European Commission

# State of Health in the EU

# Poland

## Country Health Profile 2021

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'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 policymakers and influencers with a means for mutual learning and voluntary exchange.

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

## Contents


1. HIGHLIGHTS 3
2. HEALTH IN POLAND 4
3. RISK FACTORS 7
4. THE HEALTH SYSTEM 9
5. PERFORMANCE OF THE HEALTH SYSTEM 12
   5.1 Effectiveness 12
   5.2 Accessibility 14
   5.3 Resilience 17
6. KEY FINDINGS 22


## 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 completed in September 2021, based on data available at the end of August 2021.

### Demographic and socioeconomic context in Poland, 2020

| Demographic factors | Poland | EU |
|---|---|---|
| Population size (mid-year estimates) | 37 958 138 | 447 319 916 |
| Share of population over age 65 (%) | 18.2 | 20.6 |
| Fertility rate[1] (2019) | 1.4 | 1.5 |
| **Socioeconomic factors** | | |
| GDP per capita (EUR PPP[2]) | 22 718 | 29 801 |
| Relative poverty rate[3] (%, 2019) | 15.4 | 16.5 |
| Unemployment rate (%) | 3.2 | 7.1 |

*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.*


Disclaimer: The opinions expressed and arguments employed herein are solely those of the authors and do not necessarily reflect the official views of the OECD or of its member countries, or of the European Observatory on Health Systems and Policies or any of its Partners. The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

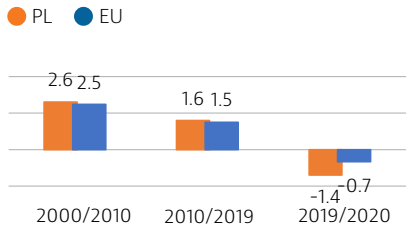
This document, as well as any data and map included herein, are without prejudice to the status of or sovereignty over any territory, to the delimitation of international frontiers and boundaries and to the name of any territory, city or area.

Additional disclaimers for WHO apply.

© OECD and World Health Organization (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies) 2021

# 1 Highlights

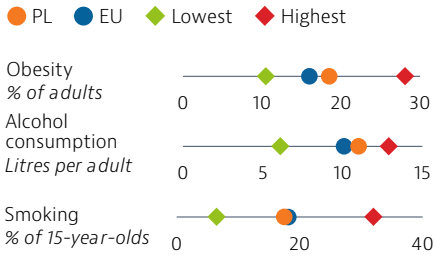
In 2020, Poland temporarily lost 1.4 years of life expectancy compared to 2019 because of deaths due to the COVID-19 pandemic. The Polish health system has been suffering from low levels of public financing for many years; this is reflected in workforce shortages and access problems such as long waiting times and high out-of-pocket payments. While the COVID-19 pandemic stimulated unprecedented use of teleconsultations in primary care, non-COVID-19 patients faced barriers to accessing specialist care. Workforce shortages were brought into focus as the key bottleneck in surging care capacity during the pandemic.




*Life expectancy gains, years*

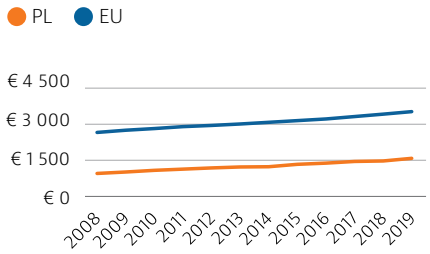
## Health Status

Life expectancy in Poland in 2020 was 76.6 years – four years lower than the EU average. High excess mortality due to the COVID-19 pandemic caused life expectancy to fall by 1.4 years between 2019 and 2020, which was among the largest reductions observed in the EU. Ischaemic heart disease, stroke and lung cancer were the main causes of death before the pandemic, but COVID-19 accounted for a substantial share of deaths in 2020.




## Risk factors

Almost half of all deaths in Poland are driven by behavioural factors, such as smoking, binge drinking and physical inactivity. Obesity has been growing and almost a fifth of adults are now obese – a higher share than in the EU. While alcohol consumption among adults has been rising, smoking rates among both adults and adolescents have been decreasing. Nevertheless, the growing popularity of e-cigarettes among young people is a concern.



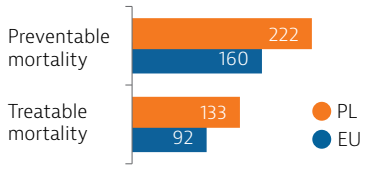

*Per capita spending (EUR PPP)*

## Health system

Over the past decade, spending on health in Poland has remained consistently below the EU average, both in per capita terms and as a share of GDP. The COVID-19 pandemic prompted additional funding injections in 2020 to support the health sector response. Around 72 % of Poland's health spending comes from public sources, but out-of-pocket spending is high, accounting for just over 20 % of current health expenditure – mostly for outpatient medicines.

## Effectiveness

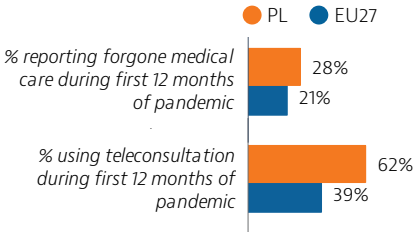
Mortality from both preventable and treatable causes in Poland is above the EU average. Efforts are being made to tackle obesity and there is also scope to strengthen tobacco and alcohol policies to improve population health. Cancer survival rates have improved but remain comparatively low.




*Age-standardised mortality rate per 100 000 population, 2018*

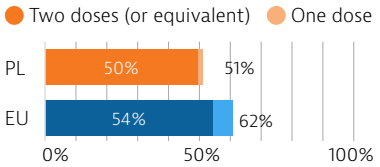
## Accessibility

The level of unmet needs before 2020 was relatively high in Poland and this continued during the COVID-19 pandemic. The growing use of teleconsultations helped maintain access to primary care during the pandemic, but access to specialist care was severely restricted for non-COVID-19 patients.




## Resilience

Primary care progressively became the first line of COVID-19 response, but limited testing and contact tracing capacity have persisted. By the end of August 2021, half the population had received two doses (or equivalent) of a COVID-19 vaccine, but vaccine hesitancy is slowing the rollout of the vaccination programme.




*Share of total population vaccinated against COVID-19 up to the end of August 2021*

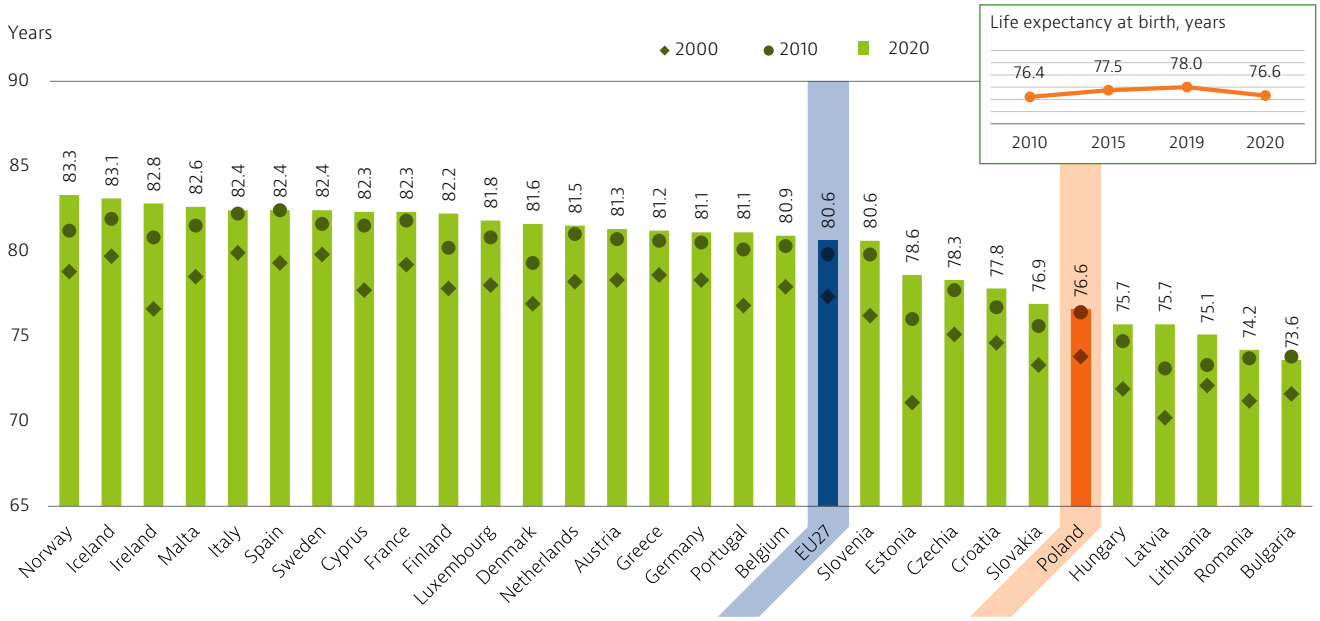
# 2 Health in Poland

## Life expectancy at birth in Poland reached 78 years in 2019, but fell dramatically in 2020

Life expectancy at birth in Poland increased by more than four years between 2000 and 2014 to reach 78 years, and fluctuated around this level until 2019, when the gap between life expectancy in Poland and the EU average was about three years. The gap was largely caused by greater exposure to modifiable risk factors among men, such as smoking and alcohol consumption (see Section 3).

In 2020, the very high level of excess deaths – many due to COVID-19 – caused life expectancy at birth to decrease temporarily by 1.4 years compared to 2019, which was among the largest reductions recorded within the EU. As a result, the gap in life expectancy between Poland and the EU widened to four years (Figure 1). The gender gap in life expectancy between men and women also increased to an estimated 8.2 years in 2020. According to national data, life expectancy at age 60 fell by almost 1.2 years compared to the year before, reducing it to the 2008 level (GUS, 2021).

**Figure 1. Life expectancy at birth in Poland is four years lower than the EU average**



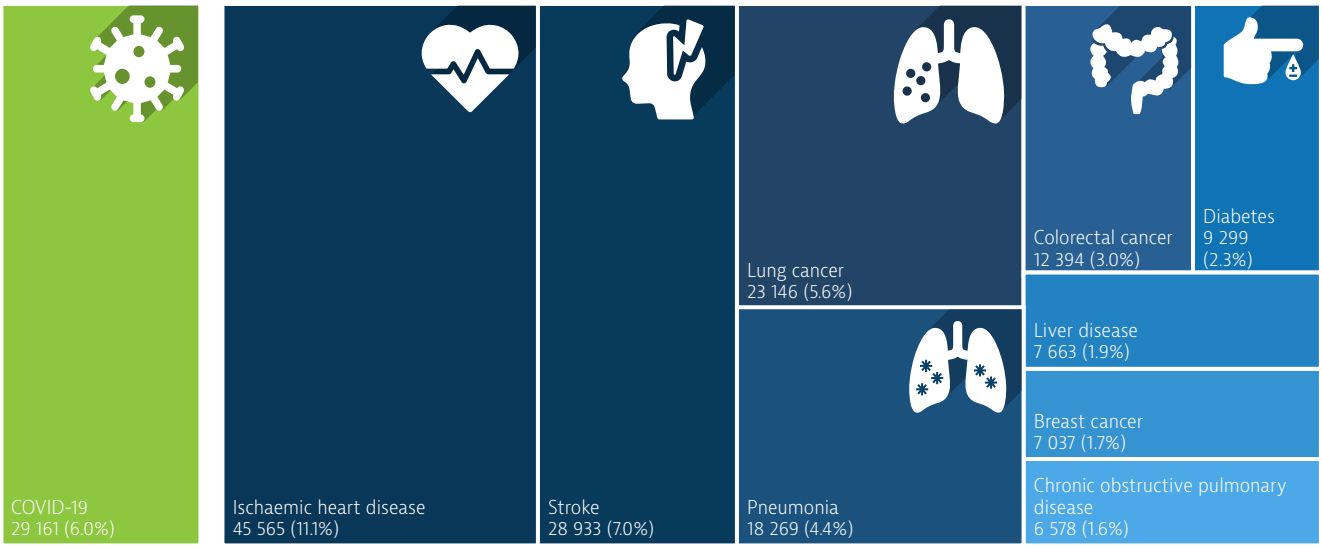

*Note: The EU average is weighted. Data for Ireland refer to 2019.*
*Source: Eurostat Database.*



## Ischaemic heart disease, stroke and lung cancer are the main causes of mortality

Despite reductions in mortality from these causes, ischaemic heart disease and stroke were still the main causes of death in 2019. Lung cancer remained the most frequent cause of death from cancer (Figure 2). In 2020, COVID-19 accounted for over 29 000 deaths in Poland (6 % of all deaths). An additional 46 000 COVID-19 deaths were registered up to the end of August 2021. However, the direct and indirect death toll related to COVID-19 in Poland is likely to be even higher than in 2020 (Box 1).

