Co-funded by the
Erasmus+ Programme
of the European Union

sienha
Strategic Innovative Educational Network
for **Healthy Ageing**

Poland

Country Profile on Healthy Ageing 2021

Co-funded by the Erasmus+ Programme of the European Union

sienha
Strategic Innovative Educational Network for Healthy Ageing

Country profiles series

SIENHA is a European research project carried out by different universities whose aim is to support healthy ageing among European countries through the competence development of social and healthcare professionals.

Country Profiles provide an overview of the SIENHA project based on each partner country's situation regarding healthy ageing including demographics and epidemiology, health status, health system and population needs. These profiles aim to provide context and highlight specific needs of each partner with the subsequent purpose of translating these results into future competencies

Content

The data and information in these Country Profiles are based, mainly, on European official statistics provided to Eurostat and the OECD, and Global Health Data Exchange to ensure data comparability. This information has been complemented by the National Statistics Institutes of each country.

1. Demographic and socioeconomic context

In relation to 2020, the population of Poland in 2021 decreased by 117,563 and stood at 37,793,902 inhabitants as of October 10, 2021. Compared to the change in the population in 2020 as compared to 2019 (down by 28,572 people), 2021 recorded a significant decrease in the population.

The distribution of the population by age group and sex can be seen in Figure 1.

In 2020, demographic growth rises rate is minus 0.20% and vegetative growth stands at 0,92 per 1000 inhabitants.

Polish population is getting older

Life expectancy reached 80,7 and 72,6 years in female and male, respectively, and the ageing index sticks up to 116.5%. However, the fecundity rate is low (1.45 children per woman) and does not allow a generational relief.

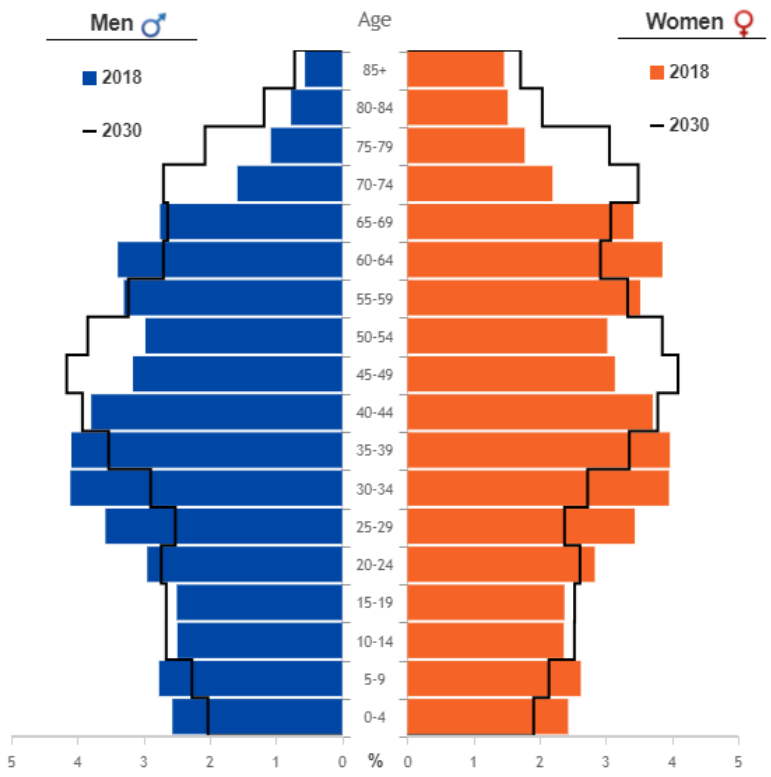


Figure 1. Population pyramid in Poland in 2018 and its projection for 2030

Adjusted gross household disposable income (2019)	17.306€
Unemployment rate (2020)	3.5 %
Degree of urbanization (2018)	60.06%

Table 1. Socioeconomic characteristics

More than half of the population has had upper secondary, post-secondary non-tertiary and tertiary education

13,7% of men and 12,2% of women have not completed primary education, whereas 62,9% of men and 53,3% of women have upper secondary, post-secondary non-tertiary and tertiary education. 23,4% of men and 34,5% of women have tertiary education. Education has an important relation with health as it has been shown that low education is associated with poor self-management, lower self-reported health status, reduced usage of health care services and higher healthcare costs.

