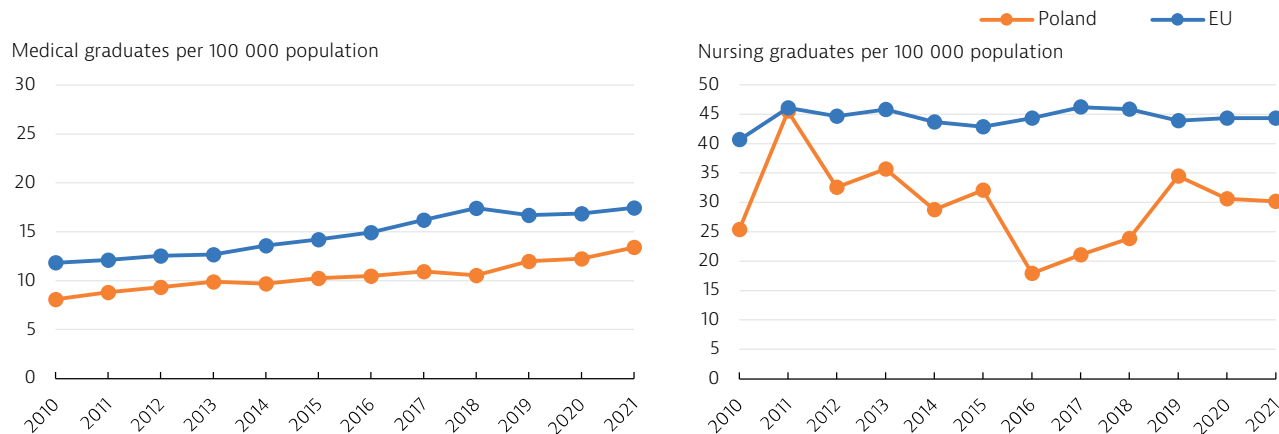
substantial increases (close to 30 % on average and higher for nurses with certain qualifications) implemented in 2022, and further increases from 1 July 2023. This has resulted in worsening financial situations for many county hospitals, and some have stopped recognising qualifications acquired by nurses and non-medical health workers to avoid increasing pay. It is expected that increases in the pricing of hospital services in 2023 will alleviate some of these problems.

### Plans are under discussion to strengthen Poland's capacity to monitor and detect epidemiological threats

Investments in hospitals – linked with reforms and restructuring of the system, health sector staffing, medical research and digital health – are earmarked in the RRP. It is hoped that they will improve the health system's resilience to future crises. In particular, planned investment in medical and health research and development includes investment in the biomedical sector and its ecosystem to strengthen capacity to monitor, detect and analyse potential epidemiological threats.

<sup>5</sup> These EU Cohesion Policy figures reflect the status as of September 2023.

**Figure 20. The numbers of new medical and nursing graduates are lower than EU averages**



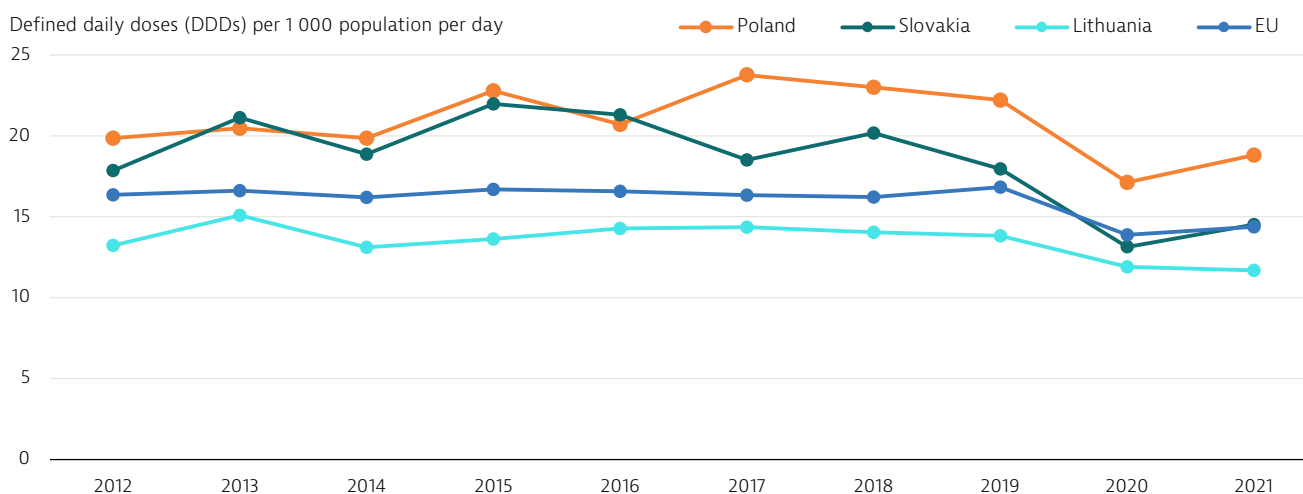
Note: The EU average is unweighted.  
Sources: OECD Health Statistics 2023; Eurostat Database.