**Figure 2. COVID-19 accounted for a large number of deaths in 2020**



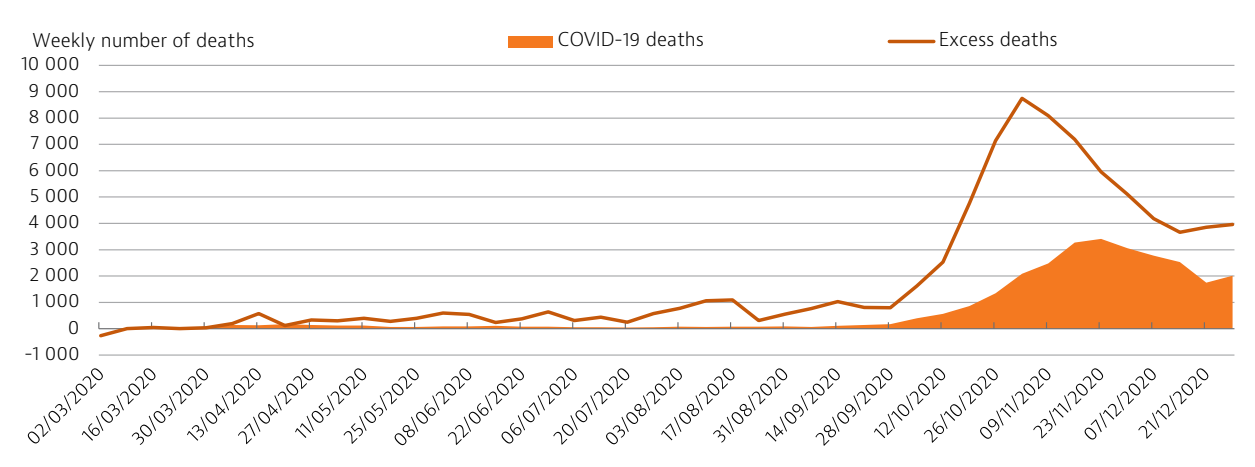

*Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2019. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2019.*
*Sources: Eurostat (for causes of death in 2019); ECDC (for COVID-19 deaths in 2020).*

## Box 1. Excess mortality in Poland in 2020 was among the highest in the EU

In Poland, as in many other countries, the actual number of deaths from COVID-19 is likely to be higher than the number of reported deaths because of limited testing and issues related to the attribution of causes of death. The number of COVID-19 deaths also does not include possible increase in deaths from other causes that may arise during or after the pandemic, such as reduced access to health services for non-COVID-19 patients and fewer people seeking treatment because of fear of catching the virus (indirect deaths). The indicator of excess mortality (defined as the number of deaths from all causes over what would have been expected based on the experience baseline from previous years) can provide a broader measure of the direct and indirect deaths due to COVID-19 that is less affected by issues related to testing and causes of death registration.

In 2020, excess mortality in Poland was generally greater than COVID-19 mortality, particularly during autumn (Figure 3). Overall, excess mortality from March to December 2020 (80 000 deaths) was more than double the reported COVID-19 deaths (29 100 deaths) over the same period. Older people were disproportionately affected by excess mortality, with deaths among people aged over 65 accounting for 94 % of all excess deaths in 2020.

**Figure 3. COVID-19 and excess deaths peaked in autumn 2020 in Poland**

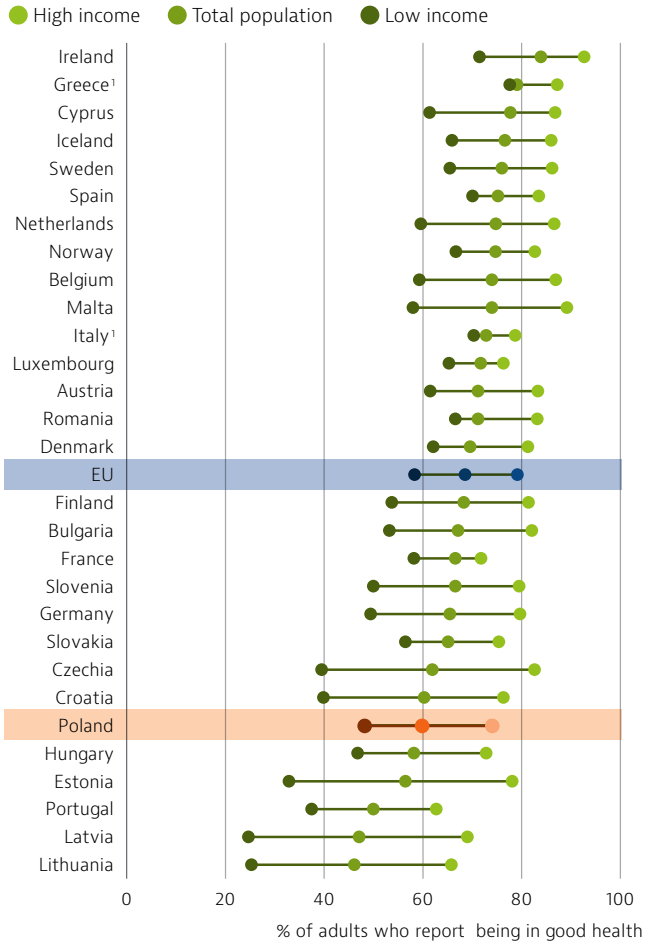



*Note: The calculation of excess deaths is based on the average with the previous five years (2015-19).*
*Sources: ECDC (for COVID-19 deaths); OECD based on Eurostat data (for excess deaths).*

## Inequalities in self-reported health by income level are substantial in Poland

Before the COVID-19 pandemic, about 60 % of the Polish population reported being in good health, which is lower than the EU average of 69 % (Figure 4). The rate was substantially lower among people in the lowest income quintile (48 %) than among those in the highest (74 %). Self-reported health also worsened with age: fewer than one quarter of Polish people aged over 65 reported being in good health in 2019, compared with two fifths in the EU.

**Figure 4. Fewer Poles reported being in good health compared to other EU countries in 2019**




*Note: 1. The shares for the total population and the population on low incomes are roughly the same.*
*Source: Eurostat Database, based on EU-SILC (data refer to 2019).*

## Nearly two in five adults in Poland have a chronic condition

Some 39 % of Polish adults reported having at least one chronic condition in 2019 – a slightly higher proportion than across the EU as a whole (36 %), according to EU-SILC. This proportion increases to 70 % for Polish people aged over 65. Many of these chronic conditions increase the risk of severe complications from COVID-19. As with self-reported health, there is a gap in the prevalence of chronic conditions by income group: 47 % of Polish adults in the lowest income group report having at least one chronic condition, compared with 32 % of those in the highest.

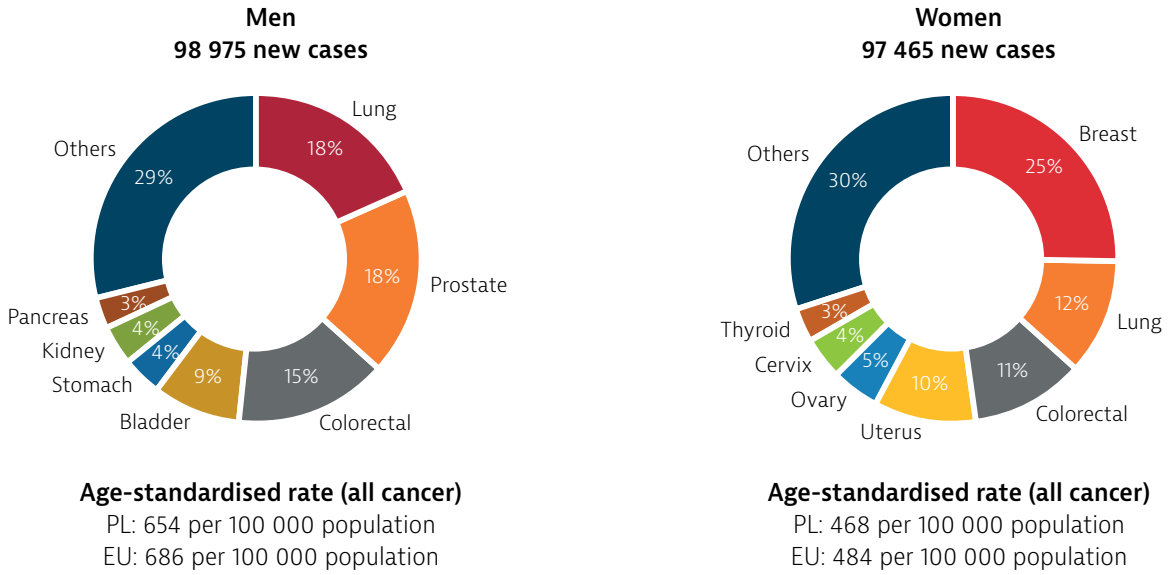
## The burden of cancer in Poland is considerable

According to the latest estimates from the Joint Research Centre based on incidence trends from previous years, almost 200 000 new cases of cancer and about 118 000 cancer deaths were expected in Poland in 2020[1]. Notably, while the overall cancer incidence rates for both men and women are lower than the EU averages, the mortality rates are 30 % higher for men and 25 % higher for women, indicating problems with timely diagnoses and treatment. Figure 5 shows that the main cancer sites among men are lung and prostate (18 % each), followed by colorectal cancer (15 %). Among women, breast cancer is most frequent (25 %), followed by lung (12 %), colorectal (11 %) and uterus cancer (10 %). Several policy initiatives have recently been launched to strengthen cancer screening and treatment (see Section 5.1).



*1. It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.*

**Figure 5. An estimated 200 000 people in Poland were expected to be diagnosed with cancer in 2020**




*Note: 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 nearly half of all deaths

One fifth of all deaths in 2019 can be attributed to tobacco consumption (including direct and second-hand smoking), while another fifth can be attributed to dietary risks, including low fruit and vegetable intake, and high salt and sugar consumption (Figure 6). Although the share of deaths due to alcohol consumption is the same as the EU average (6 %), trends in mortality attributable to alcohol consumption show an increase for both men and women and at all ages since the early 2000s (Zatoński et al., 2021). Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for an estimated 8 % of all deaths in 2019 (over 30 000 deaths) – twice the proportion in the EU as a whole (4 %).

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 prevention of overweight and obesity, healthy ageing, mental health promotion, addiction prevention and reduction of health risks arising from environmental factors and infectious diseases (see Section 5.1).

