Country profile: Poland

At a turning point: Healthcare systems in Central and Eastern Europe

AmCham EU
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Written by

ECONOMIST IMPACT

About this supplement

This country profile is a supplement to *At a turning point: Healthcare systems in Central and Eastern Europe*, a report produced by Economist Impact and supported by the American Chamber of Commerce to the EU. It features detailed data and analysis on the dynamics at play in Poland.

The main report presents a broad view of health system and funding dynamics in 13 European countries, including eight countries in central and eastern Europe (CEE)—Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania, Slovakia and Slovenia—and five countries in western Europe—Austria, Germany, France, Portugal and the UK. This report aims to highlight key differences and commonalities in healthcare financing and policy approaches as governments rise to the challenge of managing the interlinked dynamics of population health and economic uncertainty following the covid-19 pandemic.

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Key priorities for Poland

Increase investment towards **long-term** and **preventative care**

It should be a priority following covid-19 and its long-term impacts as well as its link to noncommunicable diseases (NCDs) and the projected increase in the older population.

Develop effective **adaptation measures**

The objective is to help the healthcare system cope with the influx of refugees entering Poland. This could involve allocating additional funds into the healthcare system, extending health coverage around specific services such as mental health services and communication support.

Address the ongoing **brain drain**

Increasing the salaries of healthcare workers or implementing sustainable retention measures should be prioritised. For example, granting financial scholarships on the condition that they work in their home country for a certain amount of time is a retention measure that has been adopted in other CEE countries.

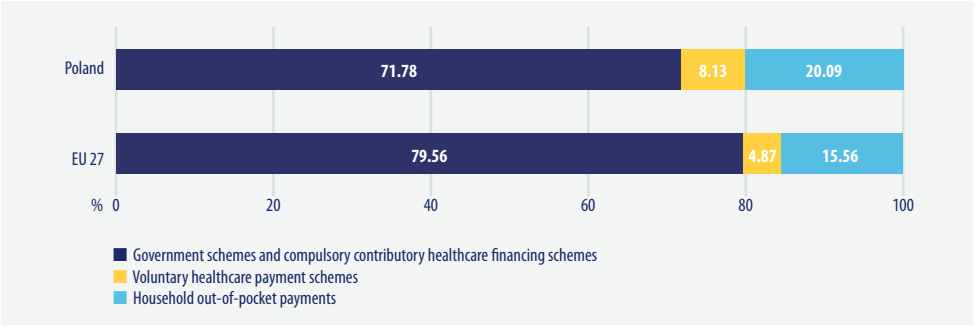
1. Healthcare financing

Healthcare spending in Poland at 6.45% of GDP in 2019 is significantly below the EU27 average of 9.9%. While healthcare spending per head has increased from €676 (or €1,286 in PPS terms) in 2014 to €906 (or €1,636 in PPS terms), it is still well below the EU27 average of over €3,000 per head.[1] While the government plans to increase spending on health, the impact of the war in Ukraine and the ongoing recession will present a challenge to budget increases.