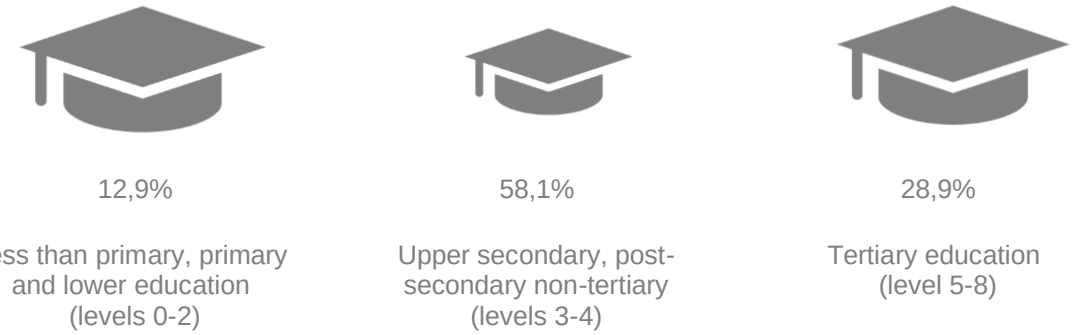


Figure 2. Percentage of population who have completed the respective levels of education

2. Health status

Self-reported health decreases markedly since adult middle age

Although Polish people live longer, not all years of life are lived with a good health perception. At age 45, self-related health starts to decrease and only 52,2% of the population arrives with a good perception of health at the end of their life.

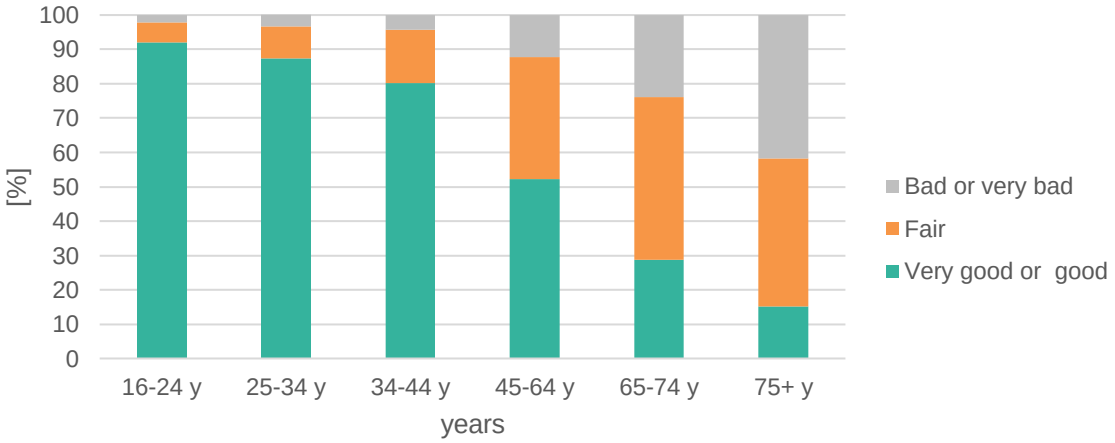


Figure 2. Self-reported health by age

Circulatory diseases and cancer top the list of leading causes of death in Poland

Increasing life expectancy since 2000 can largely be attributed to reductions in mortality from circulatory diseases, mainly ischaemic heart disease and stroke. Yet, ischaemic heart disease remained the leading cause of death.