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

*Note: 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 $PM_{2.5}$ and ozone.*
*Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).*

## Smoking among adults has decreased over the past two decades but remains above the EU average

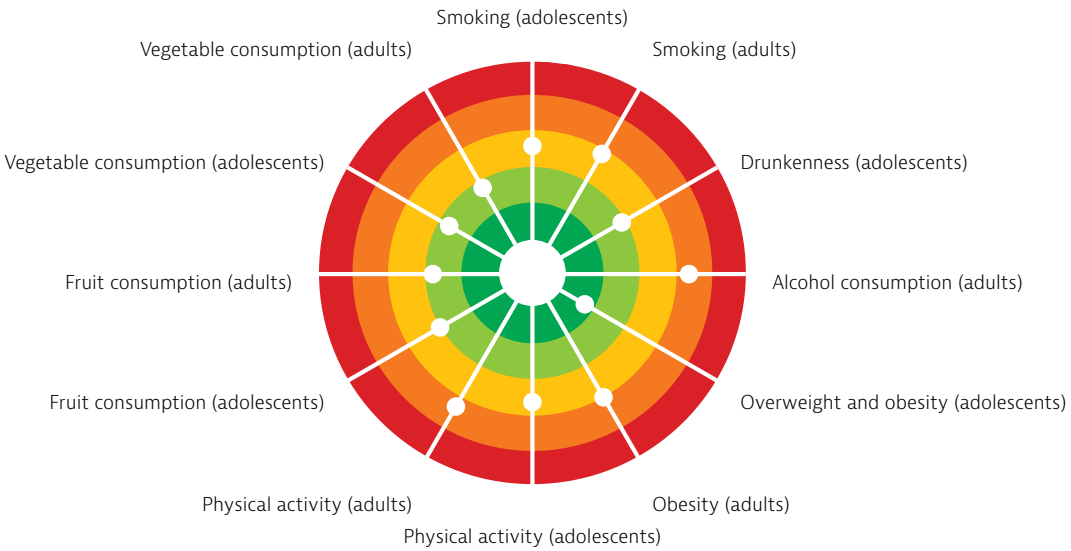
Tobacco consumption is a longstanding public health issue in Poland, particularly among men. Despite a decline in smoking prevalence, 19.8 % of adults were still daily smokers in 2019, which is slightly higher than the EU average of 19.5 % (Figure 7). A national survey conducted in 2020 found that 23 % of men and 15 % of women used traditional tobacco products at least once a day, with a larger proportion of both using electronic substitutes than in 2018 (Wojtyniak & Goryński, 2020).

Cigarette smoking among adolescents fell to the same rate as the EU average in 2018: 18 % of 15-year-olds reported smoking cigarettes in the past month – down from 24 % in 2014. However, the use of e-cigarettes has become more popular among young people: 33 % of 15-16-year-olds in Poland reported smoking e-cigarettes in 2019 – a rate more than twice the EU average of 14 %.

## Alcohol consumption among adults is higher than the EU average

Since 2012, the average alcohol consumption among adult Poles has been higher than the EU average and showed an upward trend between 2016 and 2019. In 2019, Polish adults drank, on average, 11.0 litres of pure alcohol compared to 10.1 litres across EU countries. This coincided with a weakening of alcohol control measures in Poland (Zatoński et al., 2021; see Section 5.1). Although most Poles (47 % of men and 67 % of women) did not change their drinking habits during the COVID-19 pandemic, 30 % of men and 15 % of women drank more than in 2018 or started drinking in 2020 (Wojtyniak & Goryński, 2020). In contrast, the proportion of 15-year-olds who reported having been drunk more than once in their life in Poland fell from 26 % in 2014 to 19 % in 2018, which is below the 22 % EU average.

**Figure 7. Alcohol consumption and smoking are important public health issues in Poland**




*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.*
*Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; OECD health statistics, EU-SILC 2017, EHIS 2014 and 2019 for adults indicators.*

## Obesity has been growing slowly but steadily

About 18.5 % of adults in Poland were obese in 2019 – which is above the EU average (16 %) – and rates have been rising slowly since 2004. 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 were overweight or obese in 2018 was below the EU average (16 % compared to 19 %).

# 4 The health system

## Fragmented health care governance hampers coordination across the system

Poland's health system is based on social health insurance (SHI). The Ministry of Health plays a central role in health sector governance, although it shares this responsibility with three levels of territorial government: municipalities oversee primary care; counties are responsible for (often) smaller county hospitals; and voivodeships (regions) are responsible for generally larger regional hospitals. The Ministry of Health supervises the highly specialised tertiary care providers. The Ministry also played a major role in coordinating the country's response to the COVID-19 pandemic (Box 2). Private facilities provide mainly outpatient care, while most inpatient care is provided in hospitals, which are public. This high level of fragmentation of health system governance presents considerable challenges for achieving effective coordination of activities across the health system, although recently efforts have been made to improve the situation. The National Health Fund (NHF) is the sole purchaser in the SHI system. It operates through its 16 voivodeship branches, which manage the purchasing of health care services in their regions.

### Box 2. The pandemic response was highly centralised

Poland's COVID-19 response was led by the central government, with the involvement of relevant ministries, including the Ministry of Health. The Minister of Health led the health system response, supported by a dedicated Crisis Management Team within the Ministry. This body consists mainly of representatives from various state authorities rather than independent public health specialists or scientists.

Unlike its neighbours, Poland did not declare a state of emergency, which would have provided the government with a choice of ready-made restrictive measures and other special powers to address the pandemic under the Constitution. Instead, in March 2020 the government declared a lower "state of epidemiological emergency" and then a "state of epidemic", which meant that all extraordinary measures had to be introduced via special provisions and resolutions enacted through parliament.

*Source: COVID-19 Health System Response Monitor.*

## Health expenditure remains comparatively low

In 2019, total health spending in Poland accounted for 6.5 % of GDP – a much lower share than the EU average of 9.9 %. The COVID-19 emergency prompted additional funding injections in 2020 to support the health sector (Box 3). In per capita terms, health expenditure in Poland amounted to EUR 1 582 (adjusted for differences in purchasing power), which is among the lowest amounts in the EU (Figure 8).

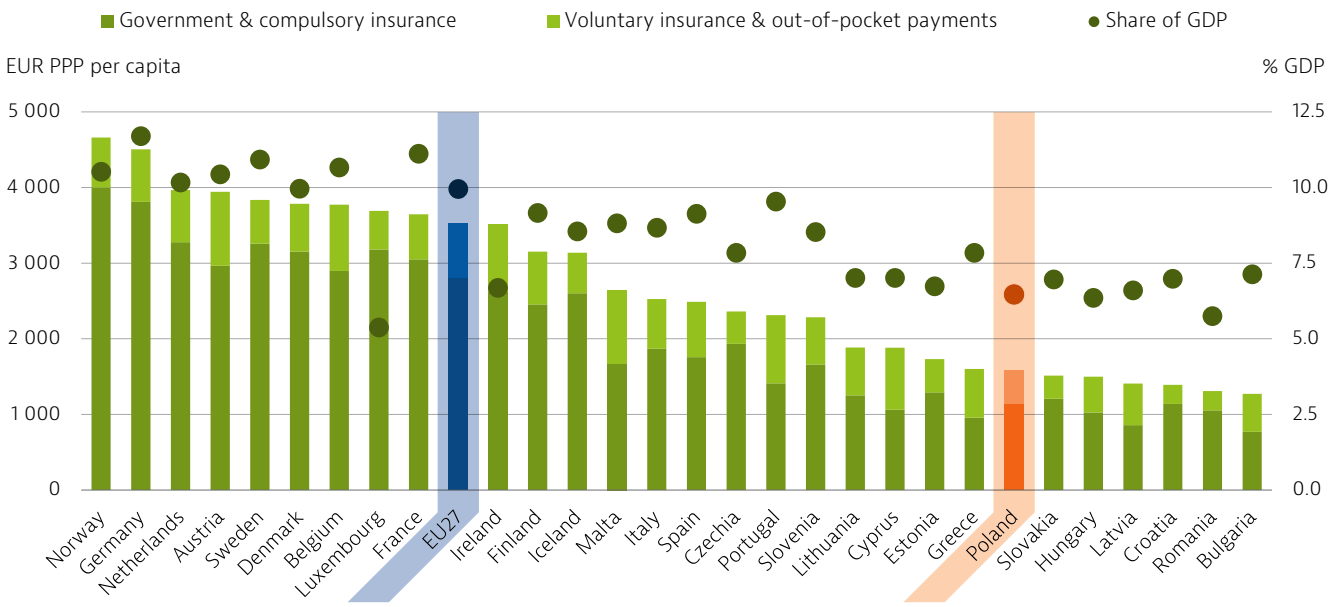
Most health expenditure is funded by SHI contributions from earmarked payroll taxes. Overall, public funding as a proportion of total expenditure was 71.8 % in 2019 – below the EU average of 79.8 %. Out-of-pocket (OOP) spending accounted for 20.1 % of all health spending, with the bulk spent on outpatient medicines (see Section 5.2). Around 8 % of total health expenditure is on voluntary health insurance (VHI), which is mainly in the form of group insurance packages covering occupational health and other health services purchased by employers for their employees. Interest in purchasing VHI has grown during the pandemic, probably due to difficulties in accessing public health services.

### Box 3. Additional public and private resources were marshalled to fight the COVID-19 pandemic

The government allocated a large financial injection of PLN 7.5 billion (EUR 1.7 billion) in 2020 to support the health sector response to the COVID-19 pandemic, with further support coming from the private sector, mainly through fundraising initiatives and donations. Most funds were transferred to the NHF, which used them to pay for health services. Extra funds were also used to compensate hospitals for revenue shortfalls that arose due to postponement of non-essential services, and to pay for increased provision of outpatient specialist services, such as remote consultations, and new services, such as patient helplines. The NHF also paid providers to cover the cost of meeting increased infection control requirements – including reorganisation of care pathways and purchasing of personal protective equipment (PPE) – and financed additional cash benefits for staff involved in the COVID-19 response.

*Source: COVID-19 Health System Response Monitor.*

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

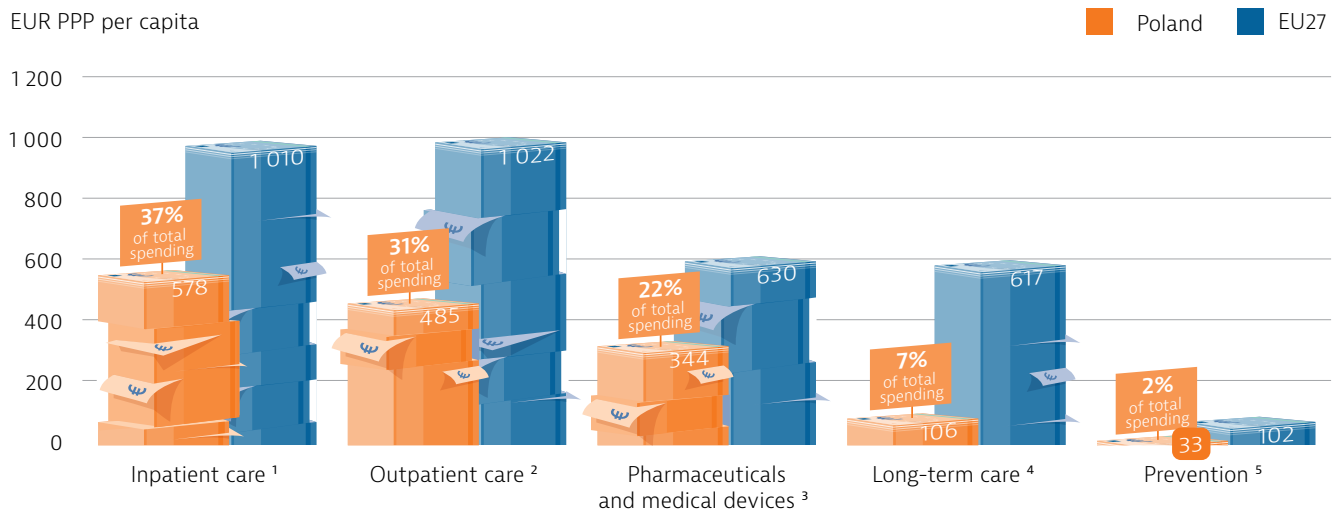



*Note: The EU average is weighted.*
*Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).*

## Inpatient care accounts for the majority of health spending

In 2019, over one third (37 %) of health expenditure in Poland was directed to inpatient care – the fourth highest proportion in the EU after Romania, Greece and Bulgaria. Outpatient care accounts for roughly another third (31 %) of the health budget. However, on a per capita basis, spending on both inpatient and outpatient care is roughly half of the EU average (Figure 9). Per capita spending on long-term care is also very low, making up 7 % of current spending compared to an EU average of 16 %. However, there is a shortage of formal long-term care facilities and services, and high reliance on informal care provided by family members. Per capita spending on preventive care in Poland is about a third of the EU average (EUR 33 compared to EUR 102).

