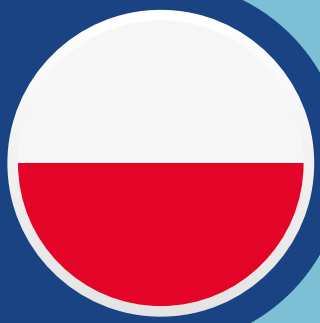
European Commission



State of Health in the EU

Poland

Country Health Profile 2017

OECD
BETTER POLICIES FOR BETTER LIVES

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

The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

Contents

Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 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 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser: http://dx.doi.org/10.1787/888933593741

Demographic and socioeconomic context in Poland, 2015

		Poland	EU
Demographic factors	Population size (thousands)	37 986	509 394
	Share of population over age 65 (%)	15.4	18.9
	Fertility rate[1]	1.3	1.6
Socioeconomic factors	GDP per capita (EUR PPP[2])	19 800	28 900
	Relative poverty rate[3] (%)	10.7	10.8
	Unemployment rate (%)	7.5	9.4

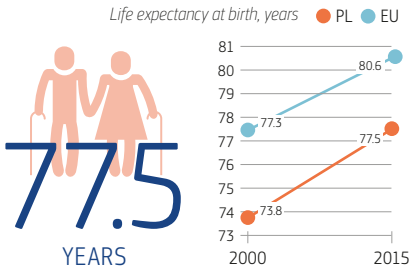
1. Number of children born per woman aged 15–49.
2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.
3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

1 Highlights

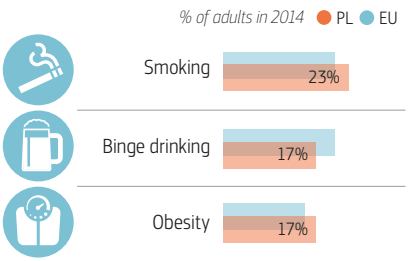
While the health status of the Polish population has improved, life expectancy still lags behind the EU average. Risk factors such as smoking, excessive alcohol consumption and low physical activity, together with an ageing population, are adding pressure to an underfunded health system. The Polish government is proposing a set of structural health system reforms to address some of these challenges.

Health status



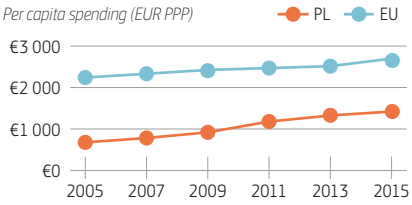
Life expectancy at birth in Poland was 77.5 years in 2015. Although it increased by 3.7 years since 2000, it remains three years below the EU average. Large inequalities exist, with women expecting to outlive men by eight years while the gap between the highest- and lowest-educated Poles is ten years. Less than half of the years lived after age 65 are spent free of disability. Cardiovascular diseases and lung cancer are the biggest causes of mortality.

Risk factors



Over a third of Poland's disease burden can be attributed to behavioural risk factors. Although the number of smokers fell over the past decade, more than a fifth of adults continue to smoke every day. Alcohol consumption has increased substantially since 2000 and one in six adults report heavy drinking on a regular basis. Obesity rates also increased and are now above the EU average.

Health system

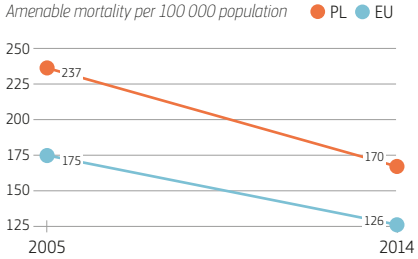


Health spending in Poland is among the lowest in the EU. In 2015, health expenditure was EUR 1 259 per capita or 6.3% of GDP compared to the EU average of EUR 2 781 or 9.9%. Public funds account for 72% of spending, lower than the EU average (79%). Out-of-pocket spending is comparatively high (22%), raising accessibility concerns.

Health system performance

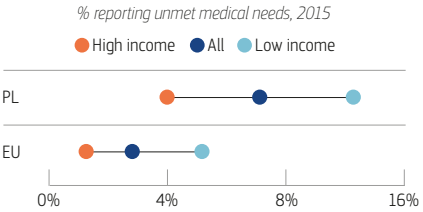
Effectiveness

Despite reductions, Poland's amenable mortality rate is still higher than in most EU countries, suggesting that the health care system could be more effective in treating people with life-threatening conditions.



Access

A relatively high proportion of the Polish population reports unmet needs for medical care. Access to health care is hampered by high out-of-pocket spending, a shortage of health professionals and a relatively high number of uninsured.



Resilience

Poland is facing challenges to train and retain a sufficient number of health workers, promote access to good-quality care and respond to growing needs for long-term care. The government is embarking on a reform programme that aims to address access and efficiency issues.

2 Health in Poland

Life expectancy is increasing, but remains below the EU average

Life expectancy at birth in Poland stood at 77.5 years in 2015, an increase of almost four years since 2000. This is still three years below the EU average, but represents a slight narrowing of the gap compared to 2000 (Figure 1).

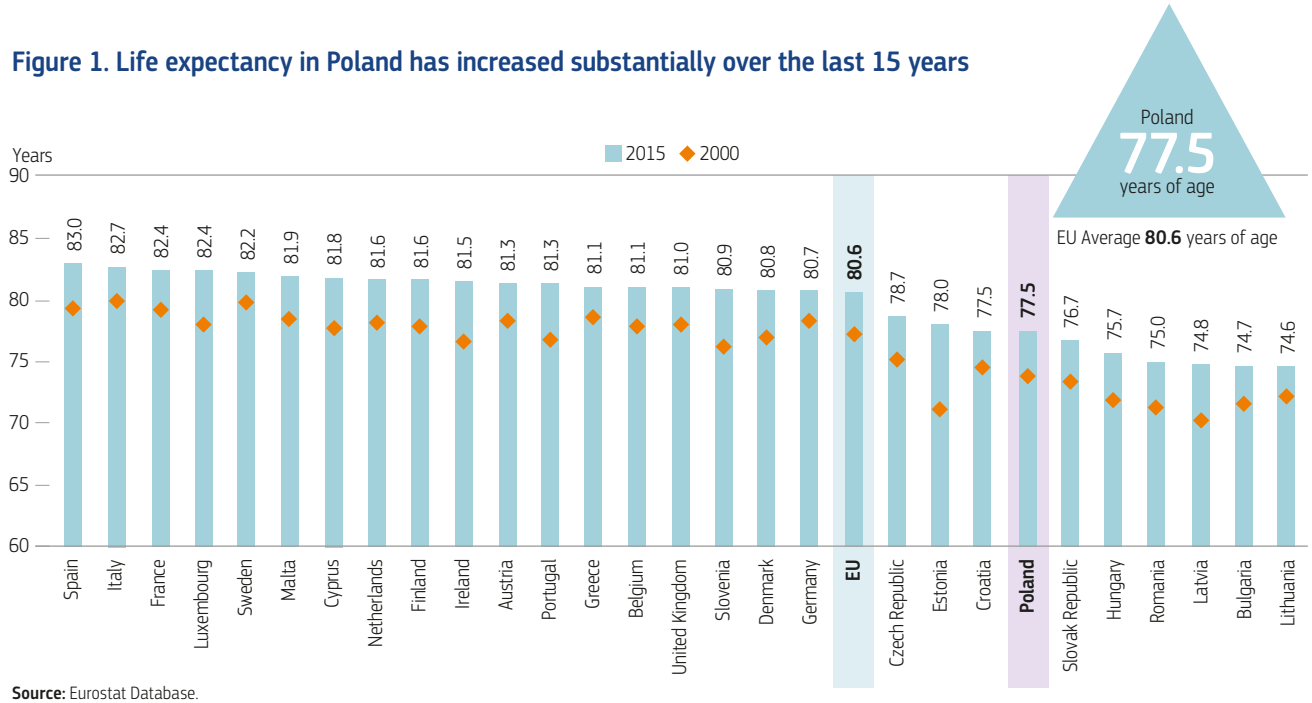
An eight-year gap in life expectancy at birth persists between Polish men and women (73.5 and 81.6 years, respectively) compared to 5.5 years, on average, in other EU countries. A considerable gap also exists by socioeconomic status: Poles with a university education live, on average, nearly 10 years longer than those who have not completed their secondary education.[1]

Most of the life expectancy gains in Poland since 2000 were driven by reduced mortality rates after the age of 65. Polish women at this age can expect to live another 20.1 years (up from 17.5 years in 2000). For Polish men this figure is 15.7 years (up from 13.5 years in 2000). However, not all of these additional years of life are lived in good health. At age 65, Polish men can expect to live about half (7.6 years) of these years free of disability, while women can expect to live only two-fifths (8.4 years) of their remaining years free of disability.[2]

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

Figure 1. Life expectancy in Poland has increased substantially over the last 15 years



Source: Eurostat Database.

