Poland

Health Care & Long-Term Care Systems

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Poland

Health care systems

1.21. POLAND

General context: Expenditure, fiscal sustainability, demographic trends

General statistics: GDP, GDP per capita; population

In 2013, GDP per capita (16,800 PPS) in Poland was below the EU level of 27,900 PPS. Poland remained with positive growth rates of real GDP during the crisis. In 2013, population is estimated at 38.1 million. ([227]) Poland's population is characterised by declining growth with an ageing population and a rising share of older age cohorts. The population is projected to decrease to 33.2 million until 2060.

Total and public expenditure on health as % of GDP

Total expenditure on health was at 6.7% of GDP in 2013 (EU: 10.1% in 2013). Public spending on health was at 4.6% of GDP (EU: 7.8%). Spending relative to GDP was increasing steadily between 2003 and 2009 and has slightly decreased since. In 2012, 10.9% of total government expenditure was channelled towards health spending (EU: 14.9%). In per capita terms, total (1,215 PPS) and public spending (845 PPS) were well below the respective EU averages (2,988 PPS and 2,208 PPS).

Expenditure projections and fiscal sustainability

Public expenditure on health care is projected to increase by 1.2 pps of GDP (AWG reference scenario), above the average increase of 0.9 pps for the EU. When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 2.2 pps of GDP from now till 2060 compared to the EU average of 1.6 pps ([228]) Overall, projected health care expenditure poses a risk to the medium and long-term sustainability of public finances. The medium-term risks are related to the unfavourable initial budgetary position and the projected impact of age-related spending. Over the long run, Poland faces medium risks to fiscal sustainability. These risks are largely due to an unfavourable initial budgetary position, but also to the necessity to meet future increases in ageing costs (notably healthcare and long-term care). ([229])

Health status

In 2014 life expectancy at birth was 81.7 years for women and 73.7 years for men, below the EU averages (EU: 83.6 for women and 78.1 for men). However, in 2013 healthy life years were slightly above the EU average for women (62.7 vs. 61.5 years), but below the EU average for men (59.2 vs. 61.4 years). Amenable mortality rates, i.e. deaths that should not occur with timely and effective care, are well above the EU average (165 deaths in Poland versus 128 deaths in the EU per 100 0000 inhabitants). Infant mortality was at the level of 4.6‰ in 2013 (EU: 3.9‰).

System characteristics

Administrative organisation, system financing, revenue collection mechanism

The health care system in Poland is described by two basic acts. Details of the operation of general health insurance system are defined by the Act of 27 August 2004 on healthcare services financed from public funds. The insurer is the National Health Fund (NHF). Rules pertaining to therapeutic activity in Poland are regulated by the Act of 15 April 2011 on therapeutic activity, having a systemic nature of the health care system. The act defines the rules for the therapeutic activity, in particular the conditions to be met by entities carrying out therapeutic activity, as well as the categories of entities and kinds of therapeutic activity.

Since 2003, a centralised National Health Fund (NHF) manages the financial resources and allocates them between providers based on individual contract. Moreover, in 1990 the Agricultural Social Insurance Fund was established in order to realise tasks connected with full servicing of farmers' social insurance. ([230])

([227]) According to the Central Statistical Office of Poland, the population on 31st June 2015 was 38.45 mln.

([228]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([229]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([230]) The main regulation defining farmers' social insurance obligations and entitlements to benefits is the act of 20

Funds are coming mostly from universal health insurance contributions collected by the NHF. Moreover, government budgets (state, regional or local authorities) contribute for specified purposes, such as health insurance contributions for specific groups of the population (e.g. unemployed receiving social security benefits, persons receiving social pensions, farmers, war veterans, etc.), capital expenditure in public health care institutions, highly specialised tertiary care procedures (such as organ transplants, heart surgery, treatments abroad) and very expensive drugs (in total around 10%).

The NHF contributions are calculated on the gross income base, which makes it a sort of earmarked type of personal income tax (PIT). The base differs slightly for some defined social groups: farmers (depending on the size of the farm), self-employed (depending on income, but with a lower limit) and beneficiaries of social security (depending on the gross amount of benefits). The contribution rate amounts currently to 9% of the base, 7.75% of which are subtracted from PIT and 1.25% are paid directly by the insured person.

In 2011, a major reform was introduced allowing for the possibility of direct transformation of public health care units, including public hospitals into corporate units (corporatisation). The law regulates that both public and private hospitals contracted by NHF will function according to the same rules. Also public hospitals that were transformed into corporate units will be allowed to offer for fees services outside the contracts with NHF. ([231])

December 1990 on social insurance for farmers. The current regulation of farmer's health insurance is included in the act of 5 December 2014 to amend the act on health insurance contributions made by farmers for years 2012-2014 (pol. ustawa z 5 grudnia 2014 r. o zmianie ustawy o składkach na ubezpieczenie zdrowotne rolników za lata 2012-2014) which prolonged previous regulations by the end of 2016).

([231]) Please, notice that the Act of 15 April 2011 on medical activity regulates the transformations of public independent health care provider (pol. samodzielny publiczny zakład opieki zdrowotnej (SPZOZ) – specific name for health care provider). In accordance with this act, if the heath care provider is not able to finance its own deficit, then its founder can defray the negative balance or is obliged to transform this provider into corporate unit (or budgetary unit) or decide on liquidation of the unprofitable provider.

The laws' purpose is to increase the efficiency of health care providers and thus improve the functioning of health care system. If the financial report on public hospital activity indicates a net loss, then hospital or his owner has 3 months to cover it. Otherwise, the owner makes a decision: transformation into corporate unit or liquidation. Since July 2011, 62 public hospitals were corporatised (1 of them was privatised). ([232]) It will be interesting to observe the law's further impact in the coming years.