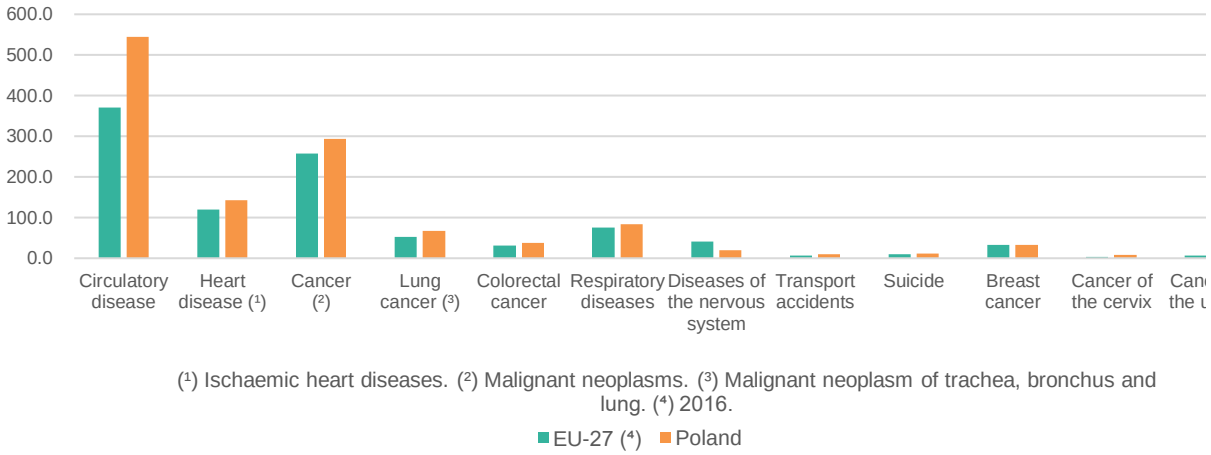


Figure 3. Causes of death — standardised death age, 2017

Regarding non-communicable diseases (NCD), the three-leading causes of disability-adjusted life years (DALYs) indicated in Poland are ischemic heart diseases, stroke and lung

cancer, whereas cirrhosis and headache disorders have lowered their positions to the tenth and twelfth spots, while alcohol-use disorders and age-related hearing loss rise to the seventh an

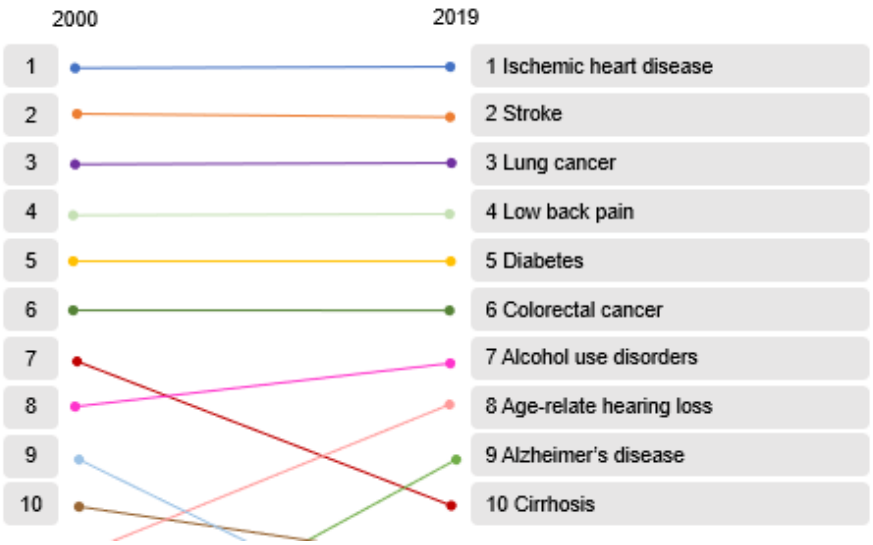


Figure 4. Ranking and evolution of non-communicable diseases of disability-adjusted life years between 2009 and 2019.

Tobacco consumption remains at the top of the risk factors list

Tobacco consumption is a public health concern in Poland, particularly among men. Smoking is the most important risk factor in Poland followed by high systolic blood pressure, high body mass index, dietary risks, and high fasting plasma glucose (Figure 5). It is estimated that almost half (47 %) of all deaths in Poland can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity. In general, greater risks for all causes increase with age (Figure 6).