**Antibiotic consumption is rising again after a sharp drop in 2020**

Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of antimicrobial resistance. Antimicrobial resistance is an area of concern in Poland,

given that the consumption of antibiotics in the community is much higher than the EU average (Figure 21). Although Poland’s total antibiotic consumption started to decline from 2017, with a sharp drop noted in the first year of the pandemic, the number of doses consumed has since started to increase.

**Figure 21. Antibiotic consumption declined sharply during the first year of COVID-19**



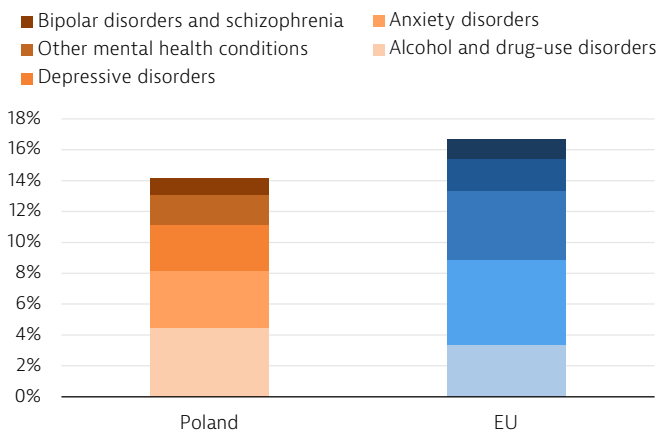
Notes: The EU average is unweighted. Data for Czechia and Cyprus refer to total consumption (including hospital).  
Source: ECDC ESAC-Net.

# 6 Spotlight on mental health

## Prevalence of mental health problems in Poland is among the lowest the EU, but this may be due to underreporting

There are no systematic epidemiological studies of mental health disorders in the general population in Poland, and information on their prevalence comes from survey data. According to the latest estimates from the Institute for Health Metrics and Evaluation (IHME), the proportion of people who reported having a mental health problem in 2019 in Poland (14 %) was among the lowest in the EU (average 17 %) (Figure 22). However, this relatively low reported prevalence could be due to factors such as a lower level of mental illness awareness and higher stigma of mental illness, as well as worse access to mental health services and thus a lower chance of an individual receiving a diagnosis (OECD/EU, 2018).

### Figure 22. One in seven people report a mental health disorder in Poland compared to one in six in the EU

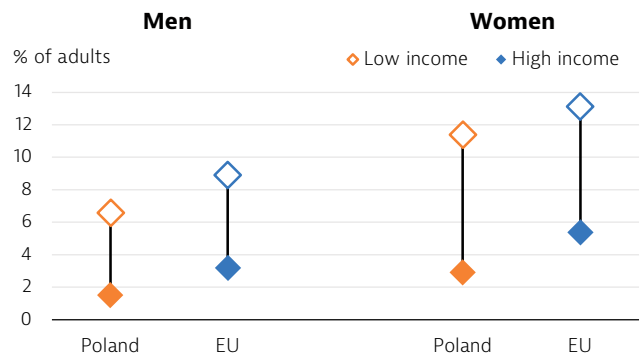


Note: The EU average is unweighted.  
Source: IHME (data refer to 2019).

### Women, especially those in the lowest income group, are more likely to report depression

In 2019, only 4 % of Poles reported having depression, compared to an EU average of 7 %, although this may be due in part to underreporting. People on lower incomes are more likely to suffer from depression. In Poland, this is particularly pronounced for women, with 11.4 % of women in the lowest income quintile reporting depressive symptoms compared to 2.9 % in the highest quintile (Figure 23).

### Figure 23. About one in nine women in the lowest income group in Poland report depression



Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).

Source: Eurostat Database (based on EHIS 2019).