Coverage and role of private insurance and out of pocket co-payments

Public health insurance covers 91.6% of the population. ([233]) Practically all social groups are covered by mandatory health insurance. There is no legal possibility to opt-out from the system on the grounds of income, social group or source of means of living. The law identifies the package of health services provided under the insurance scheme, as well as a limited list of excluded services. A number of services, defined by law, are provided for co-payments, whose level is legally limited and depends on the income of an insured person. ([234]) For dental care, a precise system of point pricing with respect to a standard basket of dental procedures and materials is established. ([235])

Shares of public and private expenditure in total health care spending have been stable over the last decade: 70% of expenditure being publicly and 30% privately financed (EU: 77% public and 23% private). As such, health financing is based to a higher degree on private sources than in the other EU countries. Out-of-pocket spending accounts for a large majority of private expenditure (22.8% of total expenditure on health in 2013; EU: 14.3%). As there are no patient charges for medical treatment by general practitioners, specialists or in hospitals, private co-payments are foremost for

([232]) By today, 191 hospitals have changed their organisational form (into corporate unit). Majority of them , (ca. 70%,) are owned or controlled by public body (mainly local government).

([233]) The guaranteed benefit baskets are stored in the regulations of the Minister of Health, not in the act.

([234]) Only charges for accommodation and catering in the care and treatment facility, nursing and care facility or in medical rehabilitation facility that provides twenty-four hour services are dependent on the income.

([235]) As a result, Poland scores about 5.9 out of 6 on the breadth, 6 in the scope and around 5.3 on the depth of basic coverage according to the OECD scoreboard.

outpatient pharmaceuticals. This suggests a relative underdevelopment of other, more institutionalised patterns of financing (such as supplementary insurance schemes).

Private expenditure also includes the pre-payment schemes, of which main components are "medical subscriptions" and different insurance policies protecting against the risk of high expenditures on health care. The former ones are mainly the expanded packages of health services offered by employers to their employees. They usually include services that the employers are obliged to provide in accordance with law and cover mostly outpatients services. The latter ones are still in the early stage of development and concern a minor number of patients.

Types of providers, referral systems and patient choice

Health care services are provided by public and non-public therapeutic entities and private medical practitioners (individual or group medical practice). All providers are independent in terms of organisation, personnel, assets and finances.

Primary health care is provided in outpatient clinics and at home (with doctors obliged to provide home services when required for medical reasons). Family physicians (or general practitioners – GPs) act as gatekeepers for specialist and hospital care. Patients have a free choice of the GP, with a limited number of changes available per year. Also, there is free choice of and direct access to certain specialists (e.g. gynaecologists, psychiatrists, oncologists, dentist and venereologist). Specialist outpatient care is based mostly on private medical practices or specialised health centres (mainly in the big cities), which developed on the basis of the former public specialised health care centres. Inpatient hospital care is provided predominantly in public hospitals. The number of non-public hospitals increased over the last decade (428 private hospitals of 1013 in 2016). ([236])

While the insurance coverage is practically universal, the supply of health care is seemingly not sufficient to provide the whole population with timely and adequate care. The number of practising physicians per 100 000 inhabitants (224 in 2013) is one of the lowest in the EU (EU: 344). The same is true for GPs (22 per 100 000 inhabitants in Poland vs. 78 in the EU in 2013), although their number has steadily increased in the last decade. The number of nurses is also low (527 per 100 000 inhabitants in 2013), and below the EU average of 837. Staff shortages are particularly perceptible in some regions and for some specialisations as the regional and sub-sectorial discrepancies in care availability are significant.

A characteristic feature of the Polish health care system is the widespread phenomenon of double (or multiple) employment: physicians keep part-time salaried job in (mostly public) health care units and simultaneously act as individual medical practitioners. Indeed, only for a small minority of individual practitioners (with the exception of dentists) this occupation is reported as their main or only job. Such practice may have a strong negative effect on the quality of services provided by the health care units and their economic situation, as their equipment and facilities are often used by the physicians for their secondary activities.

Total expenditure on inpatient care as a % of GDP was below the EU average (2.1% vs. 3.0% in 2013), as was public expenditure (2.0% vs. 2.6% in 2013). Inpatient care accounts for roughly 45% of public expenditure on health in Poland compared to 34% in the EU. High expenditure may be a sign of a health system which is oriented away from ambulatory and towards hospital care, providing potential to increase the relatively cost-effective of care, by shifting away from hospital centric health care provision.

The capacity of Polish hospitals (430 beds per 100 000 inhabitants in 2013) is higher than the EU average of 356 in spite of the reduction over the last decades (486 in 2003), which occurred in line with the decline in average length of stay (7.9 days in 2005; 6.7 in 2013 which located Poland above the EU average of 6.3 days). Also, the number of hospital inpatient discharges decreased from 16.8 in 2004 to 16.2 in 2011 per 100 inhabitants (EU: 16.5 in 2013).

Total and public expenditure on outpatient care as a % of GDP were below the EU average (1.5% and

([236]) In terms of the number of hospital beds the public sector dominates. Private hospitals are relatively small.

0.9% vs. 2.2% and 1.8% in 2012). Total and public expenditure on outpatient care as a % of current health expenditure were roughly around the EU average (23% and 20% vs. 23% and 23% in 2012).

Physicians employed by the health care units can be remunerated according to a number of contractual arrangements, although salary is the most widespread pattern. Individually practising physicians are generally paid according to the capitation principle, on the basis of patient lists.

Hospitals are financed on the basis of the contracts concluded between individual entities and the National Health Fund. A uniform classification of hospital services, mainly based on defining individual groups of procedures and prices for basic units serves as a basis for those contracts.