FIGURE 1: HEALTH SYSTEM AND FUNDING SOURCES

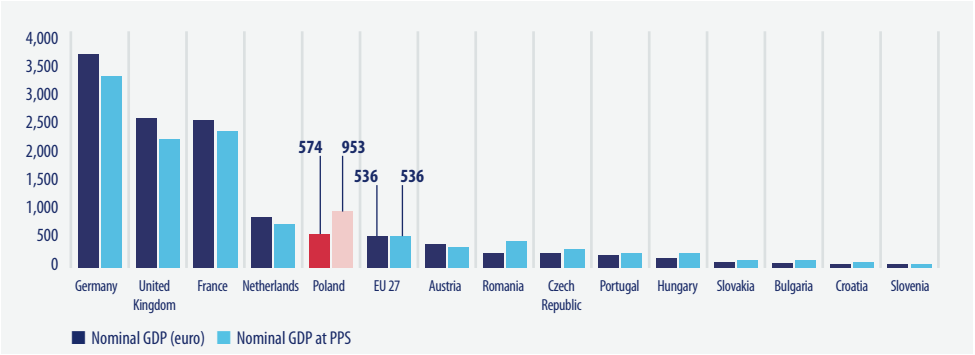
Healthcare system	Bismarck model - social health insurance system (SHI) with a single payer structure
Coverage and enrolment	SHI is compulsory for most citizens and legal residents and covers 91% of the population. SHI formally guarantees fully covered access to a broad package of healthcare services and treatment. Compulsory health insurance contributions are payable by the employee at 9% of income. Citizens without SHI coverage have access to outpatient emergency and medical care and primary care. Private facilities are the main providers of outpatient care, whilst the majority of inpatient care is provided by the public health system.[2]
Core services covered	While the services covered under the national SHI are comprehensive and include primary healthcare, ambulatory specialist care, hospital treatment, nursing and long-term care, psychiatric care, therapeutic rehabilitation, dental treatment, health resort treatment, addiction treatment, palliative care, highly specialised medical procedures and pharmaceuticals - there are reports of access challenges and long waiting lists.
Co-payment and user charges	Household out-of-pocket payments account for over 20% of current health expenditure (CHE), above the EU 27 average of 15.6%.[3] Informal payments persist in Poland despite the introduction of penalties for the acceptance of informal or "gratitude" payments in 2014.[4] The Polish government also introduced an exemption from user charges for many medicines for people aged 75 and older in 2016 in an effort to protect the growing elderly population against rising healthcare costs.[5]

FIGURE 2: FINANCING SOURCES (% OF CURRENT HEALTH EXPENDITURE)



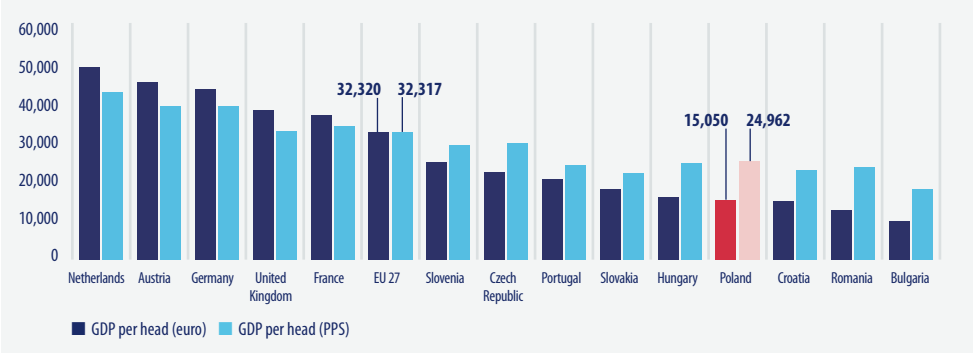
Source: Eurostat. Health care expenditure by financing scheme. 2019. EU 27 data from 2018 (latest available year)

FIGURE 3: NOMINAL GDP, 2021



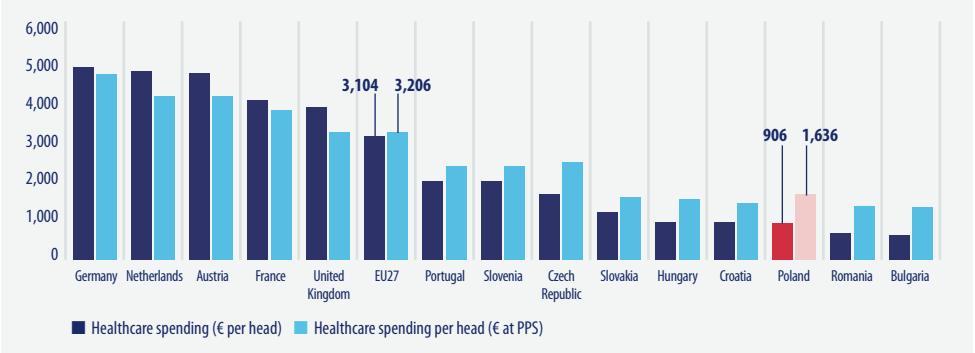
Source: Eurostat. Gross domestic product (GDP) at current market prices in € bn and Purchasing Power Standard (PPS). 2021