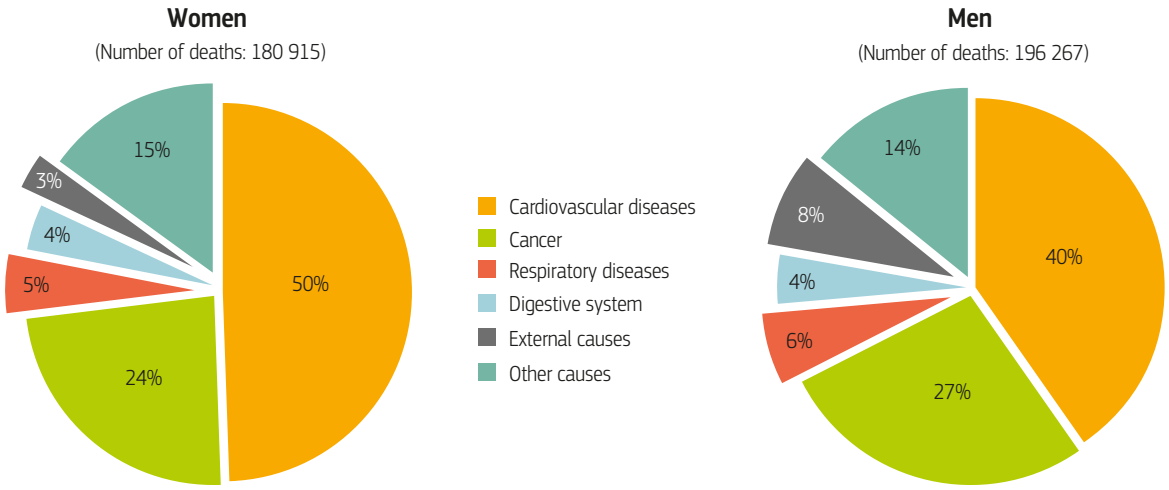
Cardiovascular diseases and cancer are the largest contributors to mortality

Cardiovascular diseases are the leading cause of death in Poland, followed by cancer (Figure 2). In 2014, around 50% of all deaths among women and 40% of all deaths among men were from cardiovascular diseases. Polish people are about 60% more likely to die from circulatory diseases than the average EU resident and the reduction in cardiovascular mortality has been slower in Poland than in most other EU countries.

More specifically, heart diseases and stroke remain the most common causes of death, followed by lung cancer and pneumonia (Figure 3). The high mortality from respiratory diseases is likely a legacy of the high smoking rates in Poland. Mortality from several forms of cancer (e.g. colorectal cancer and breast cancer) and diabetes increased between 2005 and 2014, reflecting the impact of population ageing and lifestyle factors.

The proportion of deaths arising from transport accidents has dropped since 2000, but nonetheless remains substantially higher than in most other EU countries (see Section 5.1).

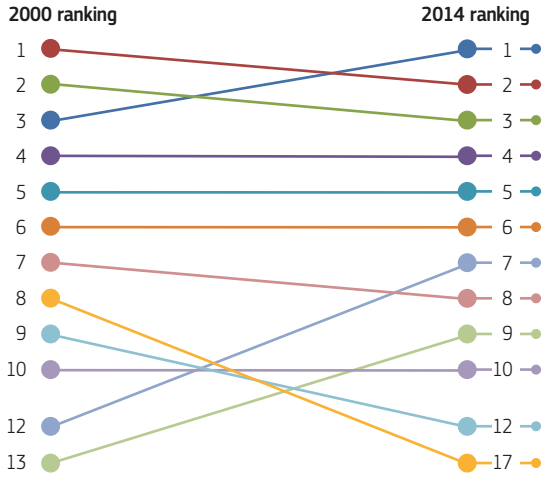
Figure 2. Cardiovascular diseases and cancer together cause more than two-thirds of all deaths in Poland



Note: The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

Source: Eurostat Database (data refer to 2014).

Figure 3. Lung cancer is the fourth leading cause of death in Poland after heart diseases and stroke



	2014 ranking	% of all deaths in 2014
Other heart diseases	1	15%
Ischaemic heart diseases	2	10%
Stroke	3	8%
Lung cancer	4	6%
Pneumonia	5	3%
Colorectal cancer	6	3%
Diabetes	7	2%
Lower respiratory diseases	8	2%
Breast cancer	9	2%
Suicide	10	2%
Stomach cancer	12	1%
Transport accidents	17	1%

Source: Eurostat Database.

Musculoskeletal problems and mental health problems are among the leading determinants of morbidity

In addition to cardiovascular diseases and cancer, musculoskeletal problems including low back and neck pain are an increasing determinant of morbidity, measured in disability-adjusted life years[3] (DALYs), in Poland. Mental health problems including major depressive disorders and self-harm (suicide and attempted suicide) are also among the leading causes of disease burden (IHME, 2016).

Self-reported data from the European Health Interview Survey (EHIS) indicate that nearly one in four people in Poland live with hypertension, one in twenty-four live with asthma and one in fifteen live with diabetes. Wide inequalities exist in the prevalence of these chronic diseases by education level. People with the lowest level of education are more than twice as likely to live with asthma, hypertension and diabetes than those with higher education.[4]

3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for socio-economic disparities.

Most of the population reports being in good health, but large disparities exist between income groups

As can be seen in Figure 4, most Polish people report being in good health (58% in 2015), although this proportion is lower than the EU average (67%). A substantial gap exists in self-rated health by socioeconomic status: 71% of people in the highest income quintile reported to be in good health in 2015 compared with just 53% of people in the lowest income quintile.

Poland has a very high incidence of rubella, but other infectious diseases are less prevalent than in other EU countries

In 2016, Poland accounted for 87% of all reported rubella cases in EU/EEA countries according to the European Centre for Disease Control (ECDC). In 2015, the figure was 93%. Compulsory vaccination against rubella was introduced in 1988 but only for girls. Vaccination for both sexes was introduced in 2003. Poland's notification rates for measles, hepatitis B, pertussis and HIV are all below the EU average.

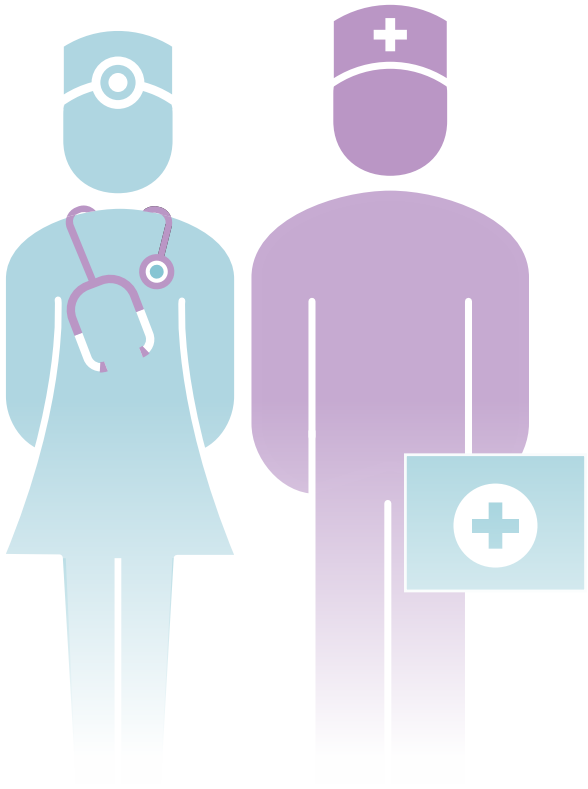
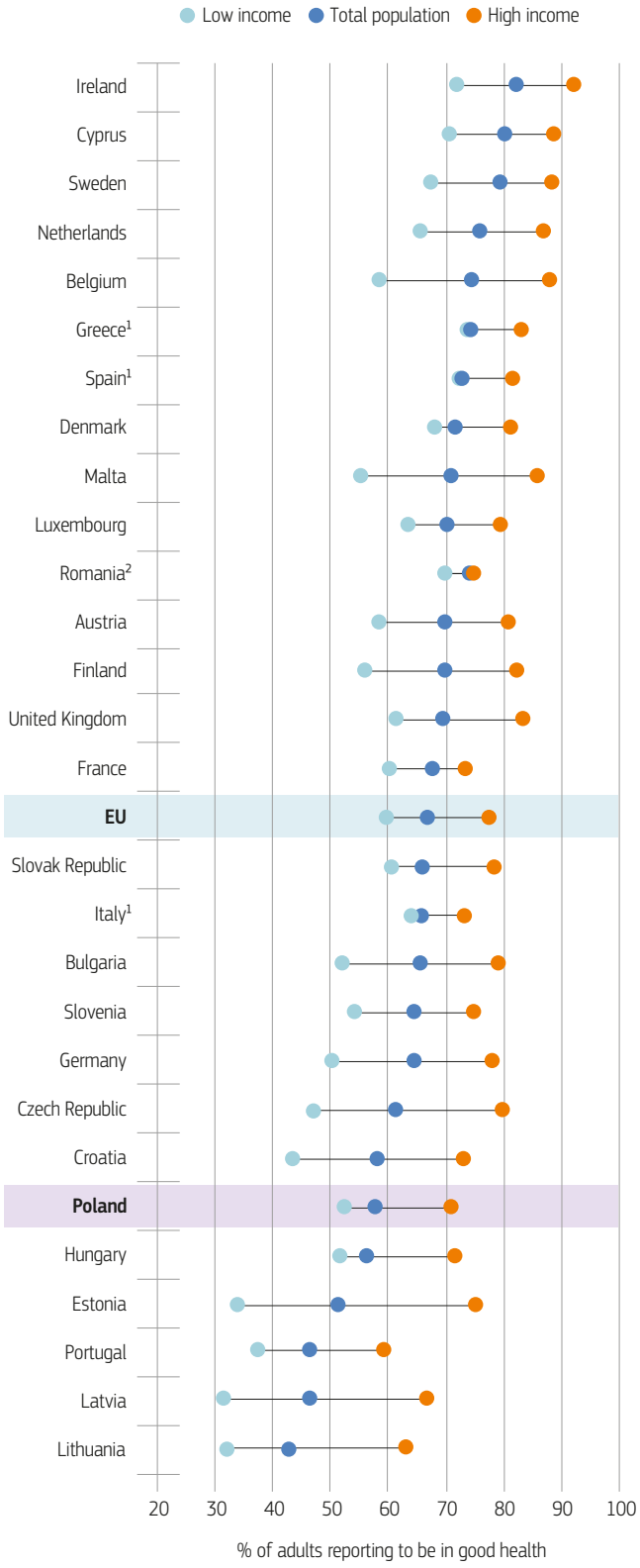