During the pandemic, those on low incomes were also at a greater risk of depression. The Living, working and COVID-19 e-survey conducted by Eurofound in 2021 showed that 71 % of people in Poland living in households that reported financial difficulties could be considered at risk of depression compared to 49 % of those living in households that did not report such difficulties. These proportions were substantially higher than the EU averages of 62 % in households reporting financial difficulties and 37 % in households that did not report such difficulties.

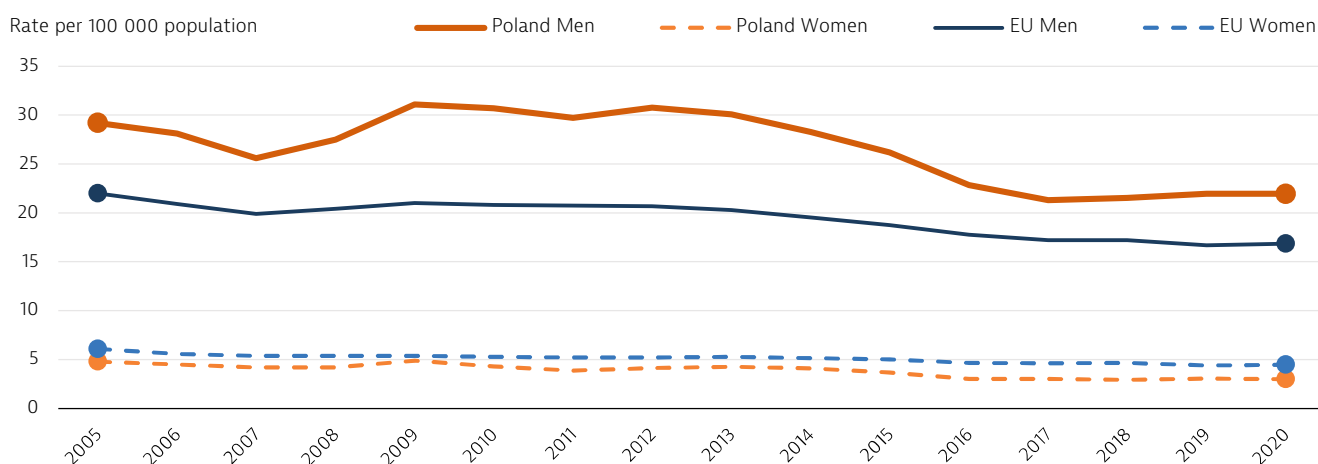
### Suicide is much more common among men than women, and the rate remains above the EU average

Nearly 4 000 Polish men died by suicide in 2020, which is a suicide rate of 22 per 100 000 population compared to 17 per 100 000 population across the EU. Although the male suicide rate declined substantially between its peak in 2009 (31 per 100 000) and 2017, narrowing the gap with the EU average, the rate stagnated and has increased slightly since then (Figure 24).

### The proportion of people reporting unmet mental healthcare needs is much higher in Poland compared to the EU

Mental healthcare funding is very low in Poland, accounting for just over 3 % of the NFZ's expenditure (Sagan et al., 2022b). Over 70 % of these funds are allocated to residential care – mostly to psychiatric hospitals, where more than two thirds of psychiatric beds are located. This concentration

**Figure 24. The declining trend in male suicide rate has stagnated in recent years**

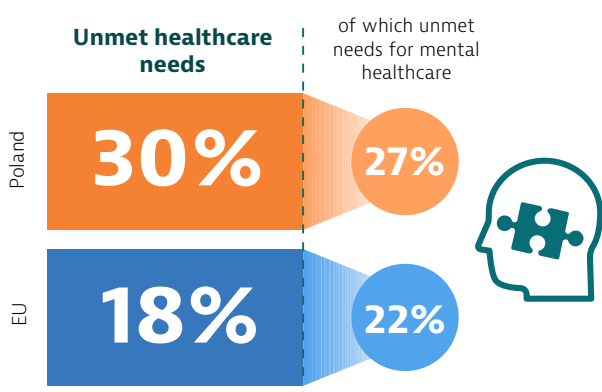


Source: Eurostat Database.

of psychiatric care in residential facilities may contribute to the social stigma associated with psychiatric patients. Most providers of mental care services are contracted to offer only one type of service, such as outpatient, community, day or emergency (hospital) care, which – given the lack of co-operation among these providers – means that patients do not have access to comprehensive and coordinated psychiatric care. Consequently, many patients with mental health disorders seek help from primary healthcare providers, and may not receive the specialist care they need.

According to a Europe-wide survey carried out in spring 2022, 30 % of Poles reported unmet needs for healthcare, of which over one quarter (27 %) concerned mental healthcare (Figure 25).