FIGURE 4: GDP PER HEAD, 2021



Source: Eurostat. Gross domestic product (GDP) at current market prices per head in € and Purchasing Power Standard (PPS, EU 27 from 2020). 2021

FIGURE 5: HEALTHCARE SPENDING PER HEAD, 2019



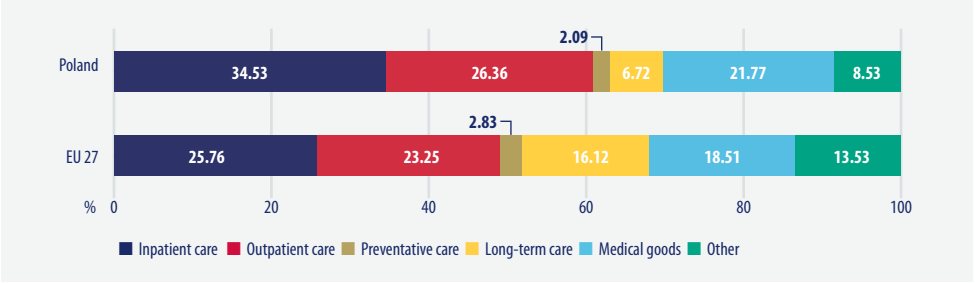
Source Eurostat. Healthcare spending per head in € and PPS. Healthcare spending as a % of GDP, 2019

2. Healthcare resources

2.1. Healthcare expenditure by function

Like many CEE countries in this study, Poland spends more on inpatient care and less on outpatient care as a percentage of current health care expenditure (CHE). Spending on preventative care is slightly below the EU27 average at 2.09% compared to 2.83%, while spending on long-term care is significantly below the EU27 average at 6.72% compared to 16.12%.[6]

FIGURE 6: HEALTHCARE EXPENDITURE BY FUNCTION (% OF CURRENT HEALTH EXPENDITURE)



Source: Eurostat. Healthcare expenditure by function. 2019. EU 27 data from 2018.

2.2. Human capital

Poland has the lowest number of practising doctors and nurses per 1,000 population in the EU, with an estimated 2.38 practising physicians per 1,000 people in 2017 (latest available).[7] The shortage of healthcare professionals reduced Poland's capacity to respond to the pandemic and continues to contribute to long waiting times and unmet healthcare needs.

While the minimum wage in Poland has been rising progressively and was reported to increase by a further 7.5% at the beginning of 2022, the government turned down demands from healthcare workers for a pay rise amid widespread protests in September 2021.[8,9]

The retention of healthcare workers is predicted to improve following the UK's exit from the EU. In addition, recent reforms to medical training in Poland allowing nurses and other staff to prescribe medicines and carry out diagnostic tests are expected to improve efficiency, cost-effectiveness, and patient management, as well as improving job satisfaction among nurses.[10]

2.3. Healthcare infrastructure

While the number of hospital beds to population has decreased from 6.64 beds per 1,000 people in 2016 to 6.17 beds per 1,000 people in 2019, the healthcare system in Poland remains over-reliant on hospital care.[11]

Public hospitals also report high debt levels and low occupancy rates, while many procedures performed in hospitals could be conducted at lower levels of care and at much lower cost. The shift from hospital to outpatient care is a key focus area for health system reform in Poland. As in many countries across the region, the government is trying to promote integrated care. In 2017 Poland established a hospital network that allocates a lump-sum payment per patient.[12,13]

3. Access to medicines

Poland's pharmaceutical market is the largest among the newer EU members. Poland spent more than all other CEE countries in this study on medical goods at €7.4bn in 2019, accounting for over 21% of CHE.[14] The State Pharmaceutical Policy for 2018-22 stipulates that at least 16.5% of the NFZ budget should be spent on pharmaceuticals.[15]

Poland's domestic pharmaceutical industry is primarily based on the production of generics and follow-on biologics/biosimilars - domestically produced pharmaceuticals account for 50% of the market in Poland.[16] Increasing the number of clinical trials to improve the availability of medicines is also a goal of the State Pharmaceutical Policy for 2018-22.[15]