Figure 4. A lower proportion of Poles report being in good health compared to most EU countries' populations



1. The shares for the total population and the low-income population are roughly the same.
2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

3 Risk factors

Behavioural risk factors are a major challenge in Poland

The health status of the population and health inequalities in Poland are linked to a number of health determinants, including the living and working conditions of the population, the physical environment in which people live, and behavioural risk factors.

It is estimated that more than one-third (36%) of the overall burden of disease in Poland in 2015 (measured in DALYs) can be attributed to behavioural risk factors such as smoking, excessive alcohol consumption, poor diet and low physical activity (IHME, 2016). This proportion is higher than the EU average (29%) but is similar to that seen in neighbouring countries.

Smoking rates declined but remain relatively high, while alcohol consumption is increasing

The proportion of daily smokers among adults in Poland fell from 28% in 2001 to 23% in 2014, but still remains higher than in most EU countries (Figure 5). The smoking rate among 15-year-old adolescents also dropped, from 21% in 2001–02 to 15% in 2013–14, but is still higher than in most other EU countries.

Alcohol consumption among adults in Poland has increased substantially since 2000, rising from 8.4 litres per adult in 2000 to 10.5 litres in 2015, and is higher than the EU average. More than one in six adults (17%) reported regular heavy alcohol consumption (so-called binge drinking[5]) in 2014, although this proportion is lower than the EU average (20%).

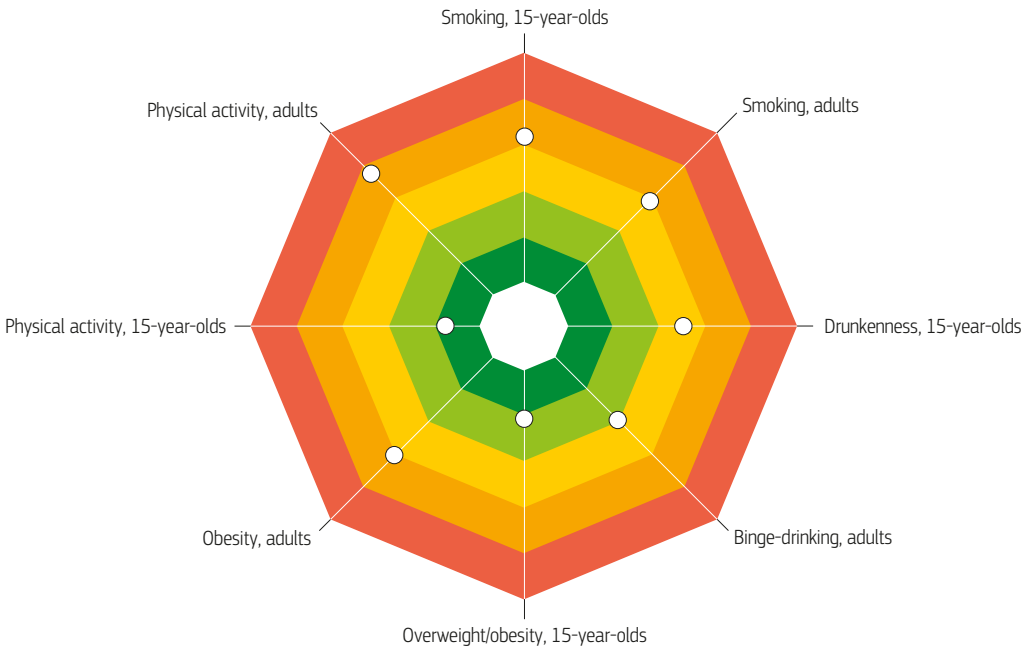
Heavy alcohol consumption is much more common among Polish men (29%) than women (8%). Among adolescents, 26% of 15-year-olds report having been drunk at least twice in their life, which is above the EU average for girls (23.5%) and slightly below the average for boys (27%).

Obesity especially among adults is a growing challenge in Poland

Poor diet and lack of physical activity contribute to rising overweight and obesity problems. Based on self-reported data (which tend to underestimate true prevalence), more than one in six adults (17%) in Poland were obese in 2014, up from one in eight in 2004.

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

Figure 5. Poland shows worse results than other EU countries for the majority of behavioural risk factors



Note: 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.

Source: OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratorio MeS).

Overweight and obesity among 15-year-old adolescents more than doubled between 2001–02 and 2013–14 (from 7% to 15%), although this still remains lower than in most other EU countries.

The level of physical activity among adults is relatively low in Poland, with only 60% of adults in 2014 reporting doing at least moderate physical activity each week. As in other EU countries, Polish women are less likely to report doing regular physical activity than men. On a more positive note, physical activity among 15-year-olds in Poland is higher than in most other EU countries, but is still relatively low, particularly among girls (only 11% reported doing moderate to vigorous physical activity each day).

Between 2016 and 2020, Poland is implementing the National Health Programme to tackle these public health challenges and promote healthy behaviours (see Section 5.1).

Behavioural risk factors are more prevalent in disadvantaged population groups

As in other EU countries, many behavioural risk factors are more common among population groups disadvantaged by education or income. In Poland, smoking rates are 60% higher among the lowest-educated than among the highest-educated. Obesity rates are almost twice as high among people with the lowest level of education. These differences in the prevalence of behavioural risk factors contribute to health inequalities.

4 The health system

A markedly decentralised health system poses challenges for effective coordination

Poland introduced a strongly decentralised social health insurance (SHI) system in 1999, replacing its previously tax-funded national health service. Sixteen mostly autonomous regional insurance funds were established with the responsibility for contracting providers.

A degree of recentralisation occurred in 2003–04, with the newly created National Health Fund charged with the overall purchasing function. Local governments at the regional (voivodeship), county (powiat) and municipal (gmina) levels are involved in health to a varying degree. They own and are accountable for the deficits of public service delivery institutions. This mostly holds for some powiats, owner of hospitals providing basic services in their territory and voivodeships who typically own a range of mostly higher-level facilities in the region. Local governments also have some responsibilities in health promotion and prevention. Additionally, Voivodeships are responsible for ensuring the availability of services in the territory.

National Health Institutes and clinics of medical universities provide services at the national level. This division of responsibilities across these levels of government and levels of care makes the coordination of services more difficult.

Since the implementation of health and local government reforms in 1999, an emergence of private health care providers has been observed, especially in primary health care.

Health expenditure in Poland increased, but remains relatively low

The share of GDP devoted to health in Poland increased from 5.3% in 2000 to 6.3% in 2015. However, this level remains well below the EU average (9.9% in 2015). On a per capita basis, Poland spent EUR 1 272 on health (adjusted for differences in purchasing power) in 2015, the fifth lowest in the EU (Figure 6).

Poland will receive almost EUR 3 billion of funding earmarked for health-related activities through the European Structural and Investment Funds scheme between 2014 and 2020. The scope of the investments targeting health and health care include emergency medical infrastructure, prevention programmes, long-term care and eHealth solutions (European Commission, 2016).

Coverage is lower than in many other EU countries and private spending is high

Compulsory health insurance covers 91% of the population but with automatic entitlement extended to a number of other population groups (e.g. children aged under 18, people with HIV and tuberculosis, people with mental health disorders). The 9% of the population not covered is mainly the result of casual or atypical work contracts. While entitlement covers a broad range of services, public underfunding means that the supply of services is limited, resulting in long waiting times.