**Figure 9. Most health spending goes on inpatient care, while spending on long-term care remains low**




*Note: The costs of health system administration are not included. 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 only spending for organised prevention programmes. The EU average is weighted.*
*Sources: OECD Health Statistics 2021, Eurostat Database (data refer to 2019).*

## The health system is skewed towards hospital care

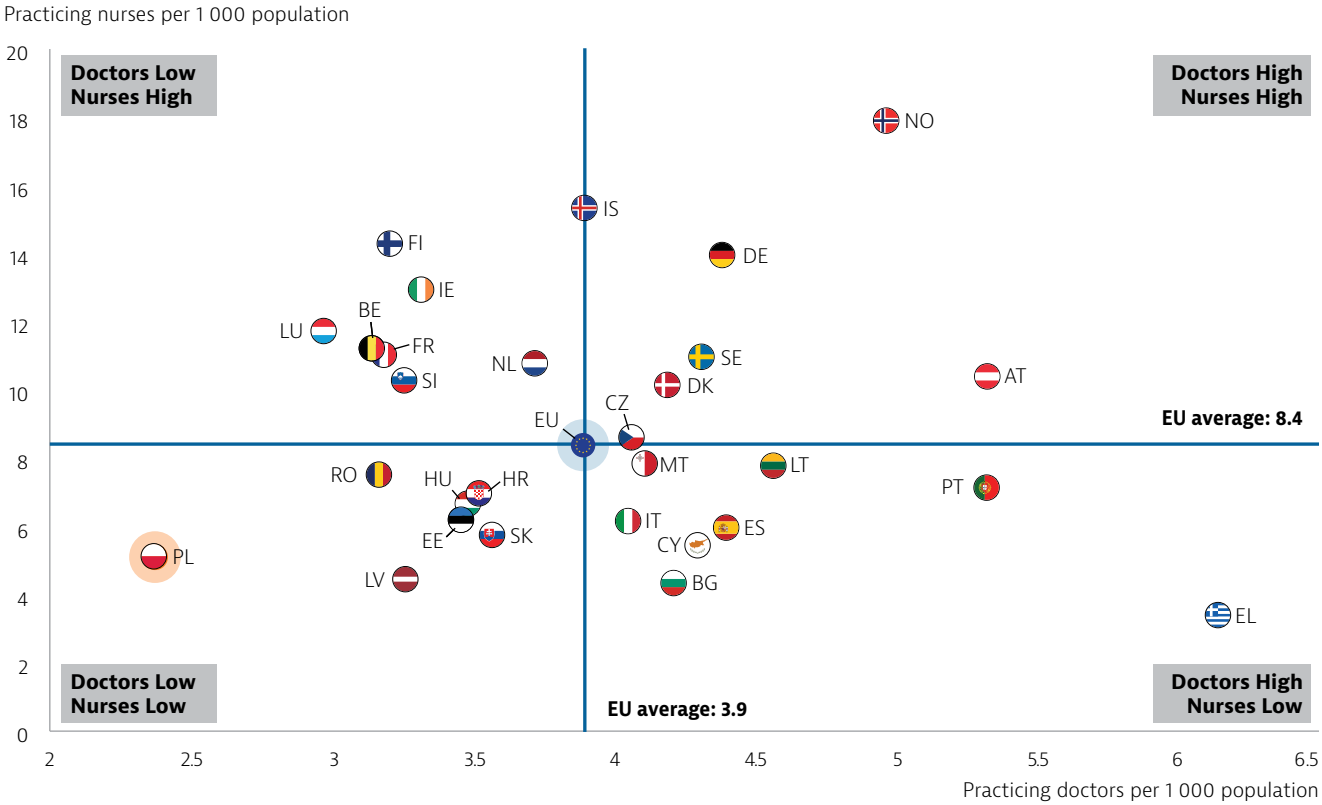
Poland's health care system is affected by large imbalances in the provision of services, with infrastructure concentrated in the hospital sector; insufficient provision of outpatient care, diagnostics and long-term care; and weak coordination between inpatient and other care. The number of hospital beds is high, at 6.2 beds per 1 000 population in 2019 compared to an EU average of 5.3, but these are unevenly distributed across the country. Current reform plans anticipate transformation of acute hospital beds into other types of beds, such as long-term care beds, rather than reducing their number.

## Poland faces acute shortages of doctors and nurses

According to Eurostat data, Poland has the lowest number of practising doctors per 1 000 population (2.4) in the EU, and the number of nurses (5.1 per 1 000 population) is also among the lowest (Figure 10). While the official national estimates appear to be higher – ranging from 3.4 to 4.4 doctors per 1 000 inhabitants (Kowalska-Bobko et al., 2021) – shortages of health workers have been reported in several regions, leading to difficulties in accessing health services. Shortages are particularly severe in small counties around large cities and in rural areas (see Section 5.2).

Primary care doctors generally serve as gatekeepers to more specialised care, although a referral is not needed to see certain specialists such as gynaecologists, obstetricians, oncologists, psychiatrists and dentists. Family medicine has traditionally not been a popular specialisation in Poland, but this has changed in the last few years, with the number of applications exceeding the number of specialisation places. To offset shortages, Poland allows internal medicine specialists and paediatricians to work in primary care. Nevertheless, the number of primary care doctors as a share of all doctors is the second lowest in the EU (9 % compared to the EU average of 21 %). Since 2019, young physicians who pass the state medical exam have been permitted to practise in primary care facilities (Kowalska-Bobko et al., 2021).

**Figure 10. The numbers of practising doctors and nurses in Poland are among the lowest in the EU**




*Note: The EU average is unweighted. 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: Eurostat Database (data refer to 2019 or the nearest year).*

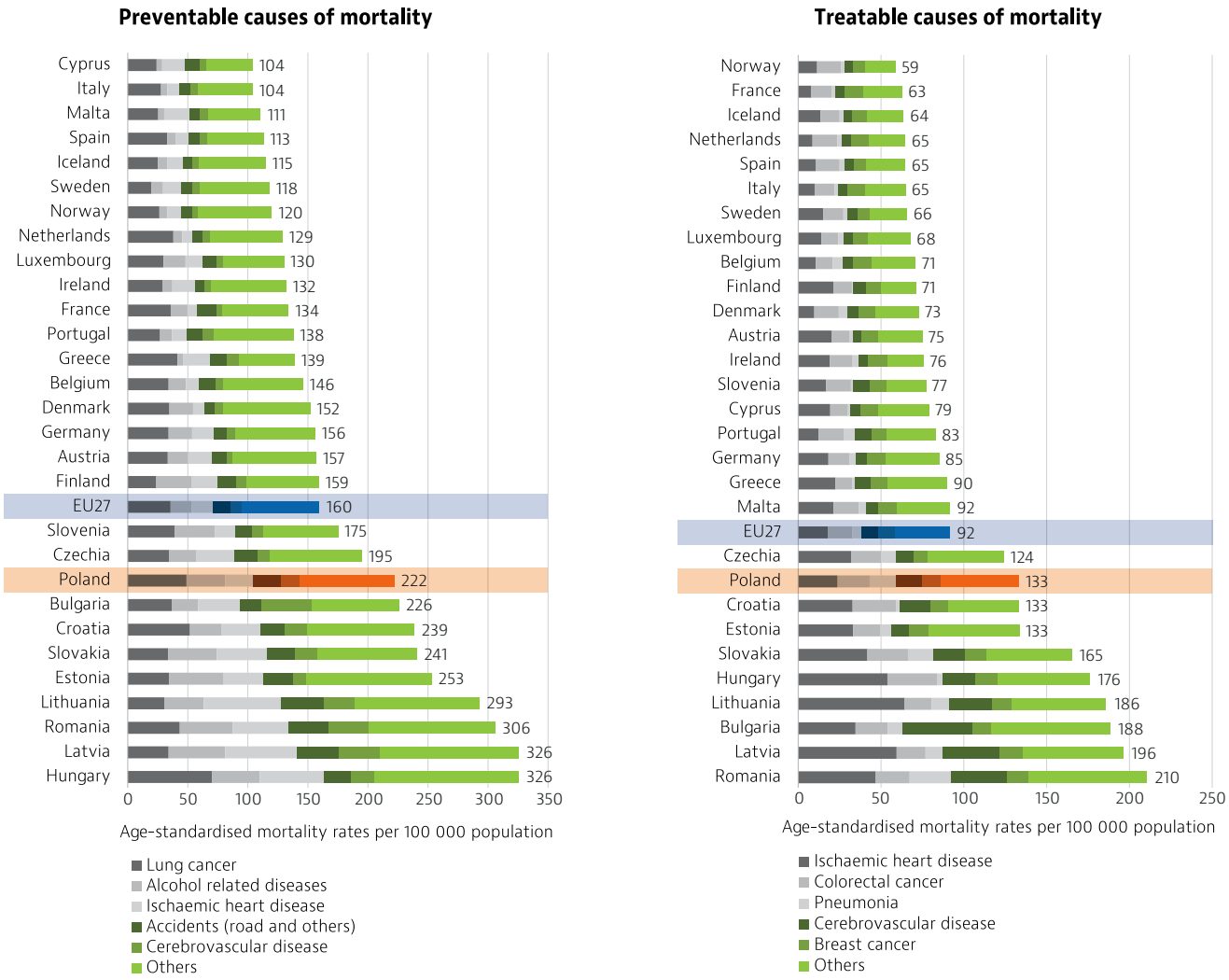
# 5 Performance of the health system

## 5.1 Effectiveness

### Preventable mortality remains higher than the EU average

Although Poland's mortality rate from preventable causes has decreased by 11 % since 2011, it continues to be higher than in most EU countries, exceeding the EU average by more than one third in 2018 (Figure 11). The high prevalence of risk factors, such as tobacco smoking and alcohol consumption, among the Polish population are key drivers of these higher preventable mortality rates.

**Figure 11. Mortality from preventable and treatable causes is higher than the EU average**




*Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.*
*Source: Eurostat Database (data refer to 2018, except France 2016).*

### Stronger tobacco control policies could further reduce smoking prevalence

Although prevalence of cigarette smoking has been decreasing in Poland among both men and women for several decades, about one fifth of the population are still daily smokers (see Section 3). Poland introduced comprehensive tobacco control regulations in the 1990s, but in 2015 the national tobacco control programme was discontinued, and annual tax increases on tobacco products were suspended. Only in 2020 was excise duty on tobacco products – including e-cigarettes – increased by 10 %.