The market for pharmaceutical products

The pharmaceutical market in Poland is divided into two segments: open (through pharmacies) and closed (through hospitals) markets. Over the last decade, the value of drugs sold has increased in both markets, while the quantity has decreased in hospitals and remained stable in pharmacies. These developments suggest a sharp increase in the average price of hospital drugs, driven mainly by a growing use of original drugs. In the open market, the shares of reimbursed and over-the counter drugs were broadly equal until 2004. Since then a significant increase in the quantity of prescribed and reimbursed drugs has exceeded significantly that of the OTC drugs. However, in terms of value the gap between the growth rates of the two groups has been much narrower, which suggests a much higher price dynamics of the OTC pharmaceuticals, resulting from high effectiveness of advertising campaigns and insufficient competition between the OTC drugs producers. More detailed analysis of the structure of pharmaceutical market allows observing the increase in the share of imported drugs, linked to the fall in their relative price, as well as the growth in the total value of sold generics, driven mainly by the relative increase in their prices, rather than quantities sold.

New drug reimbursement regulations and changes to the official list of subsidised drugs have been introduced in 2012. Now the Ministry of Health can negotiate the fixed refundable price of a drug directly with manufacturers. Thus, prices of reimbursed drugs are identical in all pharmacies. Under the reimbursement law, the list is updated every two months.

Use of Health Technology Assessments and cost-benefit analysis

The Centre for Health Care Quality Monitoring provides independent accreditation on the basis of a published set of standards. Quality requirements, national guidelines and standards are developed based on independent expertise. Further schemes include developing a better system to evaluate services. The use of technology assessment is increasing, leading to evidence-based contracting of services.

The Agency for Health Technology Assessment and Tariff System was established in 2005 as an advisory body to the Ministry of Health. It is responsible for preparing health technology assessment reports, collecting information on health technology assessment results and methodologies. The main task of the agency is to prepare for the Minister of Health recommendations on financing all health care services from public funds (especially in relation to drug reimbursement list, national and local government health care programs, therapeutic drugs programs (high-cost, innovative drugs) and hospital's chemotherapy drugs list).

eHealth (e-prescription, e-medical records)

In 2013, an electronic verification of beneficiaries' rights was introduced (so-called eWUŚ system). This allows for verification whether the person is entitled to benefits financed from public means. Also an individual health e-account (so-called ZIP) was introduced in July 2013, on which the insures' data will be collected.

The following legal regulations were adopted aiming at the modernisation of the current system of gathering, processing and usage of information in healthcare. Those regulations are deriving from the act of 28 April 2011 on information system in healthcare. The act and its implementing legislation provide the legal framework for the functioning of information system in healthcare. It is also a foundation for implementation of solutions supporting the exchange of medical data,

which need to be used in treatment process in Poland. Under this act there are IT solutions being developed currently, through which it will be possible to prepare tools for implementation of healthcare information as well as to conduct electronic medical records (documentation) in medical entities.

Currently, the following projects are done:

1. Electronic Platform for Collection, Analysis and Dissemination of Digital Resources on Medical Events (P1). Information systems which will be launched within this project will become electronic platform of medical data. The aim of this project is to build an electronic platform for public services in healthcare, enabling different stakeholders to collect, analyse and share their digital resources on medical events. The project includes the necessity to ensure appropriate level of security as regards data and services. Due to high sensitivity of data being processed (medical data), feeding the data, as well as their processing will be done with the full knowledge of patient, in compliance with the required security and confidentiality measures. Projects allow to implement ePrescription, referral, Online Patient Account as well as to exchange electronic medical documentation. The platform will be connected with local information systems of healthcare providers and with the data being processed, which makes the functioning of the system to be liable to high requirements of security level.

2. Domain-specific information and communication systems in healthcare (P4) – the project will enable building and implementation of information and communication systems supporting specific business areas, as follows:

- Healthcare Statistics System,
- Risks Monitoring System,
- Integrated System of Monitoring Trade in Medicinal Products,
- System Monitoring Education Medical Professionals,
- System of Registration of Healthcare Resources.

3. Platform P2, i.e. Platform for sharing services and resources of digital medical records with on-line businesses was established and launched at the beginning of 2013. P2 platform is a universal IT tool used to keep registers and provide electronic services. P2 platform enables electronic registration and updating of register data (e.g. it is possible to apply for permission to run a pharmacy), gives healthcare providers the opportunity to submit their applications to the register electronically, to keep documents in electronic form, provides wider usage if digital signature and assists public administration in downloading registry data. During integration with the P2 platform the registers are rebuilt so that they are consistent with the reference architecture of a medical register. The following registers were integrated with the P2 platform:

- Register of permits for running commonly available pharmacies, pharmacy points and Register of permits for running hospital pharmacies, company pharmacies as well as hospital pharmacy departments,
- Register of permits for running pharmaceutical warehouses,
- Coding Systems Register,
- Register of Medicinal Products Authorized for the Market on the territory of the Republic of Poland,
- Register of Medically Assisted Procreation,
- Residency IT System (SIR).

Full operation of the system will be possible when the above mentioned projects are finalised.

Feeding the system with medical data and electronic medical documentation is the vital requirement for full operation of the system. For this purpose healthcare providers were obliged to keep medical documentation in electronic form starting from 1 January 2018. Until that time healthcare providers can develop and process medical documentation in traditional (paper) form as well as in electronic one. Due to the solution implemented in Poland as regards exchange of medical documentation, medical documentation

will be held by healthcare providers in the information and communication system and its dissemination will be possible through Medical Information System (MIS), i.e. P1 platform, mentioned above. Healthcare provider will feed into MIS the data or medical electronic documents possible to be downloaded by other healthcare provider when necessary for the continuity of treatment and providing patients with medical products and devices. Sharing the data is possible only with the consent of patient. EPrescription and referral will be specific documents available during data sharing. It will be possible to provide those documents within P1 platform directly, through special application.