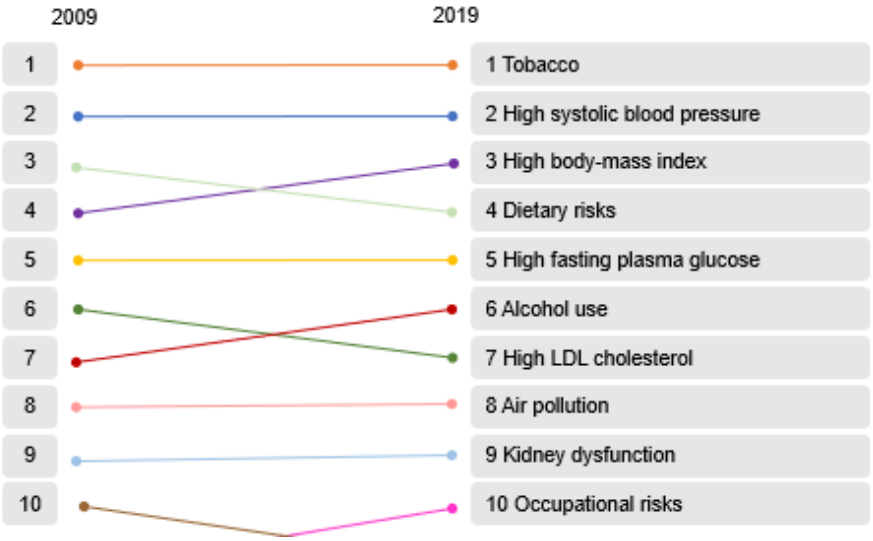
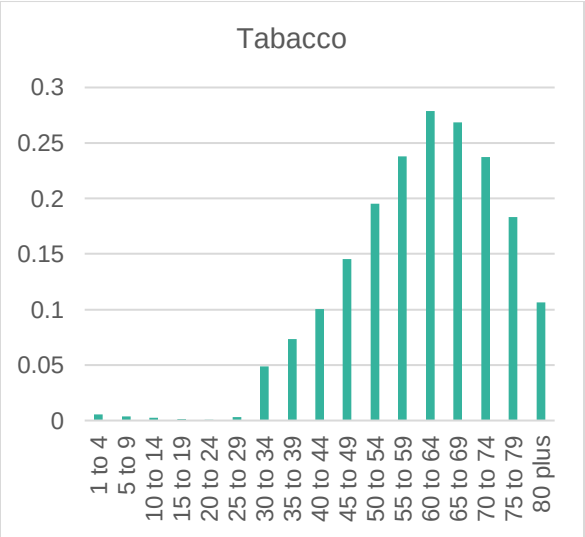
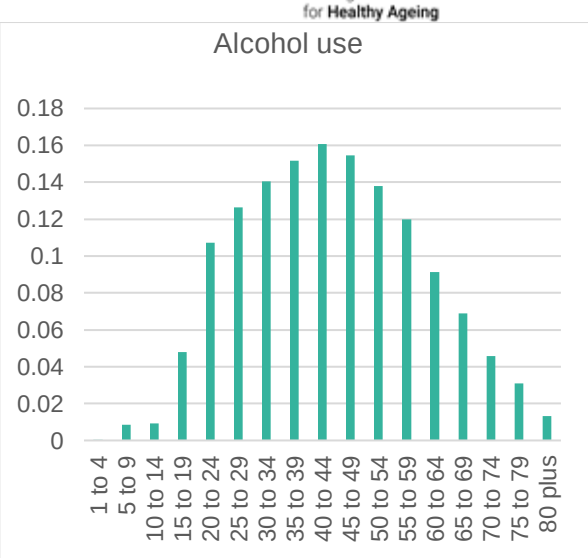
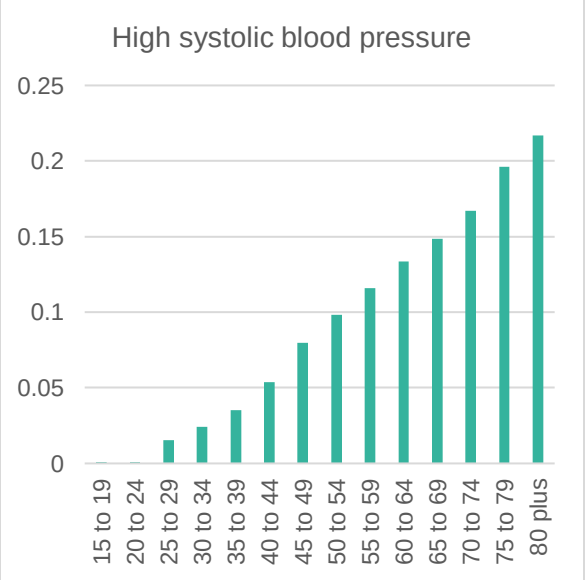
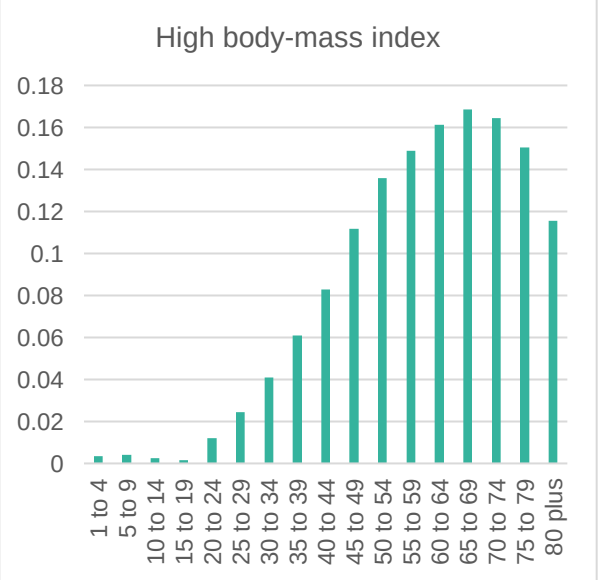