3.1. Access to innovative therapies

According to the EFPIA Patients W.A.I.T Indicator 2021, the rate of availability of access to innovative new therapies approved in the EU is lower in Poland than the EU average across all categories. Just 7% of the approved non-oncology orphan medicines and 19% of the approved orphan medicines are available in Poland. The average time to availability in Poland is among the longest in the study, just above Romania, at 844 days compared to the EU average of 511 days.[17]

Factors beyond regulation and reimbursement also influence patient access. Data from the EFPIA Patients W.A.I.T Indicator in 2020 shows that patients have access to 21% of the products that are available in Poland, which occurs when the medicine is on the reimbursement list but receives no budget allocation or is not included in guidelines or recommendations.[18]

3.2. Digital health

Poland ranks 24 out of 27 EU countries on the latest Digital Economy and Society Index (DESI) and performs below the EU average on all four indicators – human capital, connectivity, integration of digital technology and digital public services.[19]

The Polish government has made recent investments in digital health, including launching a Patient Health Analysis Tool, an AI-based decision support tool for doctors, and a central repository of medical data integrated across healthcare systems. Poland has also made significant progress in the implementation of e-prescriptions and e-referrals. As of January 2022, over 924m e-prescriptions and more than 50m e-referrals have been issued through a system launched the previous year. Pilot projects were also launched in telemedicine to support home care and monitoring of covid-19 patients during the pandemic.[19] The Warsaw 2030 strategy also aims to improve the quality of public services and governance in many areas, including social assistance and health.[20]

Despite these investments, it has been reported that Poland faces significant challenges in improving basic digital literacy and limited access to high-speed internet, both of which pose a challenge to the scale-up of telemedicine initiatives.

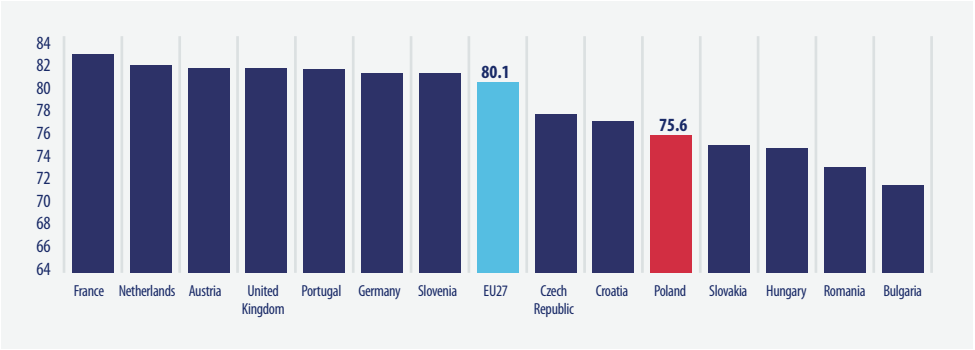
4. Health system assessment

4.1. Population health

Average life expectancy in Poland has been rising gradually from 76.9 years in 2012 to 78 years in 2019, with a decline to 75.6 in 2021 as a result of the pandemic.[21] Poland's infant mortality rate fell from 4.6 to 3.8 deaths per 1,000 live births between 2012 and 2019.[22]

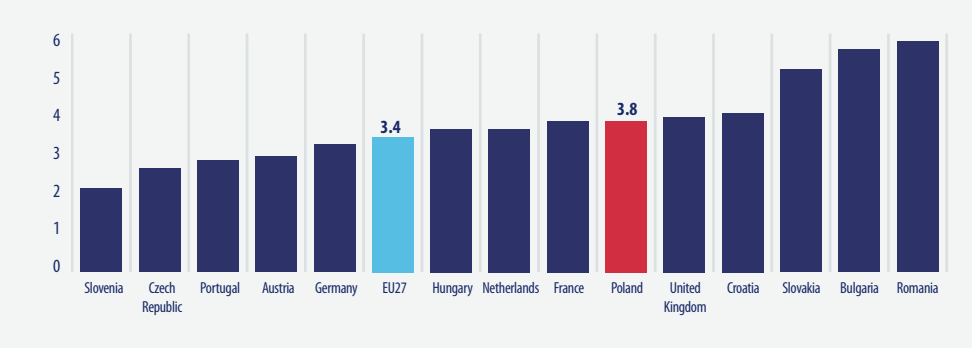
18.7% of the Polish population was over 65 in 2020. While relatively low by European standards, this is expected to rise rapidly to 23.2% by 2030, creating an additional burden on healthcare services and demand for long-term care.[23]