As mentioned above, the computerisation of healthcare system in Poland is developing dynamically. In accordance with current regulations, healthcare information system will eventually include databases functioning within:

Medical Information System (MIS), which is information and communication system used for processing data on provided, being provided and planned healthcare services shared by healthcare providers' information and communication systems, domain-specific information and communication systems (Register of Medical Services System of the National Health Fund, Healthcare Statistics System, System of Registration of Health Resources, Risks Monitoring System, Accessibility to health care services Monitoring System, Register of Medicinal Products Authorized for the Market on the territory of the Republic of Poland, Integrated System of Monitoring Trade in Medicinal Products, System Monitoring Education Medical Professionals, Reimbursement List Operation System) and Medical registers.

Health and health-system information and reporting mechanisms

The collection and processing of statistical data on health care is governed by the Council of Ministers on the program of statistical surveys. In 2016, as well as planned for 2017, the program foresees the following tests, which consist of dozens of statistical forms, as e.g. health's status of the population, health's monitoring, hospitalisation, prevention, vaccination, economic aspects of health care, the National Health Account and others. A separate branch of IT-systems is used by the National Health Fund as the primary payer. These systems include eHealth (e-prescription, e-medical records, e-referrals), a system for billing services, in which data are collected both on the number of benefits, types of benefits and costs of benefits. Together with the characteristics of patients (age, sex, region) this creates a comprehensive source of information for an effective allocation of resources.

Health promotion and disease prevention policies

Public health has gained a large momentum in 2015. The Parliament adopted the law on public health (from September 11th), which entered into force in December 2015. According to this legislation new governance, inter-ministerial coordination and financing mechanisms are in place. Overall spending on public health programmes will increase in 2016, compared to 2015. Before 2016 total and public expenditure on prevention and public health services as a % of GDP were below the EU average (0.16% and 0.12% vs. 0.24% and 0.19% in the EU). Public and total expenditure on prevention and public health services as a % of current health expenditure were at the EU average (2.6% and 2.7% in Poland vs. 2.5% and 2.5% in the EU in 2012).

Transparency and corruption

Regarding anti-corruption regulations in the functioning of the Ministry of Health, this area is particularly vulnerable to issues of lobbying, informal pressures and corruption proposals in meetings with external stakeholders, in particular with representatives of the pharmaceutical industry involved in creating the list of reimbursed drugs. In view of the need to normalise the above mentioned contacts, a special procedure was adopted on how to receive visitors in the Ministry of Health. The procedure provides transparency rules for meetings with external stakeholders, especially in the context of possible lobbying activities. The Ministry of Health collaborates with the European Healthcare and Corruption Network (EHFCN) since 2006. This cooperation relies mainly on exchange of experiences, information, data and best practices. The Network is the only international organisation in the Europe, which is dedicated to combating corruption, fraud and

losses in health care systems. The Ministry of Health also took part in the awareness-raising campaign organised by the EHFCN, the aim of which was to show the scale of corruption in the healthcare sector in Europe, by pointing to what the lost funds could be allocated due to fraud and corruption in health. The Ministry of Health takes part in the implementation of the "Government Anti-Corruption Programme for years 2014-2019", aiming at reducing the level of corruption in Poland

Recently legislated and/or planned policy reforms

Since 2012, many amendments have been made to basic governance laws of the health care insurance system. These related to the provision of health care services include: 1) Changes in the contracting of health care services by the National Health Fund – with emphasis on the complexity of the services and experience of service provider; 2) Changes in primary health care - by changing eligibility requirements for doctors which could serve as a family physician; 3) Changes in the financing of cross- border treatment in a State other than the Member State of affiliation - implementation of Community legislation.

Related to pharmaceuticals, the reimbursement system was changed. Medicinal products are reimbursed on the basis of administrative decision issued by Minister of Health. Furthermore the system of fixed prices and margins was introduced.

In 2015 the Act of 11 September 2015 on public health was introduced. It defines specific tasks of public health and indicates institutions involved in providing these tasks and rules of financing these activities. The act promotes health and enhances the disease prevention activities. The baseline for implementation of these tasks will be the National Health Program.

An amendment to the act on health care services financed from the public funds is being prepared. According to the project, people aged 75 or more will receive certain drugs (from the reimbursement list) for free.

Pharmacovigilance - a key element of the adopted amendments has remodelled the definition of "adverse reaction of medicinal product". It has basically expanded the group of people entitled to report adverse reaction of pharmaceuticals (for instant: patients, nurses, midwives, paramedics, laboratory diagnosticians), introduced possible requirements for post-authorisation studies and obligation to report adverse reaction to Eudravigilance by stakeholders.

Moreover, the obligation to pay health insurance premiums by farmers operating in farms over 6 acres conversion was introduced. Until the adoption of the Act, for all farmers, premiums were paid from the state budget.

The Ministry of Health prepared a Regional Healthcare Needs Maps of Poland in order to analyse current and projected demographic trends and the health status of the society. The analysis is conducted at a regional level with respect to available healthcare resources and infrastructure, identifying needs for policy reform. Regional Healthcare Needs Maps of Poland is created for each voivodeship and includes projections of healthcare needs of the society at a county and voivodeship level. These documents provide the basis for the Healthcare Needs Map of Poland, which additionally contains analysis of healthcare provided at national level (ex.: transplantology). This approach identifies fields of healthcare system, which require coordinated intervention of more than one voivode or appropriate State authorities. Identified priorities for healthcare policy at a regional level and Regional Healthcare Needs Maps of Poland should be taken into account by the National Health Fund at the process of contracting of healthcare providers. This should lead to more rational financing of healthcare investments and healthcare system, decrease the risk of strictly arbitral decisions and increase the transparency of the system. Until the end of 2015 Healthcare Needs Maps in the fields of oncology and cardiology were prepared.

In addition, in 2015 the Ministry of Health introduced fast-track waiting lists for cancer patients. They are now guaranteed diagnostics and treatment within specified times, and there are no financing limits for treatment. Health care providers, who ensure timeliness and comprehensiveness of health care services, face no financing ceilings.