## Preventable mortality due to alcohol-related diseases is much higher than in the EU and increasing

Preventable mortality due to alcohol-related diseases is about 50 % higher in Poland (49 per 100 000 in 2018) than the EU (32 per 100 000). Alcohol control measures have been weakened over the past 20 years, including lifting the ban on beer advertising on television (2001) and a 30 % reduction of excise taxes on spirits (2002) (Zatoński et al., 2021). In 2010, the alcohol industry began a marketing campaign associated with rising sales of smaller bottles of vodka. To counteract this, the government introduced an additional fee on alcohol sold in small bottles of up to 300 ml (from 2021), but this policy has already been largely circumvented by producers, who switched to 350 ml bottles shortly before the new tax came into force. In 2020, excise duty was increased by 10 % on all alcoholic drinks.

## More efforts are being made to tackle obesity

The increasing prevalence of obesity in Poland has traditionally been underestimated as a public health issue in medical and policy circles, but this appears to be changing: new policies to address the issue are being developed. Recent initiatives introduced by the NHF include the launch of a website dedicated to healthy eating, a cyclical health education campaign called "Prevention Wednesdays" and setting up a special team to review existing preventive programmes. From January 2021, a new "sugar tax" has been levied on sugar-sweetened beverages that contain caffeine or taurine. Improving diet, nutrition and physical activity has also been included as the first operational objective of the new National Health Programme for 2021-25.

## Demand for flu vaccination increased ten-fold in the 2020/21 season

Historically, influenza vaccination rates among people aged over 65 in Poland have been among the lowest in the EU. Currently, free flu vaccination is available for people aged over 75, while those aged between 65 and 75 are eligible for a 50 % discount. During the 2019/20 season, only about 15 % of people aged 65 and over were vaccinated, which is far below the WHO-recommended target of 75 %. Part of the available stock remained unused and had to be disposed of. In contrast, interest in getting the influenza vaccination in the 2020/21 season was about 10 times higher, and the government authorised the purchase of about 2.8 million doses – almost double the amount used in the previous season. However, due to limited supply and increased demand in other countries, only about 650 000 doses were available at the start of the season, and almost all pharmacies reported shortages.

## Mortality from treatable causes remains high

Mortality from causes that can be avoided through timely and effective health care interventions was substantially higher than the EU average in 2018 (see Figure 11). Improvements in treatable mortality rates over the last decade at least partly reflect investments in cardiac care, which have improved the quality of acute care: the 30-day mortality rate in people admitted for acute myocardial infarction (AMI) in Poland fell from 7.1 % in 2007 to 4.1 % in 2017, and is now lower than the average for the 22 EU countries with available data (6.5 %). A new model of complex patient care for AMI patients, implemented in late 2017, is meant to improve rehabilitation and secondary prevention, and has already shown promising improvements in the health outcomes of participating patients (Sagan et al., 2021).

## Cancer survival rates have improved but are still relatively low

Although cancer survival rates have increased since 2000, they remain relatively low (Figure 12), and mortality from some cancers (colorectal, breast and prostate) has increased over the same period. The National Cancer Plan for 2020-30 highlights that problems include low participation in screening programmes – which currently cover breast (54 % of target population in 2019), cervical (17 %) and colorectal cancer (18 %) – and long waiting times for diagnostics and treatment.

The introduction of a fast-track pathway for cancer patients in 2015 brought about only a marginal reduction in waiting times for these patients. Coordinated care for five cancers (breast, lung, ovarian, colon and prostate), with standard diagnostic and therapeutic pathways and monitoring of quality through cancer registers, has been piloted since early 2019 within the National Oncology Network. The pilot is expected to be rolled out nationwide from early 2022. The Network is one of the key elements of the National Cancer Plan, which is aligned with the Europe's Beating Cancer Plan (European Commission, 2021a).

**Figure 12. Five-year cancer survival rates are generally lower than the EU average**

| Prostate cancer | Childhood leukaemia | Breast cancer | Cervical cancer | Colon cancer | Lung cancer |
|---|---|---|---|---|---|
| Poland: 78 % | Poland: 87 % | Poland: 77 % | Poland: 55 % | Poland: 53 % | Poland: 14 % |
| EU23: 87 % | EU23: 85 % | EU23: 82 % | EU23: 63 % | EU23: 60 % | EU23: 15 % |

*Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.*
*Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.*

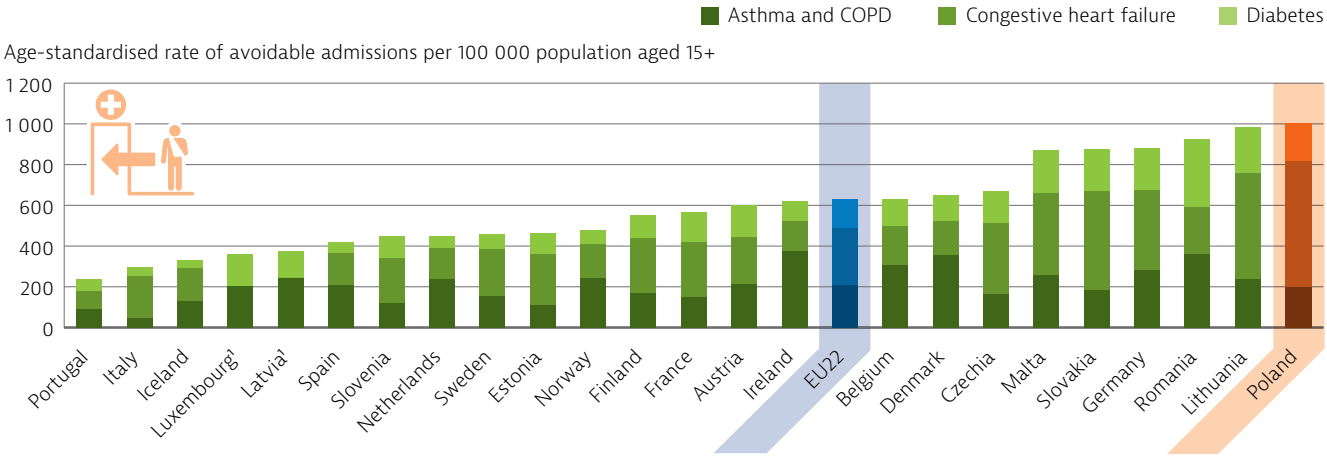
### The pandemic paused cancer screening activities but the only affected treatment timeline was surgery

The pandemic led to an interruption of cancer care, with cancer screening effectively paused in April-May 2020 and then resumed but at lower levels (National Institute of Oncology, 2021). Diagnostic services were also reduced, with the number of new cancer diagnoses falling by 19 % in 2020 compared to the previous year. Access to treatment was not significantly affected, except for cancer surgery, where the number of patients was 15 % lower in 2020 compared to 2019. Waiting time from cancer diagnosis to treatment did not change significantly in 2020 compared to 2019. However, the number of patients participating in chemotherapy programmes, which are provided in multidisciplinary oncology centres, was 15 % higher in 2020 than 2019.

### Avoidable hospitalisation rates are among the highest in Europe

Poland's hospitalisation rates for conditions that could have been effectively managed in outpatient settings are among the highest in the EU (Figure 13). These high rates point to deficiencies in the provision of primary and outpatient specialist care. Since 2018, a new organisational model has strengthened the role of primary health care in management of the 11 most prevalent chronic conditions – including chronic heart failure and diabetes – and is expected to contribute to reducing avoidable hospitalisation rates.

**Figure 13. Many hospital admissions could be prevented through stronger primary care**




*Note 1: Data for congestive heart failure are not available in Latvia and Luxembourg.*
*Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).*

## 5.2 Accessibility

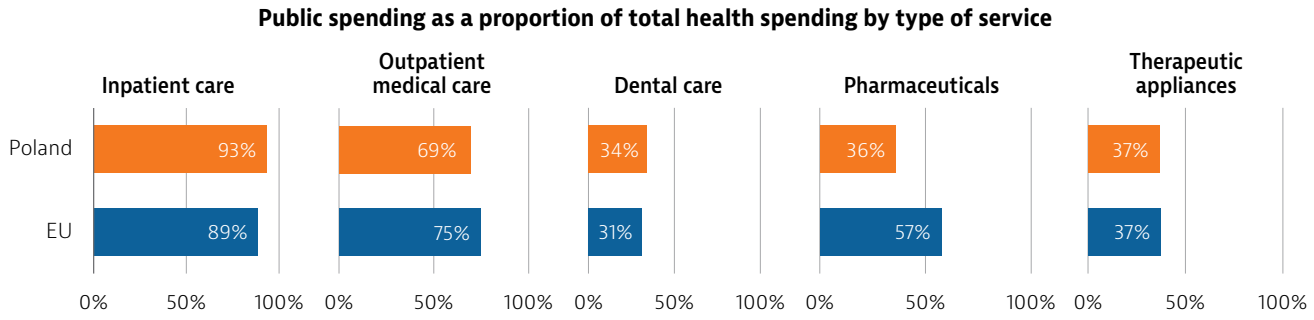
### Access to care is close to universal, but some coverage gaps remain

Compulsory health insurance covers 91 % of the population. Most uninsured Poles (9 %) are citizens living abroad but still registered as resident in Poland, and only a very small number are resident citizens employed on casual or atypical work contracts and workers in the informal economy. Some population groups (including pregnant women and children under 18) have the right to access publicly financed health care irrespective of their insurance status,

and people without SHI coverage have access to outpatient emergency medical care and primary care. All residents, regardless of insurance status, are also entitled to free services related to prevention and treatment of COVID-19.

The scope of services covered under SHI is broad and includes primary care, outpatient specialist and hospital services. Access to primary care is free at the point of use, and extensive public financing means that there are no cost-sharing requirements for inpatient care services (Figure 14). Certain vulnerable population groups have access to additional benefits, such as dental care for young children. Nevertheless, key coverage gaps exist for outpatient medicines, outpatient medical devices, dental care and long-term care, which is highly reliant on informal carers.

### Figure 14. Public spending on pharmaceuticals is low

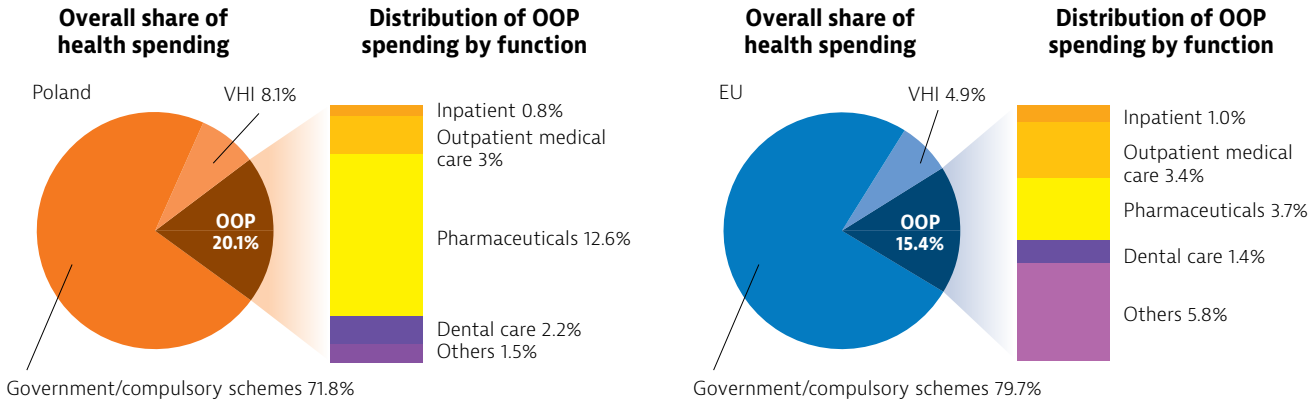



*Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.*
*Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).*

## Outpatient medicines are the largest driver of catastrophic spending

The Polish health system has low levels of financial protection and high OOP payments for outpatient medicines compared to many other countries in Europe. Public pharmaceutical spending, at 36 % of total expenditure, is the second lowest in the EU after Bulgaria. Outpatient medicines account for most OOP spending (Figure 15) and are the main driver of catastrophic spending (Tambor & Pavlova, 2020)[2]. Use of non-prescribed medicines (nominally prescription-only medicines that are purchased over the counter without a prescription) is very high: these account for over three quarters of all OOP spending on medicines.