**Figure 25. Unmet needs for mental healthcare account for more than one quarter of all unmet needs for health in Poland**



Note: Survey respondents were asked whether they had any current unmet healthcare needs and, if so, for what type of care, including mental healthcare.

Sources: Eurofound (2021; 2022).

**Efforts are being made to shift mental healthcare to the community and reduce mental health stigma**

Poland’s mental healthcare system has traditionally relied heavily on psychiatric hospitals, with limited development of community-based care. Poland’s second National Mental Health Protection Programme, which was in place between 2017 and 2022, led to pilots of community mental health centres across all regions. The number of these centres doubled from 40 in 2018 to about 80 in 2023. The pilot will run until the end of 2023, and has already demonstrated encouraging results in providing community care and reducing hospitalisations, as well as effectively adapting to the challenges posed by the COVID-19 pandemic (Sagan et al., 2022b). The new model has introduced new types of mental health professionals, such as recovery assistants (recruited among recovered patients) and mental health coordinators; collaboration with social assistance services; and a shift towards budget financing. Limited financing of mental health services and a shortage of mental health professionals have been among the key obstacles to reaching the target number of 250-300 centres by 2027. In 2022, investment in psychiatric care saw a sharp increase compared to previous years; this is attributed to the large increase in the number of people reporting mental health problems and substance abuse (Wojtyniak & Goryński, 2022).

The draft of the new Programme for 2023-30, currently under public consultation, seeks to further popularise the community care model in Poland, and to reduce mental health stigma through informational educational activities. There has also been a strong focus on addressing the specific mental health needs of children and young people (Szredzińska, 2022; Rzecznik Praw Dziecka, 2023).

# 7 Key findings

- The COVID-19 pandemic had a greater impact on mortality in Poland than in most other EU countries, with life expectancy at birth falling by 2.5 years in 2019-21. However, the trend was reversed and life expectancy improved, returning to 77.4 years in 2022. Excess deaths surpassed COVID-19 deaths reported in 2020 and 2021, which may be an indication of underreporting of COVID-19 deaths or of other challenges, such as delayed access to healthcare services during the pandemic.
- Behavioural and environmental risk factors account for a significant number of deaths, and tobacco smoking and poor diet are major contributors to mortality in Poland. Relatively high use of e-cigarettes and increasing rates of overweight and obesity among young people are public health concerns.
- About 72 % of total health spending comes from public sources, with the rest paid privately by households – primarily in the form of out-of-pocket spending, with nearly two thirds of this spent on medicines. Overall, health spending remains skewed towards inpatient rather than outpatient care, and the shares of funding allocated to long-term care and prevention are relatively low. Funding trends have reinforced the weakness of primary care, which remains underdeveloped. Total spending on health remains very low in Poland compared to other countries.
- The key challenge facing the health system is the shortage of health workers. Poland has among the lowest numbers of doctors and nurses per capita in Europe, and the numbers of medical and nursing graduates have been persistently low. However, increasing wages for health workers has challenged the financial viability of some community hospitals. Increases in the pricing of hospital services in 2023 should alleviate some of this pressure.
- 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 progress in reducing mortality from treatable causes has stagnated or regressed since 2014. Immunisation and screening data are incomplete, but rates appear to have worsened in some areas. 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.
- Poland has been the largest recipient of Ukrainian refugees since the Russian invasion of Ukraine in February 2022. Special coverage provisions have been implemented to extend social health insurance coverage to 1.4-2 million Ukrainian refugees, but this puts pressure on the health system's resources.
- Overall, public spending on health has increased over the last decade, and will be supplemented by substantial investment in the health sector earmarked in the national Recovery and Resilience Plan and the EU Cohesion Policy. These will focus on reforming the hospital sector, developing digital health and strengthening the health workforce. There are also plans to strengthen capacity to monitor and detect potential epidemiological threats, but other threats – such as rising antibiotic consumption – may need further attention.
- Prevalence of mental health problems in Poland is among the lowest in the EU, but this may be an underestimate of the true burden due to a lower level of mental illness awareness, higher mental health stigma and worse access to mental health services. Provision remains heavily reliant on psychiatric hospitals, but efforts are being made to shift mental healthcare to the community and reduce stigma. A new draft Mental Health Protection Programme for 2023-30 is currently under public consultation.

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### Country abbreviations

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

# State of Health in the EU

## Country Health Profile 2023

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 2023 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;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: [ec.europa.eu/health/state](https://ec.europa.eu/health/state)

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