Challenges

The Polish government has continued in recent years to tackle the pervasive inefficiencies of the health system. The main challenges for the Polish health system currently are as follows:

- To continue increasing the efficiency of health care spending in order to adequately respond to the increasing health care expenditure over the coming decades, as this is a risk to the long-term sustainability of public finances.

- To improve the basis for more sustainable and larger financing of health care in the future. This can improve access and quality of care and its distribution between population groups and regional areas.

- To develop a comprehensive human resources strategy that tackles spatial/regional disparities, ensures sufficient numbers of staff in general, aims at increasing the number of general practitioners relative to specialist clinicians, and in the future in view of staff and population ageing and motivates and retains staff to the sector and to the country.

- To foster the reallocation of resources aiming at reducing the high share of spending on inpatient care and increasing the relatively low share of spending on typically more on outpatient care services.

- To strengthen the role of primary health care within the system and that of general practitioners in their role as gatekeepers.

- To carry out the mapping of health care needs aiming at identifying priorities for resources re-allocation and serving as a basis for investments in the health system.

- To tackle the multiple employment phenomenon, affecting accessibility and quality of public health services, and the widespread illegal use of public equipment and facilities by the individual practitioners.

- To pursue the restructuring and reorganisation of the hospital sector, aiming at rationalising existing hospital bed capacity and improving the cost-efficiency within hospitals, ensuring that care is provided in the most clinically appropriate and cost-effective way, for example by maximising the proportion of elective care provided on a day case basis, day-of-surgery admission; To closely monitor the effects on access to and quality of care related to possibility of voluntary transformation of public hospitals into corporate units (corporatisation).

- To foster a wide use of Health Technology Assessment and information and communication technologies in health care.

- To enhance health promotion and disease prevention activities, promoting disease screening given the most recent pattern of risk factors (circulatory system diseases, cancers).