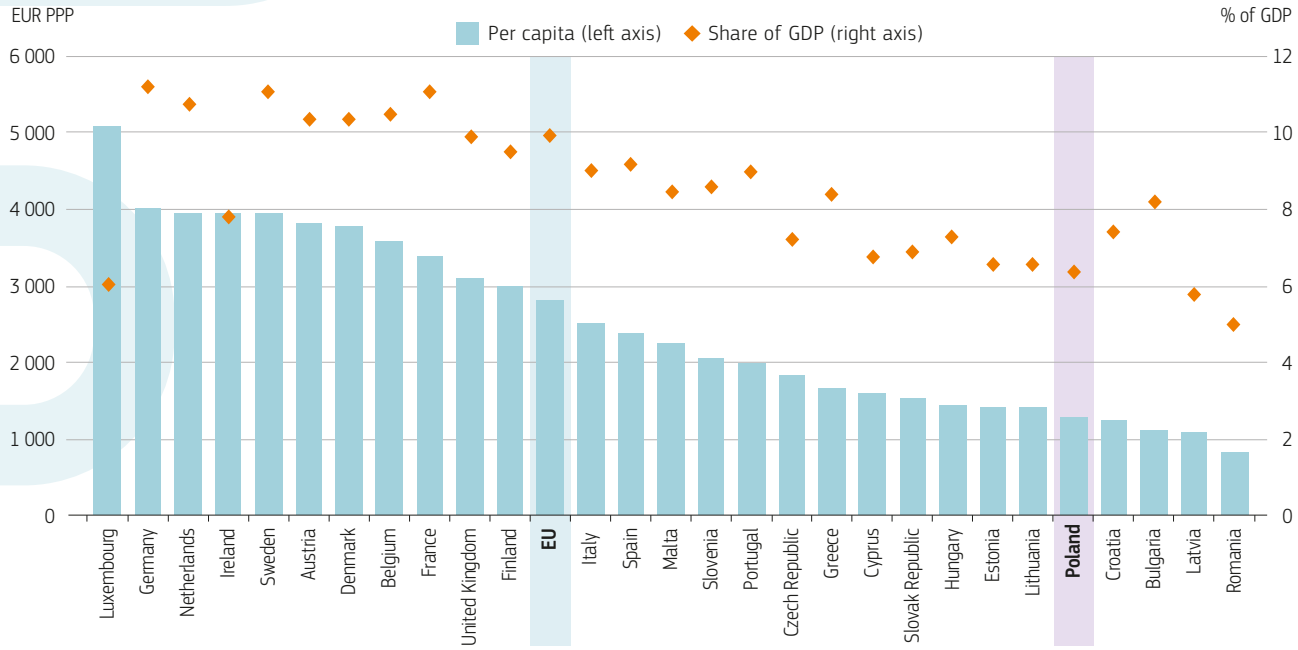
In 2015, 70% of total health expenditure was from public sources. Private spending was mainly as a result of direct formal and informal payments from households, with voluntary health insurance playing only a small role. In 2015, private out-of-pocket payments made up more than one-fifth of health expenditure (23%), versus the EU average of 15%, and were spent mainly on pharmaceuticals, for which coverage is low under the compulsory health insurance (see Section 5.2).

Poland's hospital system has a lot of capacity but is unevenly distributed

The number of hospital beds per 100 000 population has remained fairly stable in Poland since 2005, at a level well above the EU average. Poland had 663 hospital beds per 100 000 population in 2015, compared with an EU average of 515. The structure of hospital beds has not changed much since the early 2000s and a surplus of acute care beds remains.

Despite the general overcapacity in the system, access to care is limited by the uneven geographical distribution of hospitals, with some areas remaining underserved, and capacity based mainly on historical factors rather than current population health needs (see Section 5.2). At the same time, a growing number of small private hospitals are providing publicly funded services under contract with the National Health Fund NHF, especially in the more financially attractive specialties such as cardiac surgery.

Figure 6. Poland spends comparatively less than other EU countries on health



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).

A shortage of health professionals exists in Poland

Shortages of health workers are reflected in the low numbers of practising nurses and physicians, which at 5.2 and 2.3 per 1 000 population, respectively, are among the lowest in the EU (Figure 7), although this may undercount licensed physicians not working in medical entities. Polish physicians can receive better remuneration, working conditions and prospects for professional advancement abroad, so outward migration of doctors and nurses is an issue. Recruiting and retaining doctors to work in family medicine (as well as other domains, such as anaesthesiology) is a particular challenge in Poland that current reforms are attempting to address (see Section 5.3).

Primary care has grown in importance but challenges remain for patients with chronic conditions

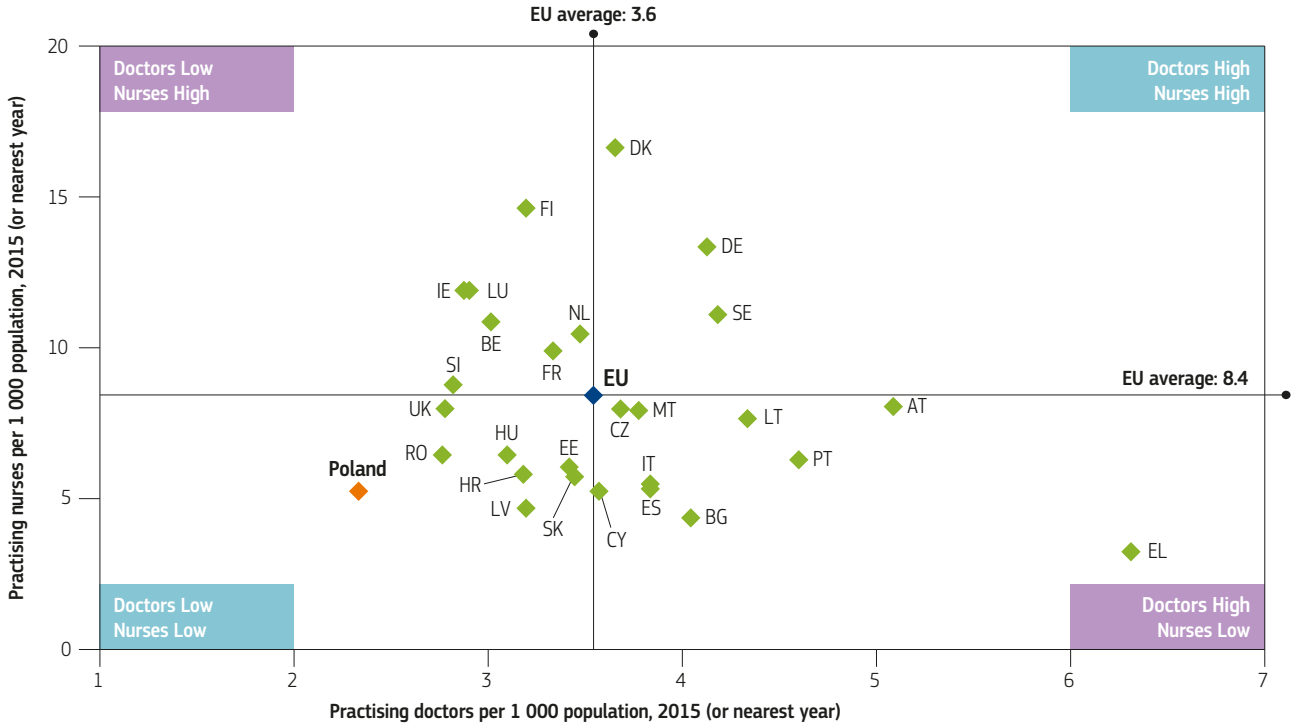
The primary care physician is typically the entry point into the health system, steering patients, as necessary, to more specialised care. Primary care physicians are also the providers of a number of preventive services such as screening and vaccinations. The role of primary care in the Polish health system has grown, as evidenced by the increased utilisation of primary care services.

However, while preliminary diagnoses are meant to be conducted at the primary care level, the system of financial incentives means that doctors often push the cost of investigation onto specialist providers. This has implications for the care of people with chronic conditions in primary care and the level of avoidable hospitalisations (see Section 5.1). In summary, the coordination of services, the role expected of a family doctor, is rarely performed.

Most hospitals are publicly owned, while outpatient (or ambulatory) care is predominantly delivered by private providers contracted by the NHF. On referral from primary care or specialist outpatient care, patients have a choice of hospitals for elective surgery, but face waiting lists that are often very long (see Section 5.2).

Given the rapid population ageing in Poland, pressure is also growing to provide formal long-term care services. Service provision has not kept pace with demand and the situation is exacerbated by shortages of nursing staff to work in the long-term care sector.

Figure 7. Poland has among the lowest numbers of practicing doctors and nurses per 1 000 population in the EU



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

Source: Eurostat Database.