### Figure 15. Pharmaceuticals absorb most out-of-pocket spending on health




*Note: The EU average is weighted. VHI also includes other voluntary prepayment schemes.*
*Sources: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).*

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

In 2016, Poland introduced exemption mechanisms for outpatient prescription charges, including granting free access to a broad range of medicines for older people. Since 2020, pregnant women have had free access to certain medicines. However, mechanisms to protect the most vulnerable population groups – such as those in low-income households or with chronic conditions – are weak, and spending on outpatient medicines is particularly high among pensioners, people with disabilities and households in rural areas. According to national statistics, approximately 7.5 % of households reported that they were often or sometimes unable to purchase prescribed or recommended medicines in 2016.

### Availability of medicines has improved but some problems remain

Price control measures introduced in 2012 to reduce government spending on pharmaceuticals have resulted in large price differences between the prices payable in Poland and those elsewhere in Europe. This has given rise to some instances of parallel exports and shortages of some drugs on the Polish market. Counter-measures introduced in 2017 limited the extent of legal exports, but the problem of illegal exports remains, such as through "reverse chain of distribution", where retail pharmacies sell in-demand medicines back to wholesalers (Gałązka-Sobotka et al., 2019). The number of essential medicines at risk of shortages increased from 178 in early 2017 to 388 in early 2019. To counter this problem, in 2019, the government introduced criminal liability for illegal export of medicines and improved monitoring of the trade in medicines and their availability.

The number of new drugs covered under SHI has increased significantly in recent years. In 2017-19, 66 new active substances were registered for reimbursement, including 28 cancer drugs. However, due to the complexity of the reimbursement process and the limited financing of the NHF, it still takes about 2-3 years from central registration by the European Medicines Agency for a new active substance to be included in the benefits package in Poland (Kowalska-Bobko et al., 2021). The new EU pharmaceutical strategy for Europe, adopted by the European Commission in November 2020, may offer avenues for improving the availability of innovative pharmaceuticals in Poland (European Commission, 2020).

### Workforce shortages persist despite increased financial incentives

The age composition of the current health workforce gives rise to concerns about future supply, particularly among nurses and midwives, with 54 % of nurses and 51 % of midwives aged over 50 (Ministry of Health, 2021). Continued outward migration of health workers and the heavy mental health burden experienced during the COVID-19 pandemic further exacerbate these concerns. Since 2012, the Ministry of Health has issued regulations specifying medical priority areas where there are acute staff deficits and more residency places, and higher remuneration has been offered to doctors pursuing these priority specialisations. Since 2017, the basic salaries of health professionals have been progressively increased to reach government-set minimum targets by the end of 2021. Financial incentives were also introduced in 2019 to attract physicians to rural areas (Kowalska-Bobko et al., 2021). During the pandemic, regulations around the recruitment of international medical staff were relaxed, despite previous opposition.

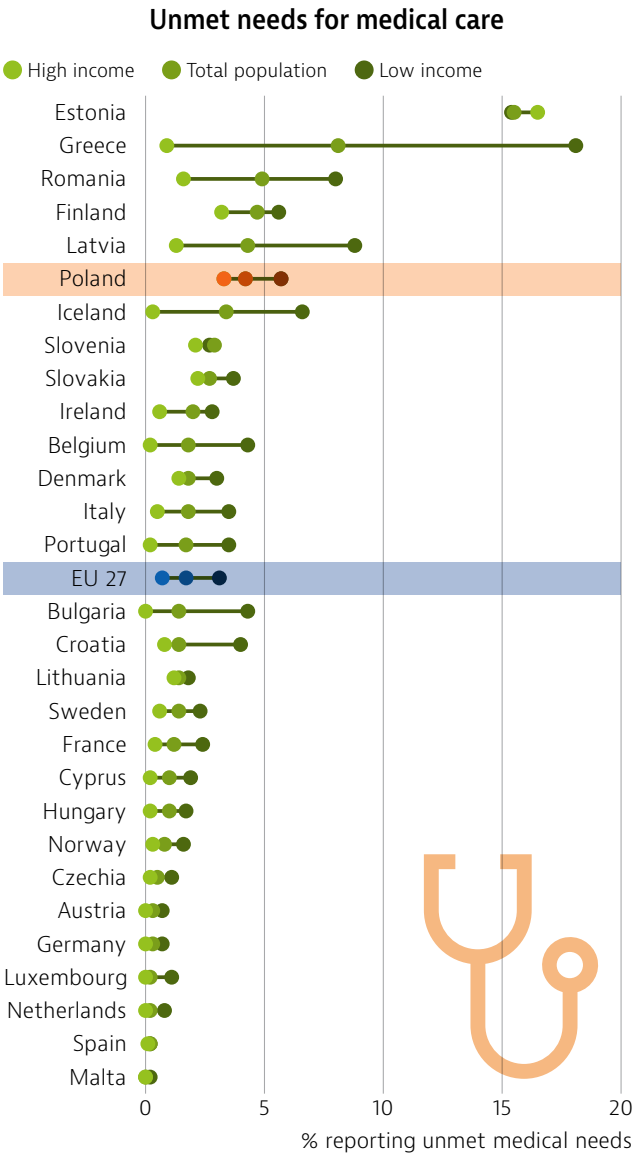
### Limited public financing and waiting times exacerbate access barriers

Although primary and inpatient care do not require cost-sharing from patients in Poland, their access to these services may still be constrained in practice by the limited financial resources of the NHF, as well as by the acute health workforce shortages, which result in long waiting times (see Section 4). There are limits on the volume of services contracted by the NHF, and no waiting-time guarantees are in place. In 2019, the average waiting time for specialist services (specialist consultations, diagnostics, treatment procedures) was 3.8 months, compared to 2.9 months in 2016, with the longest waiting times reported for endocrinology (11.6 months) and orthopaedics (10.9 months). Problems with accessing outpatient services may be one reason why people self-treat using non-prescribed medicines. This, in turn, may partly explain the high share of OOP spending directed to outpatient pharmaceuticals. Long waiting lists also encourage those who can afford it to use private care providers – usually paying directly out of pocket.

In 2019, 4.2 % of the Polish population reported unmet needs for medical examinations due to either costs, distance or waiting times (the EU average was 1.7 %). There were differences across income groups: 5.7 % of those in the lowest income quintile reported unmet needs compared to 3.3 % of those in the highest (Figure 16). Conversely, only 1.9 % of the Polish population reported having experienced unmet needs for dental care, which is below the EU average of 2.8 %. The gap in reported unmet needs for dental care by income was also much narrower (1.4 % compared to 2.7 % across the EU). During the first year of the COVID-19 pandemic, a survey found that over one quarter of Poles (28 %) reported unmet needs for medical examination or treatment (Eurofound, 2021).[3]

3. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

**Figure 16. Prior to the pandemic, unmet medical care needs in Poland were above the EU average**




*Note: 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 2019, except Iceland 2018).*

### Telemedicine supported specialist care, but access was severely limited for non-COVID-19 patients

As in many other countries in Europe, all non-emergency hospital procedures were cancelled in the early months of the COVID-19 crisis. Primary care clinics continued to operate, providing remote services (usually by telephone), with special guidelines developed for providing teleconsultations during the pandemic. Specialist outpatient consultations were more difficult to conduct remotely, as these rely more on conducting a physical examination and/or diagnostic tests (the availability of which was also limited). Nevertheless, survey data show that 62 % of the population used telehealth services in the first year of the pandemic, which was considerably higher than the EU average of 39 % (Eurofound, 2021). This was enabled by pre-existing tools and platforms, such as the Patient's Internet Account, and was further supported by countrywide implementation of e-health solutions (see Section 5.3) and through various information technology initiatives implemented during the pandemic. Elective care was severely constrained throughout the pandemic due to postponement of treatments and re-profiling of hospitals as COVID-19 hospitals.

## 5.3 Resilience

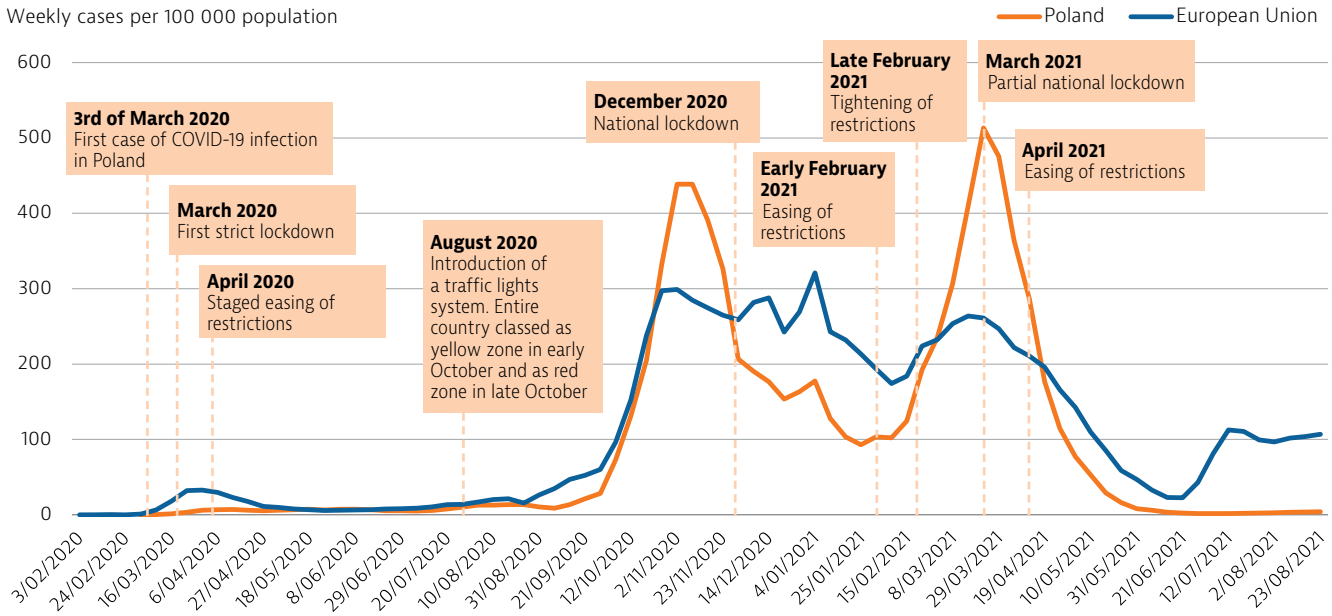
This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic.[4] As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Poland, with over 75 000 COVID-19 deaths recorded between January 2020 and the end of August 2021. Measures taken to contain the pandemic also had an impact on the economy. Polish GDP fell by 2.3 %, but this is less than the EU average of 6.2 %.