Table 1.21.1: **Statistical Annex – Poland**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	192	205	245	273	314	364	315	362	380	389	395	9289	9800	9934
GDP per capita PPS (thousands)	12.7	13.1	13.5	14.1	15.1	15.0	14.7	15.7	16.3	16.7	16.8	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	3.9	5.4	3.7	6.3	6.8	5.1	1.5	2.9	4.5	2.0	1.6	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	2.9	4.7	3.9	6.1	9.0	14.4	6.2	0.2	2.3	0.2	0.2	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	6.2	6.2	6.2	6.2	6.3	6.9	7.2	7.0	6.9	6.8	6.7	10.4	10.1	10.1
Total current as % of GDP	6.0	5.9	5.9	5.9	5.9	6.4	6.7	6.6	6.4	6.3	6.4	9.8	9.6	9.7
Total capital investment as % of GDP	0.3	0.3	0.4	0.4	0.4	0.5	0.5	0.5	0.5	0.4	0.3	0.6	0.5	0.5
Total per capita PPS	579	631	672	726	826	968	1079	1119	1185	1211	1215	2828	2911	2995
Public as % of GDP	4.4	4.3	4.3	4.3	4.5	4.9	5.2	5.0	4.8	4.7	4.6	8.1	7.8	7.8
Public current as % of GDP	4.1	4.0	4.0	4.1	4.2	4.6	4.8	4.7	4.5	4.4	4.5	7.9	7.7	7.7
Public per capita PPS	383	407	434	472	537	646	712	733	833	838	845	2079	2218	2208
Public capital investment as % of GDP	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.1	0.2	0.2	0.1
Public as % total expenditure on health	69.9	68.5	69.4	69.8	70.5	71.7	71.6	71.2	70.3	69.2	69.6	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	9.6	9.9	10.1	10.5	10.7	11.6	11.4	11.0	10.8	10.9	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	97.3	99.3	98.1	97.8	97.8	97.8	96.6	91.0	91.6	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	27.6	29.4	27.8	27.1	26.3	24.4	24.4	23.7	24.0	24.3	22.8	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	38.2	38.2	38.2	38.2	38.1	38.1	38.1	38.0	38.1	38.1	38.1	502.1	504.5	506.6
Life expectancy at birth for females	78.8	79.2	79.3	79.7	79.8	80.0	80.1	80.7	81.1	81.1	81.2	82.6	83.1	83.3
Life expectancy at birth for males	70.5	70.6	70.8	70.9	71.0	71.3	71.6	72.2	72.5	72.6	73.0	76.6	77.3	77.8
Healthy life years at birth females	:	:	66.9	62.9	61.5	63.0	62.5	62.3	63.3	62.8	62.7	:	62.1	61.5
Healthy life years at birth males	:	:	61.2	58.4	57.6	58.6	58.3	58.5	59.1	59.1	59.2	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	109	106	102	97	94	91	87	83	171	165	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	7.0	6.8	6.4	6.0	6.0	5.6	5.6	5.0	4.7	4.6	4.6	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	1.73	1.70	1.76	1.79	1.91	2.17	2.23	2.20	2.11	2.11	2.13	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.06	0.11	0.11	0.10	0.10	0.13	0.14	0.14	0.14	0.14	0.14	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.37	1.27	1.13	1.16	1.21	1.37	1.49	1.42	1.40	1.44	1.48	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.89	1.84	1.74	1.69	1.57	1.58	1.65	1.59	1.54	1.41	1.38	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.14	0.14	0.16	0.16	0.16	0.18	0.16	0.14	0.14	0.14	0.14	0.31	0.31	0.32
Prevention and public health services	0.21	0.10	0.14	0.14	0.14	0.15	0.16	0.14	0.14	0.13	0.16	0.25	0.25	0.24
Health administration and health insurance	0.09	0.15	0.09	0.09	0.12	0.11	0.10	0.09	0.11	0.08	0.21	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	1.67	1.64	1.70	1.73	1.84	2.10	2.15	2.11	2.01	2.02	2.04	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.06	0.11	0.11	0.10	0.10	0.13	0.14	0.14	0.14	0.13	0.13	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	0.74	0.64	0.66	0.70	0.81	0.91	0.84	0.79	0.81	0.88	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.76	0.67	0.66	0.65	0.59	0.61	0.64	0.63	0.61	0.47	0.44	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.04	0.04	0.07	0.08	0.08	0.08	0.06	0.05	0.05	0.06	0.05	0.13	0.12	0.13
Prevention and public health services	0.19	0.09	0.10	0.10	0.10	0.10	0.10	0.10	0.09	0.09	0.12	0.25	0.20	0.19
Health administration and health insurance	0.08	0.15	0.09	0.09	0.12	0.11	0.09	0.09	0.10	0.08	0.13	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.21.2: **Statistical Annex - continued – Poland**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	28.9%	28.7%	30.1%	30.6%	32.2%	33.7%	33.2%	33.6%	33.0%	33.3%	33.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	1.0%	1.9%	1.9%	1.7%	1.8%	2.0%	2.1%	2.2%	2.2%	2.1%	2.1%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	22.9%	21.5%	19.3%	19.8%	20.4%	21.3%	22.2%	21.7%	21.9%	22.7%	23.2%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	31.6%	31.1%	29.7%	28.9%	26.5%	24.6%	24.6%	24.3%	24.1%	22.3%	21.6%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	2.3%	2.4%	2.7%	2.7%	2.8%	2.7%	2.4%	2.2%	2.2%	2.3%	2.2%	3.2%	3.3%	3.3%
Prevention and public health services	3.5%	1.7%	2.4%	2.4%	2.4%	2.3%	2.4%	2.1%	2.2%	2.1%	2.6%	2.6%	2.6%	2.5%
Health administration and health insurance	1.5%	2.5%	1.5%	1.5%	2.0%	1.7%	1.5%	1.4%	1.7%	1.3%	3.3%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	40.3%	40.9%	42.3%	42.7%	44.3%	45.6%	44.6%	45.0%	44.4%	45.6%	45.3%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	1.4%	2.8%	2.8%	2.4%	2.5%	2.8%	2.9%	3.0%	3.1%	3.0%	3.0%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	18.5%	15.9%	16.3%	16.9%	17.6%	18.9%	17.9%	17.4%	18.3%	19.6%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	18.4%	16.7%	16.4%	16.0%	14.2%	13.2%	13.3%	13.4%	13.5%	10.6%	9.8%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.0%	1.0%	1.8%	1.9%	1.8%	1.7%	1.3%	1.1%	1.1%	1.3%	1.2%	1.6%	1.6%	1.6%
Prevention and public health services	4.6%	2.2%	2.5%	2.5%	2.4%	2.2%	2.1%	2.1%	2.0%	2.0%	2.7%	3.2%	2.7%	2.5%
Health administration and health insurance	2.0%	3.7%	2.2%	2.1%	3.0%	2.3%	2.0%	1.9%	2.3%	1.7%	2.8%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	0.10	0.19	0.20	0.19	0.27	0.29	0.37	0.47	0.48	:	0.64	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	0.6	0.8	0.9	1.0	:	1.1	0.9	0.9	0.8
CTS per 100 000 inhabitants	0.6	0.7	0.8	0.9	1.0	1.1	1.2	1.4	1.3	:	1.7	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	0.0	0.0	0.0	0.0	:	:	0.1	0.1	0.1
Proportion of the population that is obese	:	12.5	:	:	:	16.4	15.8	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	26.3	:	:	:	23.8	23.8	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	9.1	9.2	9.5	10.4	10.9	11.4	10.7	10.0	10.1	10.1	10.7	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	243	229	214	218	219	216	217	217	219	223	224	329	335	344
Practising nurses per 100 000 inhabitants	475	493	509	509	518	519	525	524	521	556	527	840	812	837
General practitioners per 100 000 inhabitants	12	13	14	14	16	22	21	21	20	22	22	:	78	78.3
Acute hospital beds per 100 000 inhabitants	486	479	469	465	462	441	439	435	429	432	431	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	6.1	6.2	6.3	6.6	6.8	6.8	6.8	6.6	6.8	7.0	7.1	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	16.8	17.2	13.8	14.3	14.0	14.2	15.7	15.5	15.6	:	16.2	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	1,630	1,878	2,105	2,685	2,818	2,894	3,770	4,050	4,362	:	4,328	6368	6530	7031
Acute care bed occupancy rates	:	:	:	:	:	:	:	:	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	:	:	7.9	7.6	7.4	7.5	7.4	7.3	7.1	6.8	6.7	6.5	6.3	6.3
Day cases as % of all hospital discharges	8.8	9.9	13.7	16.2	17.2	:	19.4	20.7	21.8	:	21.1	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	4.2	4.4	4.8	5.1	5.2	5.5	1.2	0.9
AWG risk scenario	4.2	4.7	5.4	5.9	6.1	6.4	2.2	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	38.5	38.4	37.5	36.2	34.8	33.2	-13.8	3.1

Sources: EUROSTAT, OECD and WHO

Poland

Long-term care systems

2.21. POLAND

General context: Expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at 16,800 and below the EU average of 27,900 in 2013. Poland has a population of 38.1 million inhabitants. ([425]) During the coming decades the population will steadily decrease, from 38.1 million inhabitants in 2013 to 33.2 million inhabitants in 2060. Thus, Poland is expected to face a considerable decrease of its population by 13%, while the EU average population is estimated to increase by 3%.

Health status

In 2014, life expectancy at birth for both women and men was respectively 81.7 years and 73.7 years and was below the EU average for women and men (83.6 and 78.1 years respectively). In 2013 healthy life years at birth were with 62.7 years (women) and 59.2 years (men) slightly below the EU averages (61.5 and 61.4, respectively) in 2013. The percentage of the Polish population having a long-standing illness or health problem is higher than in the Union (34.1% in Poland versus 32.5% in the EU). The percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 8.1%, which is lower than the EU average (8.7%).