5 Performance of the health system

5.1 EFFECTIVENESS

Amenable mortality rates in Poland are higher than the EU average

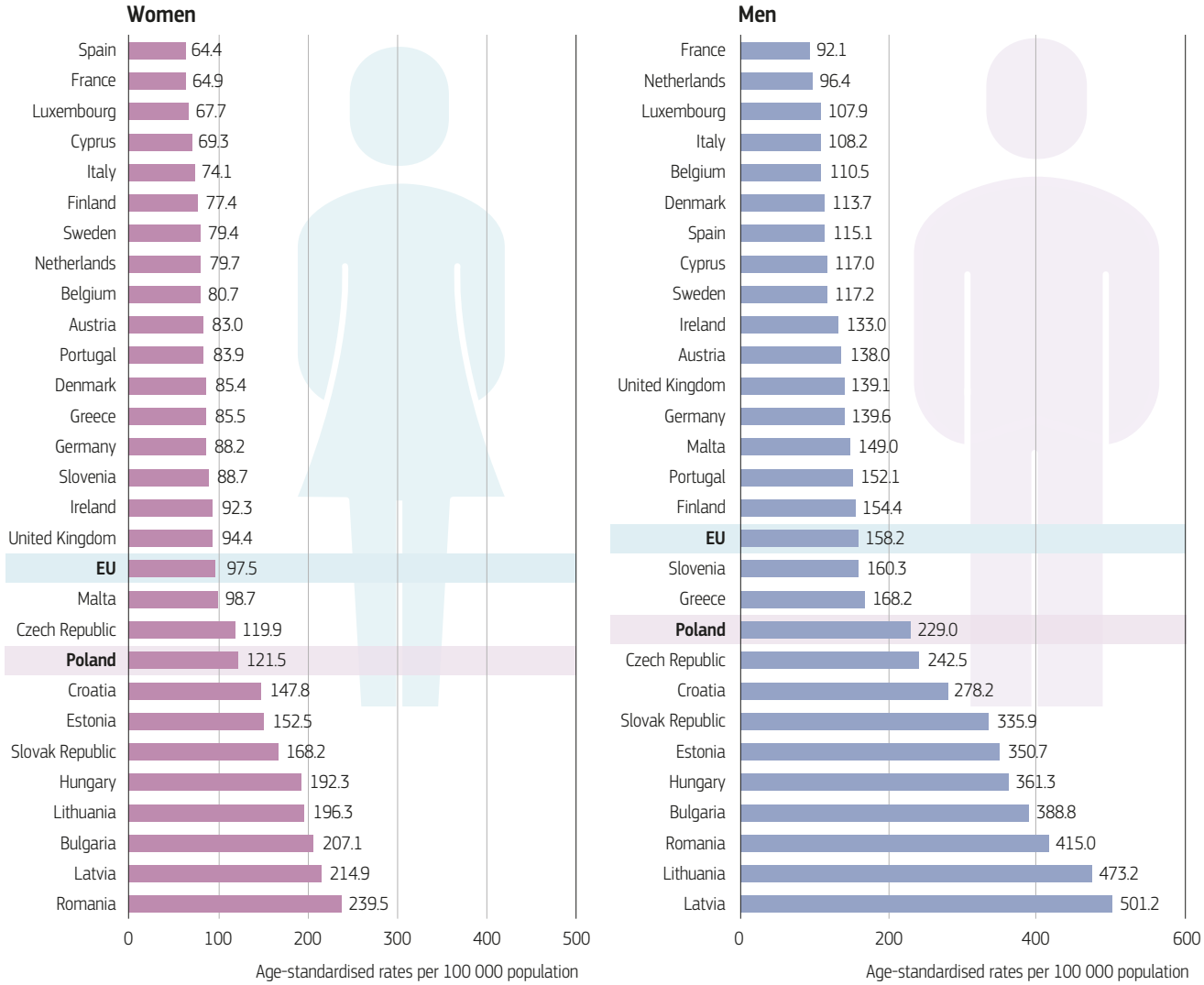
An indicator of a health care system's effectiveness is the mortality rate for conditions that are amenable to medical treatment, such as certain types of cardiovascular diseases and cancers.

In Poland, overall rates of amenable mortality[6] are higher than the EU average (Figure 8), for both women (121 per 100 000 versus 98 per 100 000) and men (229 versus 158). This is mainly because mortality rates from cardiovascular disease are higher in Poland than in most other EU countries. The overall amenable mortality rate reduced by 25% between 2007 and 2014.

Low mortality rates for people requiring acute care suggest good hospital care for some conditions

Hospitals in Poland generally provide effective treatment for people requiring acute care, most notably in the area of cardiology. Substantial progress was made over the decade in reducing mortality rates for people admitted to hospital for heart attack through improvements in treatments and care processes (Figure 9).

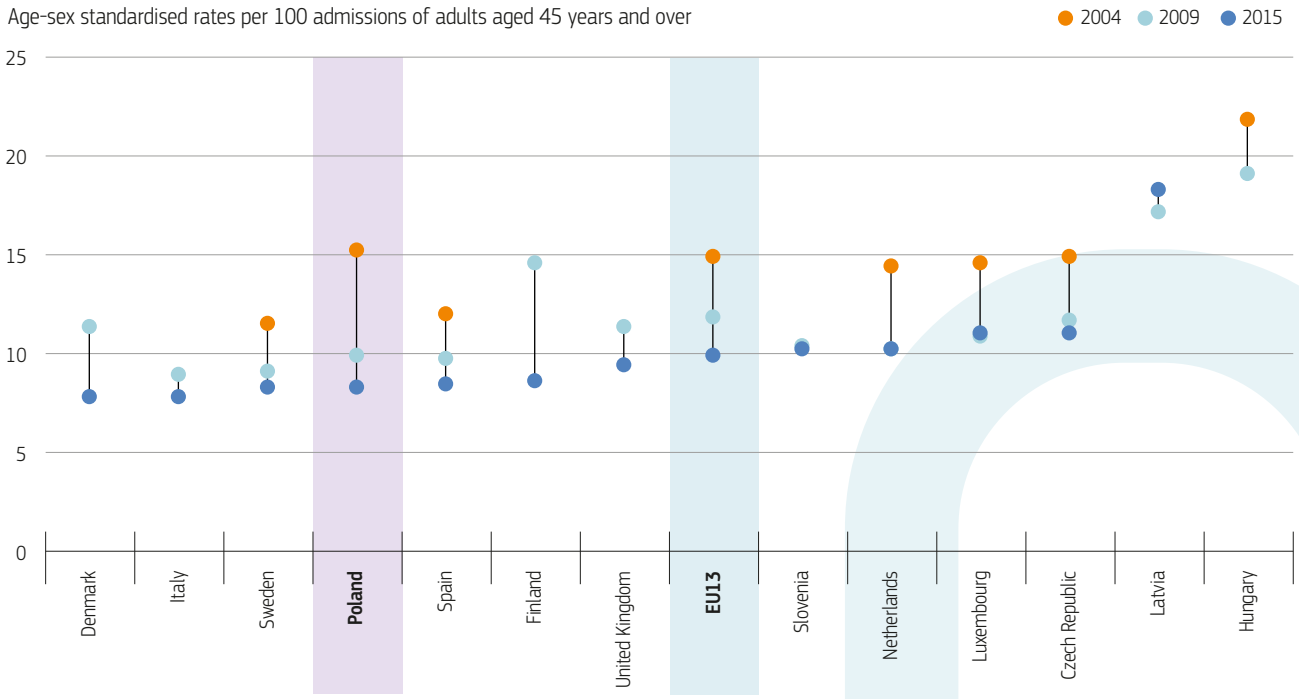
Figure 8. Amenable mortality in Poland is higher than the EU average



Source: Eurostat Database (data refer to 2014).

6. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Figure 9. Thirty-day mortality rate after hospital admission for heart attack in Poland fell considerably



Note: This indicator is based on patient-level data. The EU average is unweighted.

Source: OECD Health Statistics (data refer to 2015 or nearest year).

Cancer care improved but still lags behind other EU countries

Survival of cancer patients in Poland is generally lower than in most other EU countries. Data from the CONCORD programme show that the five-year net survival rate for cervical cancer in Polish women was 55% over 2010–14, one of the lowest among the EU countries. This is in spite of comparatively high cervical cancer screening rates in women aged 20–69 (OECD/EU, 2016). The five-year survival rate for men and women diagnosed with colorectal cancer is also among the lowest in the EU, as is Poland's colorectal cancer screening rate.

In addition to nationwide cancer screening programmes and increased screening coverage for both breast and cervical cancers, Poland introduced a comprehensive 10-year Cancer Strategy in 2015 in a more systematic and targeted approach to improve outcomes. This has a clearer focus on the governance of cancer care, promoting prevention, diagnosis and treatment of cancer, and improving patients' quality of life. Objectives are set in each policy area and progress is monitored regularly.

