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Overview of Healthcare in Poland

Portrait of a System Under Pressure

The Republic of Poland is the largest country in central and eastern Europe, in terms of both population (38.2 million) and area (312,685 km2). In 1989, Poland was the first country among the central and eastern European countries to re-establish democracy after 44 years of communist rule. After a severe economic downturn in the early 1990s, Poland's macroeconomic situation has stabilised, showing steady growth since the mid-1990s. In May 2004, Poland was admitted into the European Union (EU).

Poland has a mixed system for public and private health care financing. Social health insurance contributions represent the major public source of healthcare financing. Health insurance contributions are mandatory at a rate, in 2005, of 8.5% of the income base, which corresponds for most people to taxable income.

National Health Fund

The National Health Fund (NHF) along with its regional branches, administers the social health insurance scheme, following the demise in 2003 of a decentralised system of 17 sickness funds, after just four years of existence. The NHF has responsibility for planning and purchasing public financed health services.

Health insurance contributions for certain groups of individuals not covered by the standard scheme and specific public health activities are funded directly by the state through general taxation. Complementary sources of financing include both formal and informal out-of-pocket payments, and to a lesser extent pre-payment schemes. Private health expenditure accounted for 27.5% of total healthcare expenditure in 2002.

There is a strict separation between outpatient specialised care and inpatient care. Outpatient specialised care is mostly based on private medical practices in large cities and independent health care institutions in the other areas.

Poland's population is currently experiencing greater longevity, with life expectancy reaching 78.9 years for women and 70.5 years for men in 2003. A decrease in infant mortality and a greater focus on health prevention and promotion are also noticeable. Unfavourable trends and challenges include: limited access to care, underfunding of the public healthcare system and rising dissatisfaction with low salaries among health professionals; this dissatisfaction has given rise to the "braindrain" of doctors and nurses to western European countries.

Current health policy reforms are primarily aimed at tackling the demographic challenges of population ageing; reducing hospital debts; restructuring the health sector; introducing alternative sources of revenue for health care financing; and improving the control of rising health expenditures. .

The Ministry of Health

The Ministry is responsible, in general, for national health policy, for major capital investments, and for medical science and education. It has administrative responsibility only for those health care institutions that it directly finances.

The Ministry is also responsible for implementing national public health programmes, for training healthcare personnel, for partly funding medical equipment, and for setting and monitoring healthcare standards. For some areas, the Ministry has kept direct managerial functions, including the State Medical Emergency Service, health resort treatment, and the regulation of the medical professions. It is responsible for coordinating health policy programmes according to cost–benefit aspects.

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