### Swift pre-emptive action protected the country during the first wave of the pandemic

Poland was very quick to react with protective measures once the first cases of COVID-19 were detected within its borders (Figure 17). Steps such as closures of schools, bans on mass gatherings and export bans for certain medicines were taken even before the state of epidemiological emergency was declared on 14 March 2020 (see Box 2). The government introduced infection prevention measures, including closures of non-essential businesses, a ban on non-essential movement for the population and the closure of national borders. Restrictions were progressively relaxed from the end of April 2020, but with few restrictions in place over the summer, the number of COVID-19 cases rose quickly. The government responded with localised restrictions, following a "traffic light" system. By the end of October 2020, the entire country was effectively again in lockdown, and the number of new cases peaked in late November 2020. A second national lockdown was introduced for 20 days from 28 December 2020. Restrictions were relaxed from early February 2021, although the number of cases was rising again. After record levels of cases were recorded, a third (soft) national lockdown was implemented from 20 March 2021. Easing of restrictions started at the end of April, ahead of the summer holidays when case numbers remained relatively low and stable.

4. *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 Assessment, 2020).*

**Figure 17. COVID-19 cases were kept low initially but in autumn 2020 they surged well above the EU average**

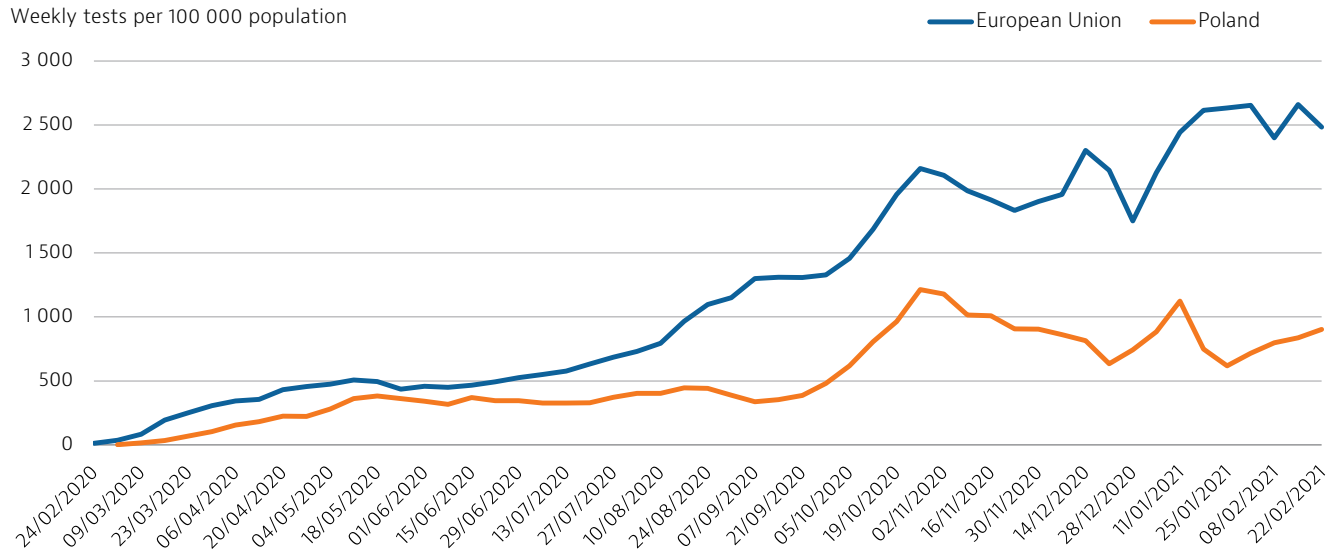



*Sources: ECDC for COVID-19 cases and authors for containment measures.*

## Both testing and contact tracing capacity were low

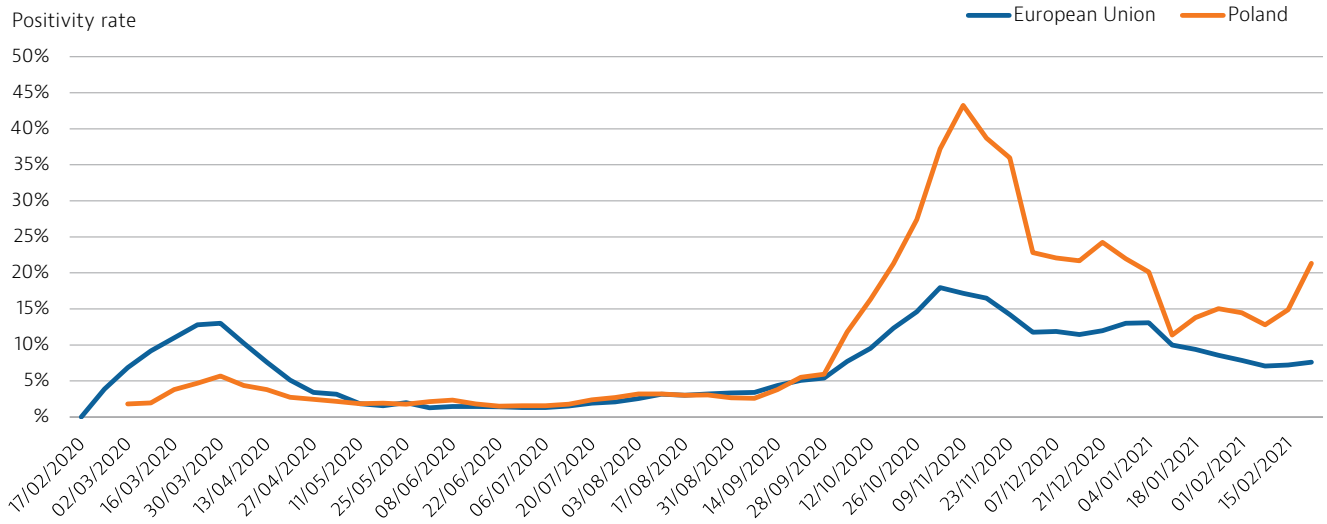
Despite efforts to scale up testing capacity by establishing drive-through testing points (their number increased from 180 to about 660 between March 2020 and April 2021), and the use of special ambulances (so-called "swab buses") to collect samples from people in quarantine, testing capacity remained low. The gap between the number of weekly tests in Poland and the EU average widened sharply after summer 2020 (Figure 18). The high test positivity rates, which reached 40 %, reflect Poland's testing strategy, whereby mainly symptomatic patients were tested (Figure 19). This means that the true number of COVID-19 infections in the country is underestimated (see Box 1). Given the initial success of the containment measures, contact tracing capacity was deemed adequate in spring 2020, so it was not expanded over the summer to address personnel shortages and underfunding of the State Sanitary Inspectorate.

**Figure 18. COVID-19 testing volumes failed to keep up as infection spread in October 2020**




*Note: The EU average is weighted (the number of countries included in the average varies depending on the week).*
*Source: ECDC.*

**Figure 19. Test positivity rates were very high in October 2020**




*Note: The EU average is weighted (the number of countries included in the average varies depending on the week).*
*Source: ECDC.*

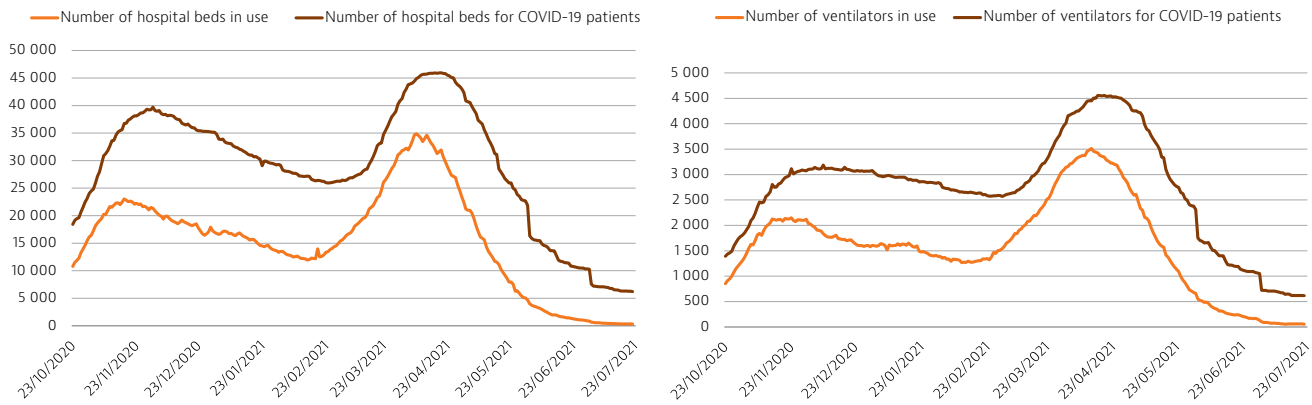
## COVID-19 care initially used the extensive hospital capacity, but this changed during the pandemic

For many years seen as a source of inefficiency, the relatively high number of hospital beds became an asset during the pandemic when infection rates soared. In 2019, Poland had 10.1 intensive care unit beds per 100 000 people, which was more than in many countries in the EU (and nearly double the rate in Finland, for example).

Bed capacity for treating COVID-19 patients was initially secured by suspending all elective care and reserving beds for treating COVID-19 cases. A total of 22 hospitals – at least one in each voivodeship – were transformed into COVID-19 hospitals, designated for the sole use of COVID-19 patients. This secured a total of 10 000 beds. However, these decisions were sometimes controversial, as many of the reserved facilities remained severely underutilised before autumn 2020, and the number of COVID-19 beds was progressively reduced. The situation changed from October 2020, with both bed and respirator capacities coming under strain, despite the number of COVID-19 beds increasing to 45 000 (Figure 20). Other measures to increase bed capacity included repurposing of existing facilities – for example, adapting hospital wards to treat COVID-19 cases and separating them from other wards with physical barriers to keep patients apart, and building field hospitals.

Over the course of the pandemic, this hospital-centred model of COVID-19 response was replaced with one centred on primary health care: most patients with no or mild symptoms were looked after by primary care doctors rather than at infectious diseases hospitals, and most diagnostic tests were ordered at the primary health care level (Ministry of Health, 2020).

**Figure 20. Hospital bed and respirator capacities came under strain in autumn 2020 and spring 2021**




*Source: Based on Ministry of Health data.*

### Issues with procurement of personal protective equipment and other supplies persisted throughout 2020

The availability of equipment, such as personal protective equipment (PPE) and ventilators, was initially limited, but stocks were built up quickly – mainly through centralised procurement from abroad. Private companies provided material support by, for instance, donating cleaning and disinfectant products to hospitals or providing free courier services to help to deliver PPE supplies. Shortages of some pharmaceuticals and other medical products (such as flu vaccines) were also acute throughout 2020 (Kowalska-Bobko et al., 2021).

### Given pre-existing shortages, it was difficult to scale up the number of medical professionals

Efforts to increase hospital capacity had to ensure sufficient medical staff, which was especially challenging due to pre-existing shortages (see Sections 4 and 5.2). During the early stages of the pandemic, measures to maintain the capacity of the existing health workforce included asking health professionals to work extra hours; cancelling leaves of absence; suspending limitations on night shifts and on-call duties; prohibiting health workers from leaving the country; and automatically extending the operating licences of practising health professionals. Health workers were also redeployed to work in other settings, such as in infectious diseases departments or elsewhere where help was needed. To further increase capacity, volunteering by final-year medical and nursing students was encouraged, and these students were allowed to perform support roles, such as conducting contact tracing interviews. Poland also simplified procedures to allow non-practising nurses, midwives and paramedics to return to work. To speed up the COVID-19 vaccination rollout, physiotherapists, pharmacists and laboratory diagnosticians who completed relevant training were authorised to administer the vaccines.