Avoidable hospital admissions are among the highest in EU countries

Poland has comparatively high hospitalisation rates for chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD), diabetes and congestive heart failure. These conditions are generally considered to be manageable in the primary care sector, outside of the hospital. Potentially avoidable hospitalisations therefore suggest a lack of effectiveness and coordination in the non-acute sectors. Admissions of patients with congestive heart failure are in particular high compared to other EU countries (Figure 10).

High preventable mortality points towards a need for more effective prevention policies

Key indicators of preventable mortality, notably deaths related to traffic injuries, smoking and harmful alcohol consumption, place Poland above the EU average. Poland has one of the highest traffic accident mortality rates in the EU (over 10.3 per 100 000 population in 2014 compared to the EU average of 5.8), although the rate has halved since 2000.

Smoking rates declined over the last decade but the proportion of regular smokers was traditionally high and Poland's lung cancer mortality is among the highest in the EU.

To tackle rising obesity rates, Poland implemented a mass media campaign to promote healthy eating and increase fruit and vegetable consumption (Jarosz and Tarczyk, 2011). The promotion and advertising of certain foods sold at primary and secondary schools is also regulated by law. Economic levers such as taxes and broader regulations of sales (similar to the strategies for limiting alcohol consumption) have not been adopted (OECD, 2015).

Poland implemented a National Health Programme to address these public health challenges and promote healthy behaviours. The National Health Programme is aiming for a 2% reduction in the share of the population smoking by 2020, a halving of the growth in obesity and diabetes rates by 2025, and a 10% cut in the number of alcohol abusers by 2025.

5.2 **ACCESSIBILITY**

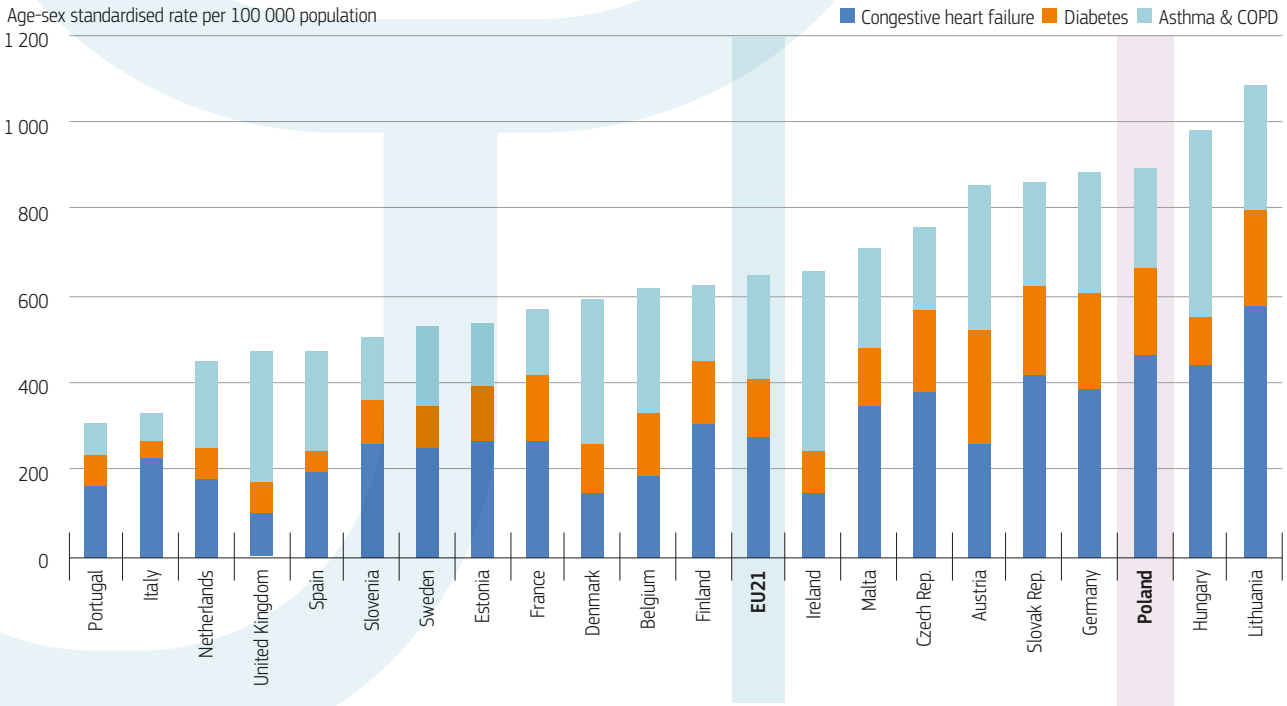
Poland's levels of unmet medical needs are comparatively high, with a considerable gap between income groups

Unmet needs for medical care in Poland ranks fifth highest in the EU. About 7% of the population reports some unmet needs of this type, with a considerable gap between high- and low-income groups (Figure 11) and between regions. About 4% of high-income households report unmet medical needs compared to 10% in the lowest income bracket. Costs and waiting times are the greatest contributors to unmet needs in Poland.

The health care benefits package is narrow, but Health Technology Assessment is in place to assess cost-effectiveness

Polish authorities explicitly define the pharmaceuticals and medical procedures covered in the benefit package under the public health insurance scheme. While most conventional medical procedures are included, the list of reimbursable drugs is narrow. Consequently, the share of out-of-pocket expenditure on pharmaceuticals in Poland (60%) is the fourth highest in the EU (after Romania, Bulgaria and Croatia) and considerably higher than the EU average (44%).

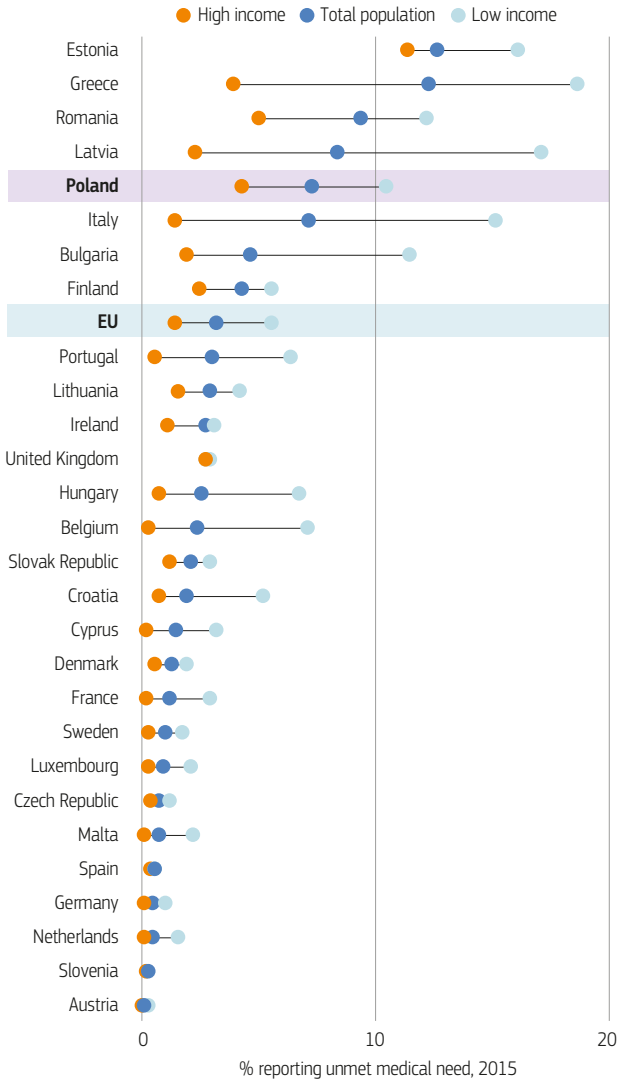
Figure 10. Avoidable hospital admissions for chronic conditions are high in Poland



Note: Rates are not adjusted by health care needs or health risk factors.

Source: OECD Health Statistics (data refer to 2015 or nearest year).

Figure 11. Poland has the fifth highest level of unmet needs for medical care in the EU



Note: The 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.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

A recent amendment to the Act on health services covered by public funds provides for a greater number of drugs to be fully reimbursed for people aged 75 and over. The list is updated every two months. It is expected that this will reduce out-of-pocket payments among people aged 75 and over by up to 60% by 2025.