FIGURE 7: LIFE EXPECTANCY, AVERAGE (YEARS), MALE AND FEMALE, 2021



Source: Eurostat. Life expectancy. 2021. Available from https://ec.europa.eu/eurostat/databrowser/view/demo_mlexpec/default/table?lang=en

FIGURE 8: INFANT MORTALITY RATE (PER 1,000 LIVE BIRTHS), MALE AND FEMALE, 2019



Source: Eurostat. Infant mortality rates. 2019. Available from https://ec.europa.eu/eurostat/databrowser/view/demo_minfind/default/table?lang=en

4.2. Disease burden and risk factors

Ischaemic heart disease, stroke and lung cancer were the leading causes of deaths in Poland in 2018.[24] Mortality due to ischaemic heart disease at 125 deaths per 100,000 people is lower than many other CEE countries in the study but still above the EU27 average.[25] The rate of cancer deaths at 175 per 100,000 people is the second highest in the study after Hungary.[26] Whilst the overall cancer incidence rates for men and women are lower than the EU average, the mortality rates are 30% higher for men and 25% higher for women, highlighting issues with diagnoses and treatment.[24]

While Poland introduced population-based screening programmes for breast, cervical and colorectal cancer in 2006, participation remains low among the eligible population at 16%, 20% and 40% respectively, according to 2014 data.[27]

Approximately 39% of Polish adults report having at least one chronic condition, just above the EU average of 36%. This proportion increases to 70% for Polish adults over 65. In 2019, one-fifth of all deaths were attributed to tobacco consumption, with another fifth to dietary risks.[24]

FIGURE 9: LEADING CAUSES OF MORTALITY

Cause of mortality	Total number of deaths in 2018	As a % of total deaths for 2018
Ischaemic heart disease	45,565	11.1
Stroke	28,933	7
Lung cancer	23,146	5.6
Pneumonia	18,269	4.4
Colorectal Cancer	12,394	3
Diabetes	9,299	2.3
Liver disease	7,663	1.9
Breast cancer	7,037	1.7
COPD	6,578	1.6

Source: Eurostat, 2018. Extracted from 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.

4.3. Quality of care

Mortality from both treatable causes and preventable causes is higher than the EU average (133 compared to 92 per 100,000 and 218 compared to 160 per 100,000 respectively), indicating a need for investment in preventative care and screening for leading causes of mortality.[28]

The polish population report higher levels of dissatisfaction with the healthcare system than other EU counterparts. In 2017, 3.3%, of the Polish population, well above the average of 1.6%, reported unmet needs for medical examinations due to cost, distance or waiting times. The share was higher, at 4.7%, for people of low income.[29] Furthermore, during the first year of the pandemic, 28% of Poles reported unmet needs for medical examinations or treatments.[30]

5. Future outlook

The Polish government is focusing on its "de-Russification" programme, aimed at insulating the economy from the effects of the war in Ukraine by simplifying the tax system and providing subsidies to boost disposable incomes.[31]

In June 2022, the European Commission conditionally approved Poland's recovery and resilience plan, potentially unlocking €35.4bn in EU grants and loans .The recovery plan highlights the need to improve the quality of key public services such as health, long-term care and education.[12]

Since the start of the war in Ukraine, Poland has welcomed more than two million refugees.[32] This will inevitably place significant pressure on the Polish healthcare system and a need to provide care for refugees with pre-existing chronic conditions - non-communicable diseases are the biggest contributor to the disease burden among Ukrainian adults.[33]

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