Dependency trends

The number of people depending on others to carry out activities of daily living increases significantly over the coming 50 years. From 2.6 million residents living with strong limitations due to health problems in 2013, an increase of 45% is envisaged until 2060 to more than 3.7 million. This applies to the "demographic scenario" of the 2015 Ageing Report, which assumes that the dependent population evolves in line with the total elderly population and all gains in life expectancy are spent in bad health. That is a steeper increase than in the EU as a whole (40%). In a less pessimistic scenario, and assuming that half of the projected gains in life expectancy are spent without disability (AWG reference scenario), the increase in the number of the dependent population is 3.4 million, i.e. a 32% increase (EU: 30%). Also as a share of the population, the dependents are becoming a bigger group and an increase of 68% is projected (from 6.7% to 11.2%). This is considerably above the EU-average increase of 36%.

([425]) According to the Central Statistical Office of Poland, the population on 31st June 2015 was 38.45 mln.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the AWG reference scenario, public long-term care expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.9 pps of GDP by 2060. ([426]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.9 pps of GDP by 2060. This reflects, that coverage and unit costs of care are comparatively low in Poland, and may experience an upward trend in future, driven by demand side factors.

Overall, projected long-term care expenditure poses a risk to the medium and long-term sustainability of public finances. The medium-term risks are related to the unfavourable initial budgetary position and the projected impact of age-related spending. Over the long run, Poland faces medium risks to fiscal sustainability. These risks are largely due to an unfavourable initial budgetary position, but also to the necessity to meet future increases in ageing costs (notably healthcare and long-term care). ([427])

System Characteristics

There is no explicit and separate LTC insurance scheme in Poland. Long-term care is very fragmented and governed by several laws relating to healthcare, social care, family benefits (nursing benefits and nursing allowance), pensions and rehabilitation. The coverage by formal LTC is low, and traditionally, LTC in Poland is provided by

([426]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.

([427]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.

family members at home. LTC is financed by both the public and private stakeholders. There are co-payments on formal care, and the large provision of care is delivered informally by family members, and as such privately financed.

Polish legislation includes two kinds of separate LTC benefits: cash benefits and in kind benefits. Institutional care in Poland is split between the health sector (financed by the National Health Fund) and social assistance sector (financed indirectly by the Ministry of Family, Labour and Social Policy). The range of health benefits available to a patient in need of care is contained in the provisions of the regulation of the Ministry of Health on the guaranteed benefits (under the general health insurance), which determines the list and the terms of the guaranteed benefits of the above range.

Public spending on LTC reached 0.8% of GDP in 2013 in Poland, below the average EU level of 1.6% of GDP. Near 56% of the benefits were in-kind, while 44% were cash-benefits (EU: 80% vs. 20%). Thus, Poland seems to have below average usage of cash benefits.

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 70% higher in Poland. However, overall only 56% of these dependents receive formal in-kind LTC services, while the remainder 44% receive a low amount of cash benefits. Overall, 4.6% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 81% of public in-kind expenditure (EU: 61%), 19% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States Poland has a focus on institutional care (within formal care), which may not be surprising regarding the fact that overall little formal care is provided.

Types of care

Both cash benefits and in kind benefits are available. Cash benefits include, apart from social assistance benefits which may also be awarded to persons in need of long-term care in difficult situations: medical care supplement and medical care allowance. Three types of care are provided: home care, semi-residential care and residential care. Home care includes in-kind nursing and social services as well as cash benefits. Semi-residential care is provided in day care and support centres. Residential care is provided via the "social assistance house", care and treatment facilities, nursing and care facilities.

Eligibility criteria and user choices: dependency, care needs, income

In the health sector eligibility is defined by severity of needs measured on a Barthel scale of disability. In the social assistance sector, and according to the act on the social assistance, the provided care services are granted on the basic of a special individual needs evaluation (including age, level of illness or disability). If the recipient of care requires all day care, which cannot be provided at home, then that person is entitled to a place in the social assistance house. The income situation of the patient, however, is taken into account to determine the payment for care services and charge for staying in the social assistance house. The eligibility for other in-kind benefits which are provided within the social assistance is defined by an income-test. Nursing care for people treated in residential homes is provided as a part of general costs of stay. There is co-payment for this kind of services, residents cover 70% of the accommodation costs, and except for people with the lowest income (in this case co-payment is shared with the municipality).

Persons requiring long-term care are also entitled to long-term care in home settings and institutional long term care. The Ministry of Health regulate access to guaranteed benefits in this field. In accordance with the regulations, a patient, who in the "Barthel scale" received 40 points or less, shall be awarded general health services within the institutional or home-based long term care. Patients cared for in institutional settings are financed by the National Health Fund. For institutional care there is also co-payment in place,

with the patients' coverage of the accommodation costs set at 70%.

A nursing allowance is given to entitled recipients as a supplement to an old-age, disability or survivors' pension at the age of 75 or more, as well as to recipients of any age entitled to an old-age, disability or survivors' pension being incapable to do paid work and requiring assistance in daily activities. All in-kind benefits require a co-payment by the patient. A medical care allowance is given to recipients fulfilling specific health and age criteria, independent of family income. These are children up to the age of 16 requiring permanent assistance from another person and children older than 16 years with a moderate degree (level) of disability that began at the age of entitlement to the family allowance, or disabled persons with severe degree (level) of disability, without age criteria, and persons aged 75 or more.