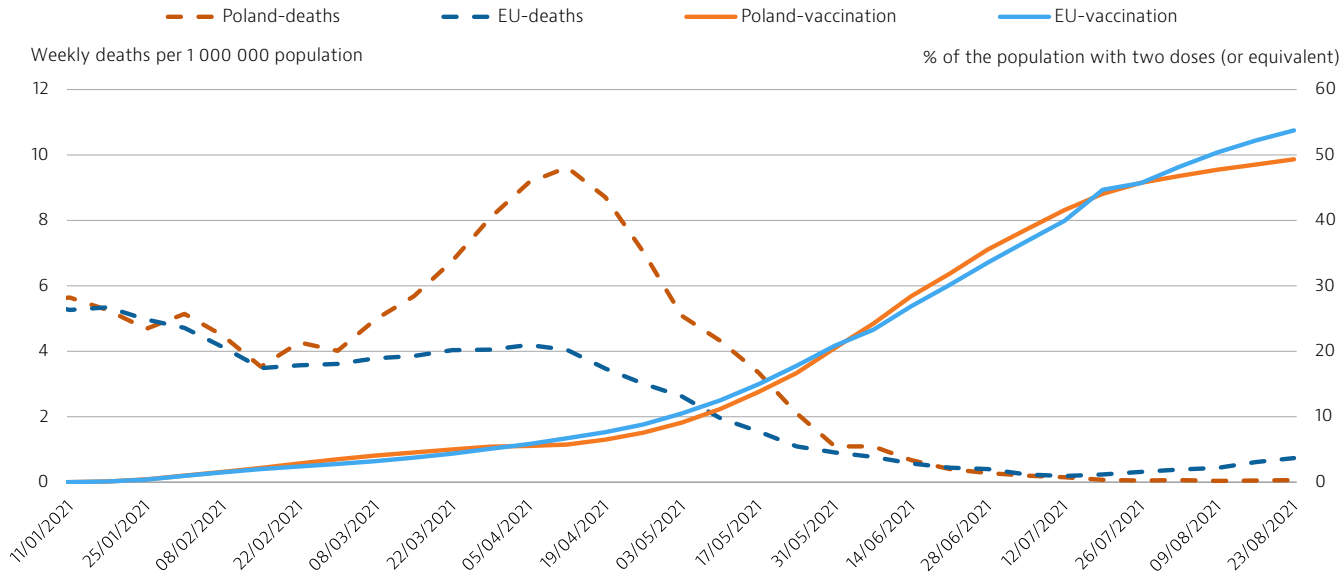
Health workers involved in the COVID-19 response received financial (higher remuneration and bonuses), material (free childcare, public transport and hotel accommodation) and psychological (dedicated helplines) support. However, plans in October 2020 to grant further financial bonuses to all health personnel involved in COVID-19 care were scrapped on the basis that it would have put an unacceptably large strain on the national budget. While additional benefits were later authorised, the amounts were smaller than what was originally planned.

### Field hospitals were used as COVID-19 vaccination points

With the introduction of vaccinations, most of the temporary field hospitals that had been built were turned into vaccination sites. Vaccines were also administered in hospitals, clinics and other health facilities, with over 6 100 vaccination points nationwide. As of late August 2021, 51 % of the population had received two doses of vaccine (or equivalent), which is slightly below the EU average (Figure 21). Vaccine hesitancy is one factor hampering vaccination coverage (Sowa et al., 2021).

COVID-19 vaccines are free of charge for all legal residents, which is particularly relevant for the large number of Ukrainian citizens who work or study in Poland. Health professionals and cancer patients receiving chemotherapy or radiotherapy were initially prioritised. Residents of social care facilities, people aged over 60, those in the armed forces, police officers and teachers received their jabs during the first stages of the vaccination campaign, which progressively opened up to the entire population, including children aged 12-15. From May 2021, companies with over 300 employees could join the vaccination campaign, and some offered financial incentives to encourage employees to get vaccinated. As well as inoculating younger Poles, the government took other steps to boost vaccination rates, such as introduction of a financial bonus for family physicians to incentivise provision of vaccinations and announcing a range of financial incentives to encourage people to register for vaccination.

**Figure 21. About half of the population was vaccinated by August 2021**




*Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).*
*Sources: ECDC for COVID-19 cases and Our World In Data for vaccination rates.*

## Problems with data collection undermined capacity for data-informed decision making

Established epidemiological surveillance and early warning systems ensured monitoring at the start of the pandemic. However, due to underfunding and understaffing of these systems, together with missing communication links to enable effective pooling of data, they were put under severe strain. There were some discrepancies at the initial stage in the number of COVID-19 cases reported between data published at the county and voivodeship levels, as well as aggregate data published by the Ministry of Health. Before December 2020, there was no official database drawing together all historical data from the county sanitary-epidemiological stations. Unofficial crowdsourced databases were developed, but from November 2020 only the central government portal was authorised to publish COVID-19 data.

## Progress has been made in the implementation of e-health solutions

Great effort has been made in recent years to implement an electronic health data platform and related e-health tools. From 2019, medical records have to be kept electronically by health care institutions and doctors. From January 2020, with a few exceptions, only e-prescriptions have been allowed. Implementation of e-referrals started in January 2021 in facilities that have the necessary information technology capacity, and from July 2021 all health care providers are expected to exchange medical health records electronically.

The pandemic response has shown that successful implementation of these tools is closely connected to the level of digital skills of both health care providers and service users. Poland's efforts in the area of digital health will be supported through the European Health Data Space initiative, which aims to promote better exchange and access to different types of health data, including electronic health records, genomics data and data from patient registries, and to support health care delivery, health research and policy making (European Commission, 2021b).

## EU funding is contributing to greater investment in health infrastructure including during the pandemic

Poland was the largest recipient of EU funding between 2014 and 2020, having received a total of EUR 105 billion from the EU budget (European Commission, 2021c). It has made submissions for a further EUR 170 billion within the 2021-27 Multiannual Financial Framework and the newly established Recovery and Resilience Facility to invest strategically in the health sector. These set out plans to invest in health sector infrastructure and digitalisation, including further development of e-health solutions and investments in human resources, research and development, and the pharmaceutical sector.

# 6 Key findings

- High mortality from COVID-19 caused life expectancy in Poland to fall temporarily by 1.4 years between 2019 and 2020, and widened the gap in life expectancy at birth between Poland and the EU average to four years. Inequalities in life expectancy by gender and education remain pronounced.

- Behavioural and environmental risk factors account for nearly half of all deaths in Poland. Although decreasing, smoking rates remain high and alcohol consumption is also higher than the EU average. Obesity is a growing health issue, and policy efforts to tackle it have increased, including the introduction of a "sugar tax" on beverages in 2021. Preventable mortality is far above the EU average, drawing attention not only to the relatively low spending on health promotion and disease prevention but also to the scope for strengthening tobacco and alcohol control measures.

- The share of GDP dedicated to health remains low, accounting for only 6.5 % in 2019, and per capita funding for health is much lower than the EU average. Although the benefits package is fairly broad with no cost sharing for primary and inpatient care, financial coverage of outpatient medicines is low: public pharmaceutical spending is among the lowest in the EU, and outpatient medicine costs are the single largest driver of catastrophic spending on health in Poland. Over three quarters of OOP spending on medicines goes on directly purchased medicines for self-treatment – possibly due to long waiting times to access specialist care. Efforts have been made in recent years to control the prices of medicines and to expand access, particularly for older people, through co-payment exemptions.

- Low levels of financing are likely contributors to health workforce shortages, which are more severe than in most EU countries. These shortages contribute to access problems such as long waiting times, particularly in rural areas. In the EU, Poland has among the lowest number of doctors and nurses per capita. Further, many doctors and nurses are approaching retirement age, which exacerbates concerns about future supply. During the pandemic, regulations around the recruitment of international medical staff were relaxed, despite previous strong opposition.

- The early COVID-19 response allowed Poland to contain the first wave of infections effectively. It also offered an opportunity to build contingencies, but the health system quickly came under strain when the infection rate surged during the second wave. Capacity issues affected the large inpatient sector, where shortages of health workers proved to be a major bottleneck to upscaling care, even when infrastructure such as additional intensive care unit beds was mobilised quickly. Over the course of the pandemic, primary health care increasingly became the first line of response to COVID-19.

- Thanks to the use of telemedicine solutions and supportive platforms and tools, it was largely possible to maintain primary care services during the pandemic. This was more difficult with specialist consultations, which tend to rely on physical examinations and diagnostic tests. Provision of inpatient care for non-COVID-19 patients suffered the most, as health resources were reallocated to treatment of COVID-19 patients. Poland has bolstered access to the COVID-19 vaccine by assembling a range of vaccination sites to administer the inoculation. In the face of some vaccine hesitancy, it has also provided incentives to encourage the population to get vaccinated.

# Key sources

Sowada C et al. (2019), *Poland: health system review. Health Systems in Transition*, 21(1):1-235.

OECD/EU (2020), *Health at a Glance: Europe 2020 – State of Health in the EU Cycle*. Paris, OECD Publishing.

# References

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), *Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement.*

Eurofound (2021), *Living, working and COVID-19 survey, third round* (February-March 2021).

European Commission (2020), *A pharmaceutical strategy for Europe.*

European Commission (2021a), *Europe's Beating Cancer Plan.*

European Commission (2021b), *The European Health Data Space.*

European Commission (2021c), *European Structural and Investment Funds: Country data for Poland.*

Gałązka-Sobotka M et al. (2019), *Przyczyny ograniczonej dostępności leków w Polsce: diagnoza i propozycje rozwiązań*. Warsaw, Uczelnia Łazarskiego, Instutut Zarządzania w Ochronie Zdrowia.

GUS (2021), *Komunikat w sprawie tablicy średniego dalszego trwania życia kobiet i mężczyzn.* Warsaw.

Kowalska-Bobko I et al. (2021), *Sustainability and resilience in the Polish health system.* London, Partnership for Health System Sustainability and Resilience.

Ministry of Health (2020), *Strategia walki z pandemią COVID-19.* Wersja 3.0. jesień 2020, Warsaw.

Ministry of Health (2021), *Zdrowa przyszłość. Ramy strategiczne rozwoju systemu ochrony zdrowia na lata 2021-2027, z perspektywą do 2030 r.*

National Institute of Oncology (2021), *Wpływ pandemii COVID-19 na system opieki onkologicznej*, Warsaw.

Sagan A et al. (2021), Improved coordination of care after acute myocardial infarction in Poland since 2017: promising early results. *Health Policy,* 125(5):587-92.

Sowa P et al. (2021), COVID-19 Vaccine Hesitancy in Poland—Multifactorial Impact Trajectories, *Vaccines 2021*, 9(8), 876.

Tambor M, Pavlova M (2020), *Can people afford to pay for health care? New evidence on financial protection in Poland*. Copenhagen, WHO Regional Office for Europe.

WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021), COVID-19 Health Systems Response Monitor – Poland.

Wojtyniak B, Goryński P, eds. (2020), *Sytuacja zdrowotna ludności Polski i jej uwarunkowania.* Warsaw: Narodowy Instytut Zdrowia Publicznego– Państwowy Zakład Higieny.

Zatoński WA et al. (2021), Alcohol-related deaths in Poland during a period of weakening alcohol control measures. *JAMA,* 325(11):1108-09.

## 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 | | |

European Commission

# State of Health in the EU
## Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2021), *Poland: Country Health Profile 2021, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264465664 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

OECD
BETTER POLICIES FOR BETTER LIVES

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