Figure 5. Ranking and evolution of risk factors between 2009 and 2019









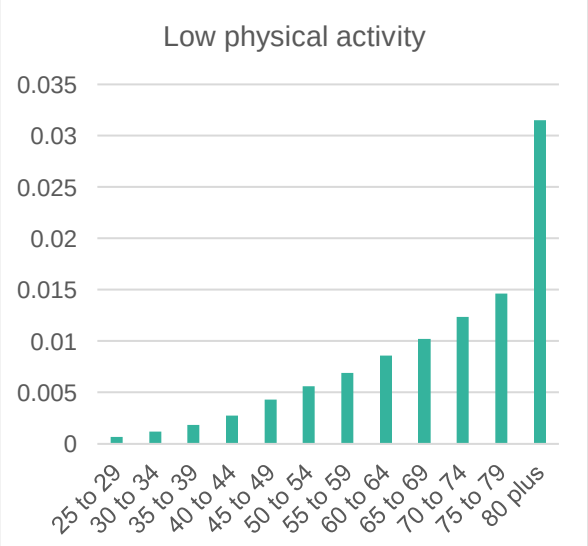


Figure 6. Risk factors in disability-adjusted life years by age

3. Health system

Poland's health system is based on Social Health Insurance (SHI). The Ministry of Health shares governance and responsibility for health care with three levels of territorial government: municipalities are in charge of primary care, counties are responsible for (often) smaller county hospitals, and districts (voivodeships) for generally larger district hospitals. The Ministry of Health is the founder of the national health institutes and has a supervisory role over medical university clinics. Private facilities provide mainly outpatient (or ambulatory) care, while the majority of hospitals are public. Compulsory health insurance covers 91 % of the population.

People without SHI coverage have access to outpatient emergency medical care, and certain population groups (e.g. pregnant women and children under 18) have the right to access publicly financed health care irrespective of their insurance status. Access to primary care is free, and there are no cost-sharing requirements for inpatient care services.
Polish health care expenditure ascends to 31501,68million €, which corresponds to 829,54 euros per inhabitant. This is much lower than the European mean which is 2981,76 euros per inhabitant (Figure 7).