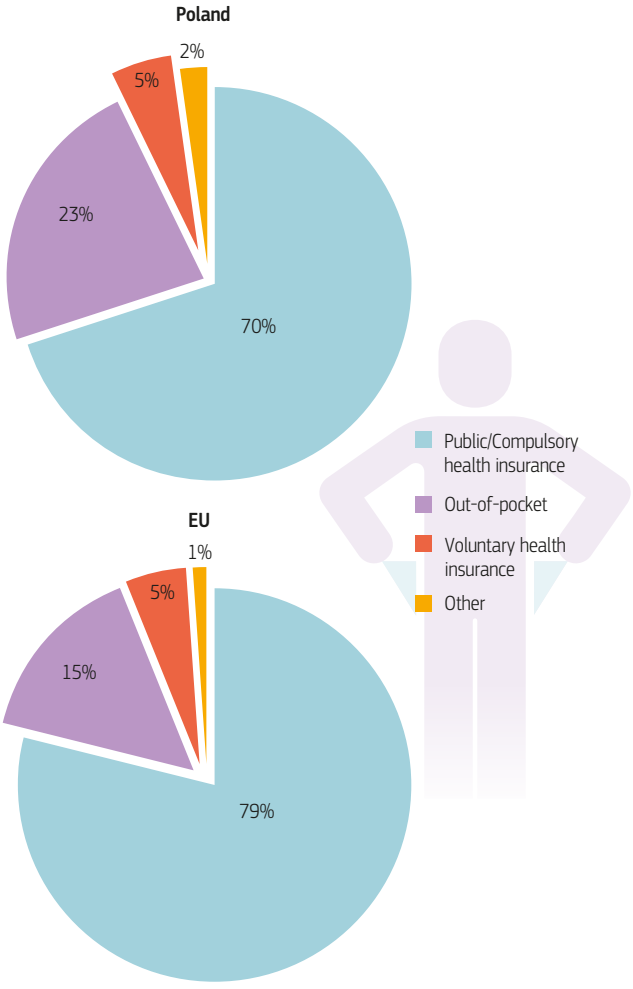
Poland has a comprehensive approach to Health Technology Assessment (HTA). Coverage and reimbursement decisions are made centrally. Poland is also one of the few countries to compare the cost-effectiveness of alternative technologies, to periodically reassess technologies in the benefit package, and to publish the incremental cost-effectiveness ratio used to inform coverage decisions (the current threshold is set at three times the Polish GDP per capita). Patient representatives are included in HTA decisions through the Polish Ombudsman for Patients' Rights (Auraaen et al., 2016).

Affordability of health care is a key concern in Poland

The shares of public and private health expenditures in total health care spending were stable over the last decade, with about 28% financed out of private sources (mainly through out-of-pocket payments). Direct out-of-pocket payments by households are greater than in most other EU countries (Figure 12).

As a share of household consumption, average out-of-pocket expenditure by Polish residents was 2.5% in 2015, close to the EU average of 2.3%. However, the share of the population facing 'catastrophic' out-of-pocket payments[7] in Poland was over 8% in 2014 – high compared to most other EU countries, although comparable to countries like Estonia and Hungary.

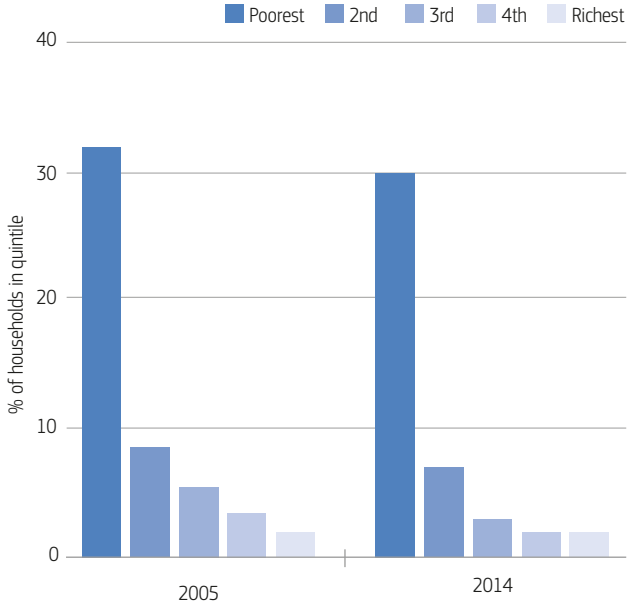
Figure 12. A large share of health care spending in Poland is paid out of pocket



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

7. Catastrophic expenditure is defined as household out-of-pocket spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).

Figure 13. Catastrophic out-of-pocket health care spending is especially high among Poland's poorest households



Source: Woźniak, 2017.

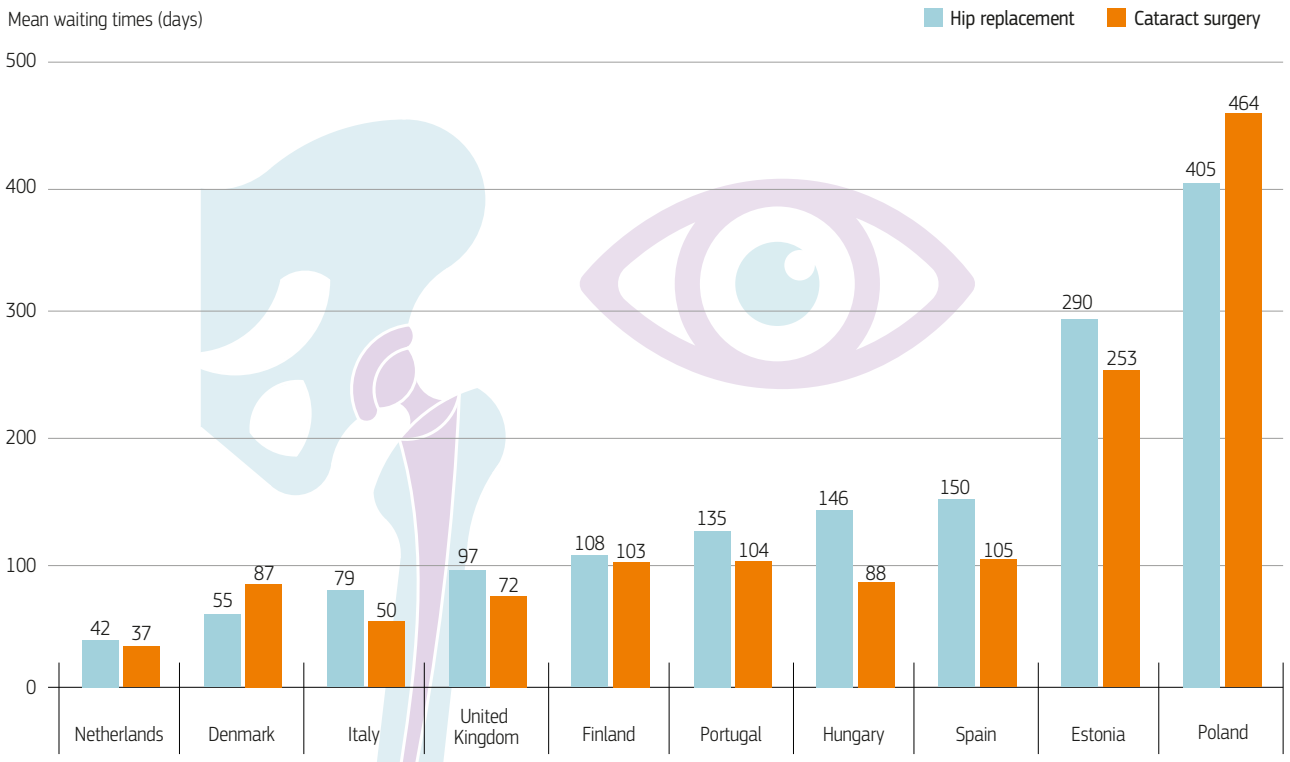
The lowest income quintile is disproportionately affected by catastrophic out-of-pocket payments (Figure 13). This pattern has been quite steady in recent times. In addition to the limited coverage of pharmaceuticals described above, this can be attributed to the unregulated, unofficial private practice by many providers – funded by informal out-of-pocket payments – relatively low coverage of the population (see Section 4) and the absence of a formal private health insurance market in Poland.

Poland has some of the longest waiting times in the EU

In addition to costs, the availability of services in Poland is constrained by the low number of health care practitioners. The result is that Poland has the longest waiting times in the EU for health care interventions such as cataract and joint replacement surgery, such as cataract and joint replacement surgery (Figure 14). Specialists may have an incentive to maintain waiting lists to boost demand for their own private services paid out-of-pocket by patients, and the practice of double employment is fairly widespread and poorly regulated in Poland (European Commission, 2016).

Contributing to this problem is the uneven geographical distribution of services and allocation of resources. For example, waiting times for some specialities can be up to 12 months in some regions (Kowalska et al., 2014). In addition, the share of patients waiting for a neurology, ophthalmology, cardiac, endocrinology or orthopaedic appointment in 2014 varied almost three-fold across Poland's 16 regions (World Bank Group, 2015).

Figure 14. Poland has the longest waiting times for cataract surgery and hip replacement



Source: OECD Health Statistics, Eurostat Database (data refer to 2015).

5.3 **RESILIENCE**[8]

While the Polish health system faces medium financial sustainability risk, investment in its health workforce is needed

Health expenditure in Poland is comparatively low, both in per capita terms and as a share of GDP (Section 4). The risk to health system financial sustainability is considered to be medium by the European Commission's Economic Policy Committee, principally due to an unfavourable budget position and the need to meet the coming demographic challenges (European Commission, 201 6).

