Poland: health care indicators
Group 6: Hungary, Ireland, Italy, New Zealand, Norway, Poland, United Kingdom

A. Efficiency and quality

B. Amenable mortality by group of causes

C. Prices and physical resources

D. Activity and consumption

E. Financing and spending mix

F. Policy and institutions

Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g., Australia has more scanners than the OECD average country).
In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area).
In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations.
In Panel F, data shown are simple deviations from the OECD average.
POLAND

GROUP 6: Mostly public insurance. Health care is mainly provided by a heavily regulated public system, with strict gate-keeping, little decentralisation and a tight spending limit imposed via the budget process.

<table>
<thead>
<tr>
<th>Efficiency and quality</th>
<th>Prices and physical resources</th>
<th>Activity and consumption</th>
<th>Financing and spending mix</th>
<th>Policies and institutions</th>
<th>Weaknesses and policy inconsistencies emerging from the set of indicators</th>
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</thead>
<tbody>
<tr>
<td>Above average DEA score but higher amenable mortality rate and inequalities in health status</td>
<td>Low health care spending per capita and as a share of GDP</td>
<td>Low publicly-financed share</td>
<td>Large scope and depth of basic insurance coverage. Very limited market mechanisms in the insurance market</td>
<td>The Polish system relies on both more market mechanisms and more regulations to steer the supply of health care services. The reasons behind the high inequalities in health status should be examined</td>
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<td>Lower length of stay in the acute care sector</td>
<td>More acute care beds per capita</td>
<td>More hospital discharges per capita</td>
<td>High out-of-pocket payments</td>
<td>More private provision and volume incentives but also more regulation on provider prices and less information on the quality and prices of services</td>
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<td>Low quality of out-patient care as measured by the number of avoidable in-patient admissions</td>
<td>Less doctors, nurses and medical students</td>
<td>High drug share</td>
<td>More choice of providers and less gate-keeping</td>
<td>Devise strategies to improve the quality of out-patient care. Combining the existing capitation system for GPs with some elements of fee-for-services could be an option</td>
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<tr>
<td>Low administrative costs</td>
<td>Low prices</td>
<td></td>
<td>Less regulation on medical staffing and equipment</td>
<td>Efforts to increase consistency in the allocation of resources across government levels could contribute to raise spending efficiency</td>
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