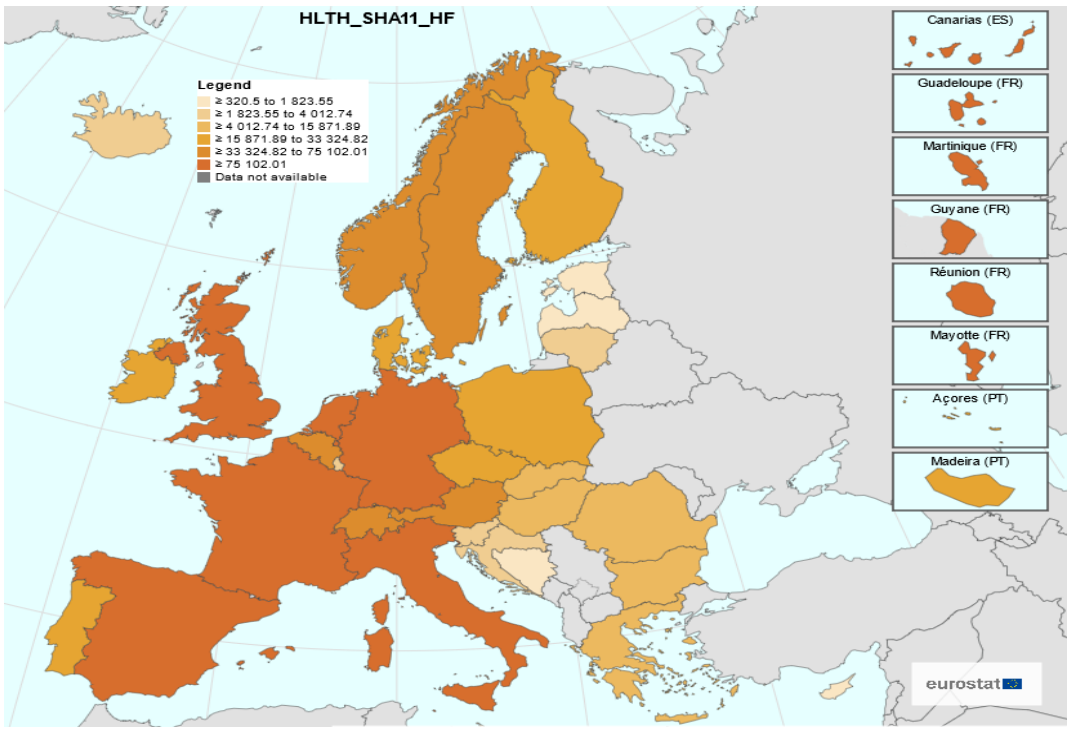


Figure 7. Health care expenditure

While 57.4% of the budget is allocated to curative care, only 2.3% is allocated to prevention (Figure 8).