That said, some medium-term strategies are required to: address the shortage of health workers (Section 4) and restore a better balance between specialists and generalists; address the dual nature of physician employment; and increase capacity of the long-term care sector. Structural health system reform is currently underway in Poland (see Box 1).

The relative oversupply of hospital and undersupply of non-acute and long-term care capacity undermine allocative efficiency in the medium term. Long waiting lists and low rates for some elective procedures (hip and knee replacements), while lowering costs in the short term, generate considerable patient dissatisfaction.

The long-term care sector is underfunded, and overly reliant on informal care and the hospital sector

Another factor undermining the sustainability and efficiency of the Polish health system is the current organisation and financing of long-term care. Currently, about 2.6 million Polish people (6.8% of the population) live with severe disabilities due to health problems, and this number is projected to increase to more than 3.7 million people (11%)[9] by 2060.

Long-term care in Poland is currently very fragmented and underfunded. It is governed by several laws and principally provided by family members (European Commission, 2016). This may not be sustainable in a context of population ageing combined with broader societal changes such as more women joining the workforce. It is also often provided in hospitals, which is inefficient. It is likely that more funding will be required to respond adequately to future demand for long-term care, coupled with a rebalancing of resources between hospitals and long-term care facilities.

Investing to promote digitisation of the health sector

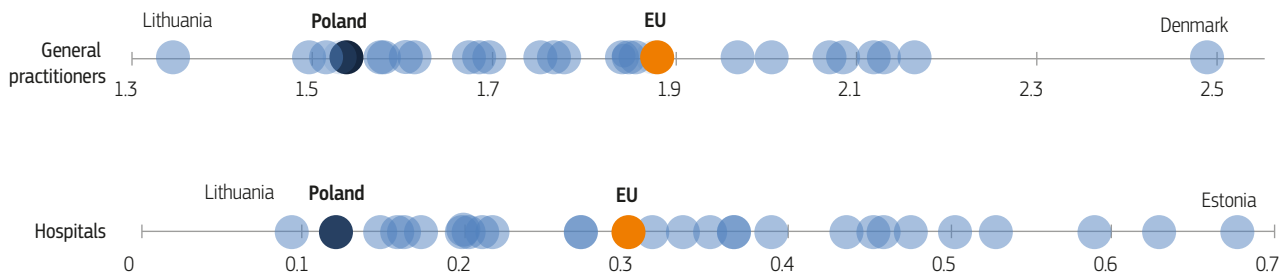
Several projects, partly funded by European Structural and Investment Funds (Section 4), to digitalise the health care system and help Poland catch up in the spread and adoption of ICT are currently underway (Figure 15). In 2013, eHealth adoption among General Practitioners was fifth lowest in the EU (European Commission, 2013). Similarly, the availability and use of ICT in hospitals was second lowest, behind Lithuania..

Public health can be strengthened through better targeted spending

Poland dedicates 2.6% of its health expenditure to public health initiatives and health promotion activities compared to the EU average of 3.0%, with about half of this allocated to occupational health. Given the high levels of behavioural risk factors such as smoking, harmful alcohol consumption and obesity, a better balance between disease prevention and care may help to improve population health status and reduce health inequalities, while at the same time reducing pressures on the health and long-term care systems.

Premature deaths from preventable causes, particularly among men, are reducing employment and economic growth (OECD/EU, 2016). The aforementioned National Health Programme

Figure 15. The adoption of eHealth among general practitioners and hospitals was among the lowest in 2013



Note: The composite indicator on GP ranges from 0 to 4 whereas the composite indicator on hospitals ranges from 0 to 1.
See *OECD/EU (2016), Health at a Glance: Europe 2016 – State of Health in the EU Cycle* for further information.

Source: European Commission (2013, 2014).

8. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

9. Based on OECD projections of the future population of Poland https://stats.oecd.org/Index.aspx?DataSetCode=POP_PROJ#

is a step forward in strengthening public health policies. The programme explicitly aims to improve health status and reduce health inequalities by setting up six strategic goals covering: nutrition and physical activity; addiction prevention; mental health and well-being; environmental risks including work, habitation and education; healthy ageing and reproductive health.

Reform will need to be matched by strong governance and accountability

Health care financing and care delivery underwent substantial changes in Poland over the past 30 years. The current financial management model built around the central role of the NHF has proved inefficient, resulting in some of the problems outlined in this profile (e.g. long waiting times). The Polish government has embarked on a programme of ambitious reforms of the health system, and some of these reforms will influence health care governance, accountability and planning (Box 1).

The creation of regional health authorities to perform a range of financing, supervisory and planning functions will have profound implications on accountability, allocation of resources and strategic planning. Similarly, the replacement of activity-based funding with prospective annual budgets, and the switch from maximum to minimum limits, represent a substantial transition in hospital management and administration, and pose a challenge to ensure financial and clinical accountability, as well as monitoring and evaluation of performance.

BOX 1. **FUNDAMENTAL HEALTH REFORM IN POLAND**

In 2016, the Polish Ministry of Health embarked on a far-reaching health reform programme aimed at improving access to care and care coordination, improving efficiency and reducing duplication. This includes a commitment to increase public expenditure on health by about 35% over the next seven years.

The most fundamental reform proposal is the abolition of the NHF to be replaced by a new funding system controlled by the Ministry, and financed out of tax revenues. Health authorities will finance health services at the regional level, supervise hospitals, and be responsible for forward planning.

The reforms will change the contracting process for acute care. Activity-based funding will be replaced with annual budgets. The number and structure of hospital beds will be adjusted based on health need. Current maximum contractual limits will be replaced by minimum volumes that hospitals will have to meet to receive funding.

A linkage of inpatient with outpatient and ambulatory services is proposed, with bundling of budgets across care types a key lever to achieve this.

The creation of health care teams comprising doctors, nurses, school nurses, midwives and dieticians aims to strengthen primary care. The objectives of these teams will be health promotion, as well as gatekeeping and coordination of care for patients across settings.

To address health workforce shortages, the government is proposing to increase salaries for medical staff. Implementation of this ambitious reform programme is expected to begin in 2017–18.

All activity – from budgeting to clinical practice – will be at risk during the transition period, and will need to be monitored closely. The reforms centralise more control to the Ministry. It will be interesting to observe what shape the necessary accountability and oversight framework will take and how it will be implemented to accompany the restructuring. Communication and engagement of key stakeholders – health professionals, system administrators and of course the public – will be a crucial determining factor in the success of these reforms.

6 Key findings

- Life expectancy at birth in Poland is higher than in most neighbouring countries, but lower than the EU average. Disparities in life expectancy are observed between different population groups. Eight years separate Polish men and women, while the gap between those with the lowest and highest education levels is 10 years. Polish men and women aged 65 can expect to live another 16 and 20 years, respectively, but less than half these years will be free from disability.

- The proportion of Polish residents who report being in good health is low compared to other EU countries. Many more high earners report good health than those on lower incomes. About a third of the total burden of disease can be attributed to behavioural risk factors, especially alcohol consumption (which is increasing among adults), obesity and physical inactivity. Polish people are about 60% more likely to die from a circulatory disease than the average EU resident and the reduction in cardiovascular mortality has been slower than in most other EU countries.

- Acute care in Polish hospitals is relatively effective and of high quality, especially for cardiac patients. Poland has one of the lowest case-fatality rates for heart attack patients in EU countries that report these data. On the other hand, outcomes for cancer care in Poland are less favourable. Survival rates for breast, cervical and colorectal cancers are low compared to other EU countries and the cancer mortality rate is higher than the EU average. Programmes to improve screening and prevention are currently being implemented. Poland also has high hospitalisation rates for chronic conditions such as asthma, COPD and congestive heart failure, suggesting room for improvement in non-acute sectors.

- Affordability and unmet medical needs are key concerns in Poland. Due in part to workforce and allocative imbalances, Poland has high levels of unmet need for medical care and the longest waiting lists for elective procedures in the EU. Compulsory health insurance covers only 91% of the population. While entitlement covers a broad range of services, public underfunding means that the supply of services is limited. An undeveloped private health insurance market and limited public coverage of pharmaceuticals have resulted in high levels of out-of-pocket payments. As a result, a large number of lower-income Polish households face catastrophic health care costs.

- Long-term care in Poland is in need of reform. The sector is fragmented and governed by numerous laws. Some long-term care is often provided in hospitals, but the principal source of provision is informal care by family members. This is unsustainable given changing demographics and women's growing participation in the workforce. Increased funding, infrastructure investment, and better planning and management could improve this situation.

- The government is in the process of implementing structural reforms of the health system, aimed at improving access and coordination and improving allocative and technical efficiency. The reforms include fundamental changes to health care financing and planning, health promotion and care coordination. Sound governance, accountability and oversight are needed to ensure these reforms do indeed result in better outcomes for the Polish people.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		

European Commission

State of Health in the EU

Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

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