Recently legislated and/or planned policy reforms

Since 2012, there have not been any significant reforms in the field of LTC within social assistance. Minor changes referred to the standardisation of certain services which regulate rehabilitation activities and others. However, income criteria were verified in 2015 (verification is done every three years) as well as the amount of cash benefits from social assistance. As a result, increased income criteria were established: for a single person – 634 PLN (increase by 92 PLN; 17% in comparison to the previous criteria established in 2012); for one person in a family – 514 PLN (increase by 58 PLN; 12.7%). The regulation came into force on October 1, 2015. Income criteria form the basis of social assistance benefits, the amount of payment for care services and payment for staying in residential care homes.

Planned reforms in the field of LTC include among the others the further standardisation of services, support for the development of services and the creation of daily care residential homes for the elderly and dependent in local environments, reconstruction of institutional care buildings, including modifying the method of payment for staying in residential care homes. In 2013, 86,967 persons benefited from social assistance benefits, whereas the number of people benefiting from residential care homes equalled 84,112.

Moreover, several government resolutions were passed in the 2013-2015 period related to "elderly people policy". Among others, these include:

The Cabinet Resolution No 237 from December 2013 on establishing The Governmental Programme for Social Activity of Elderly People in2014-2020: the aim of the Programme for Social Activity of Elderly People (The ASOS Programme) is to improve the quality and level of living of elderly people to allow ageing with dignity through social activity. It is planned that the State budget will spend 280 mln PLN in total on this Programme during the 2014-2020 period.

The Cabinet Resolution No 238 from December 2013 on accepting the Assumptions of the Long-Term Elderly People Policy in Poland in2014-2020: this resolution fulfils the commitment stated in the Governmental Programme for Social Activity of Elderly People in 2012-2013 (The ASOS Programme). The ASOS Programme is the first nation-wide programme prepared on such a large scale, designed for elderly people and cross generational cooperation.

The Cabinet Resolution No 34 of from March 2015 on establishing a multi-year programme “Senior-WIGOR” in 2015-2020: the strategic aim of the programme is supporting elderly people through subsidising the activities of the local government units intended to develop networks of Day Care Centres “Senior-WIGOR”. Special focus of the programme is on local government units which have low income or high fraction of elderly people in the total population or have no infrastructure of social services for providing care services for the elderly outside their home. It is planned that the state budget will allocate 370 mln PLN in total on this programme during the 2015-2020 period.

Challenges

Poland has a relatively fragmented system of LTC, with low coverage and a large provision of informal care that is privately financed. The main challenges of the system appear to be:

- **Improving the governance framework**: to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities with

respect to the provision of long-term care services; to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** to face the increased LTC costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage; to reduce the risk of impoverishment of recipients and informal carers.

- **Encouraging home care:** to develop alternatives to institutional care by e.g. developing new legislative frameworks encouraging home care and regulation controlling admissions to institutional care.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care**: to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 2.21.1: **Statistical Annex – Poland**

GENERAL CONTEXT

GDP and Population	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
GDP, in billion euro, current prices	192	205	245	273	314	364	315	362	380	389	395	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	12.7	13.1	13.5	14.1	15.1	15.0	14.7	15.7	16.3	16.7	16.8	26.8	27.6	28.0	28.1	27.9
Population, in millions	38.2	38.2	38.2	38.2	38.1	38.1	38.1	38.0	38.1	38.1	38.1	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	:	1.0	1.0	1.0	1.0	:
Per capita PPS	31.0	42.7	46.2	49.6	54.0	56.8	58.9	68.1	72.5	80.0	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.9	0.9	0.9	0.9	0.9	0.9	0.9	0.9	1.0	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	78.8	79.2	79.3	79.7	79.8	80.0	80.1	80.7	81.1	81.1	81.2	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	70.5	70.6	70.8	70.9	71.0	71.3	71.6	72.2	72.5	72.6	73.0	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	:	66.9	62.9	61.5	63.0	62.5	62.3	63.3	62.8	62.7	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	:	61.2	58.4	57.6	58.6	58.3	58.5	59.1	59.1	59.2	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	32.2	32.6	32.1	30.9	32.8	33.6	34.1	34.5	34.1	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	2.3	6.3	6.9	6.6	7.4	7.9	7.3	7.5	8.1	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**EU 2009**	**EU 2010**	**EU 2011**	**EU 2012**	**EU 2013**
Number of people receiving care in an institution, in thousands	:	:	:	:	46	73	100	127	130	133	86	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	5	18	32	45	46	46	118	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.1	0.2	0.3	0.5	0.5	0.5	0.5	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	1,214	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.21.2: **Statistical Annex - continued – Poland**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	38.1	38.4	37.5	36.2	34.8	33.2	-13%	3%
Dependency								
Number of dependents in millions	2.56	2.79	3.14	3.49	3.58	3.72	45%	40%
Share of dependents, in %	6.7	7.3	8.4	9.6	10.3	11.2	68%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.8	0.9	1.1	1.3	1.5	1.7	112%	40%
AWG risk scenario	0.8	1.0	1.3	1.7	2.1	2.7	235%	149%
Coverage								
Number of people receiving care in an institution	85,891	98,245	116,858	143,286	154,708	164,923	92%	79%
Number of people receiving care at home	118,136	135,206	161,532	198,372	216,039	231,057	96%	78%
Number of people receiving cash benefits	1,583,250	1,735,589	1,962,179	2,272,236	2,420,029	2,531,404	60%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	4.6	5.1	6.0	7.2	8.0	8.8	90%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	69.7	70.5	71.3	74.9	77.8	78.8	13%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	56.0	56.5	57.8	57.6	58.2	60.0	7%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	44.0	43.5	42.2	42.4	41.8	40.0	-9%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	81.3	81.1	80.8	80.3	80.1	79.8	-2%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	18.8	18.9	19.2	19.7	19.9	20.2	8%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	164.0	161.8	162.0	152.3	156.8	164.0	0%	-2%
Unit costs of home care per recipient, as % of GDP per capita	27.5	27.4	27.8	26.9	27.9	29.6	8%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	8.6	8.7	8.7	8.8	9.0	8.9	4%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".