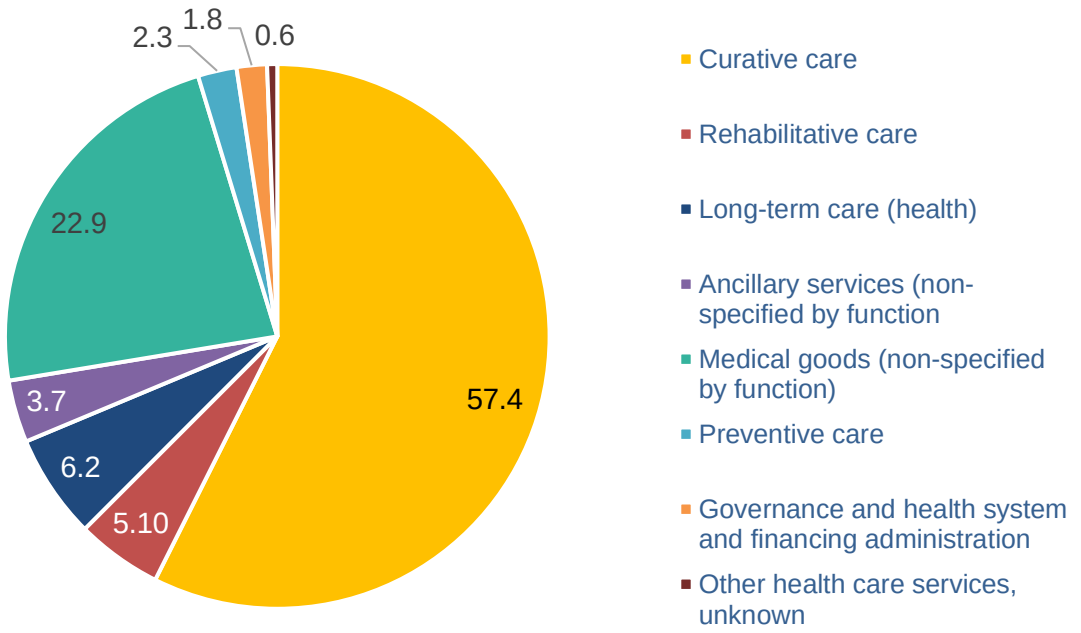


Figure 8. Health care expenditure (in %) by function

The overall strategic planning of the health workforce is still not well developed in Poland, leading to shortages of health professionals and difficulties accessing care services. Health workforce shortages have become even more acute since Poland's accession to the EU in 2004, which has facilitated a large outflow of health professionals from the country. The number of doctors per 1 000 population (2.4) is the lowest among all the countries in the EU. The age composition of doctors exacerbates concerns for their future supply, as about a quarter of practicing doctors are above retirement age – a share nearing 40 % for some specialties, such as general surgery. The number of nurses (5.1:1 000 population) is also among the lowest in the EU.

	Number	Per thousand inhabitants
Nurses	219845	5,1
Medical doctors	88437	2,4
Pharmacists	28 121	0,73
Physiotherapists	25 145	0,76
Dentists	12603	0,4

Table 2. Number registered health professionals

4. Key findings and population needs

The Polish population has one of the lowest life expectancies in Europe. At 76.6 years, life expectancy at birth in 2020 has increased markedly since 2000 but remains three years below the EU average. Differences in life expectancy between men and women and by educational level are among the highest in Europe. Life expectancy at age 65 has also increased, yet two thirds of older people live with at least one chronic disease and almost half live with depressive symptoms.

The Social Health Insurance system provides access to a broad scope of benefits but there are important coverage gaps, most notably for outpatient medicines. The health system tends to rely excessively on hospital care and faces shortages of health workers, particularly primary care doctors. Current reform priorities include improving the coordination of care, rationalising hospital care and strengthening the provision of ambulatory care. The public share of health care spending in Poland, both as a share of GDP and in per capita terms, is one of the lowest in Europe. This low level of funding is insufficient to provide timely access to high-quality care, particularly given rising health care needs due to population ageing. In 2017, the government pledged to increase the public share of health expenditure to 6 % of GDP by 2024, up from 4.6 % on average over the last 15 years. This should translate into higher total spending in real terms, bringing total health expenditure levels closer to the EU average. Health workforce shortages have been a long-standing problem in the Polish health sector. Over the years, various measures have been implemented to address this problem, including shortening educational pathways and increasing university quotas to train more doctors and nurses, but with limited results. More recently, following repeated strikes, the number of residency places funded by the state has been increased and, in September 2018, the salaries of resident doctors and nurses were raised. In addition, to address the geographical imbalances in the distribution of doctors, medical degrees have been offered at non-medical universities in the districts with doctor shortages.

Ischaemic heart disease is still the main cause of death, followed by stroke and lung cancer. Strikingly, more than half of Polish over 65 report symptoms of depression, compared to a fifth in the EU.

Behavioural risk factors account for almost half of all deaths in Poland. Smoking rates have decreased, contributing to a reduction in mortality from lung cancer, but remain higher than the EU average. Smoking has long been recognised as a major public health problem and has been the focus of dedicated national programmes and legislation. Anti-smoking policies include a smoking ban in many indoor public places and workplaces, including restaurants, and a nearly comprehensive ban on tobacco advertising and promotion. Yet, existing bans are not always respected, and cigarette prices are among the cheapest in Europe. Access to smoking cessation support treatment (including pharmacological treatment) is restricted, and there is no national system to support smoking cessation overall. Binge drinking among adults is slightly below the EU average but rising among teenagers. The obesity rate, is also above the EU average. . About 17 % of adults in Poland are obese, which is slightly higher than the EU average of 15 %. This share has increased by about a third over the past ten years. Overweight and obesity trends have also been rising among children. Unhealthy dietary behaviours and low physical activity contribute to this growing public health issue, which has been largely neglected so far.

Mortality from treatable causes continues to be much higher than the EU average and survival rates for cancers are consistently lower than in the EU, indicating that there is much scope for improvement in early diagnosis and timely, effective treatment.

Sources

Eurostat. Database [Internet]. [cited 2021 Oct 13]. Available from: https://ec.europa.eu/eurostat/data/database

Global Health Data Exchange. GBD Results Tool [Internet]. [cited 2021 Oct 13]. Available from: http://ghdx.healthdata.org/gbd-results-tool