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Socio-economic determinants of health status in Poland

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Introduction

Almost 30 years after the introduction of a revolutionary economic transformation programme, Poland has become a very successful example of a transition country. Over the last three decades output has expanded vigorously and living standards have improved. Since 1990s the shift from previous centrally planned economies to market economies, has also brought about some elements of Western countries, including aging, as well as new unhealthy lifestyle patterns, like sedentariness and processed food consumption.

Despite this welfare-improving transformation and the GDP per capita in 2020 being almost three times greater than in 1995, reaching US\$ 17,407, still Poland has one of the lowest life expectancies in Europe. On top of that, according to the OECD 2019 health data, Poland suffers significant within country inequalities in health status, especially in terms of educational status: the gap in life expectancy between lower and higher educated men amounts to 12 years, while the average gap in the EU countries is equal to 7.6 years. Furthermore, there is a considerable regional variation in life expectancy. In the case of men, the gap reaches almost 8 years. These regional heterogeneities are likely to uncover regional variations in social and human capital, which were promoted unevenly during the communist era, leading to structural differences in living conditions across specific territories of the country.

Education is by far one of the most frequently used measure of socio-economic status that to a large extent determines individual health status. As such, countries with wide educational gaps feature massive health inequalities too. However, the issue with studying the nexus between health and education is complicated by the endogeneity of the two phenomena. Better education status warrants better health, but better health enables individuals to obtain better education. Additionally, there is a wide range of third unobservable factors, that penalize health and socio-economic status in Poland. We can think of genetic and epigenetic endowment, poverty, behavioral risks and others. For example, in Poland life expectancy gains following the economic transformation in the early 1990s were likely to be attenuated in voivodeships where large workplaces were closed, and where the transition to market economy brought high unemployment and important social exclusion mechanisms. This heritage from the transformation period is likely to have deepened the socio-economic and health gaps over time across regions and individuals.

The scope of this analysis is to summarize potential socio-economic sources of health inequality in Poland, and discuss the status of some of the indicators that best describe the phenomenon in terms of both its evolution over time and the current situation.

Poland today: three decades of change

Since 2004, Poland is one of the European Union (EU) Member States. Its population reaches 38 million individuals positioning at the top of the ranking among the central European countries and among the largest EU countries. As seen in [Table 1](#), GDP in Poland has increased over the years, both in absolute and in per capita terms, with average annual growth rates exceeding 4% since 1990's till now. GDP per capita is still lower than in other member countries and represents roughly 70% of the EU average.

After the Second World War, Poland was dominated by Soviet influence, and its government and parliament by socialist parties. With the fall of communism occurred in the end of the 1980s, Poland underwent a rapid and harsh transformation, which could be described by an overnight transition from central planning to market economy. A real life experimentation of these two opposing economic mindsets was run with the introduction of the so-called "Balcerowicz Plan". The plan consisted of a set of drastic reforms which were introduced in order to deal with important macroeconomic destabilization, sky rocketing levels of inflation, supply shortages and historically famous queues. The main aim of the Plan was to restore a sustainable economic equilibrium and the tools it proposed comprised a full liberalization of prices and foreign trade through the removal of large subsidies and taxes. Eventually, the economic transition was also aimed reaching development capacity in order to promote well-being and adequate socio-economic status among the population. After only a few years significant instability, the country started to recover, and as seen in [Table 1](#), it started to grow at 7% a year (with an inflation rate of 2%, reaching comparable levels of the rest of the EU in 2005). Among various reforms, local government transformation gave rise to a more efficient local administration, which especially after the EU access in 2004 promoted an effective absorption of EU structural funds mainly for infrastructure investments. Important gains in the levels of education and human capital development helped the labor force to adapt to new labor market needs which were evolving with the increasing levels of foreign capital inflows.

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Table 1. Macroeconomic and health indicators - selected statistics (1995-2019)

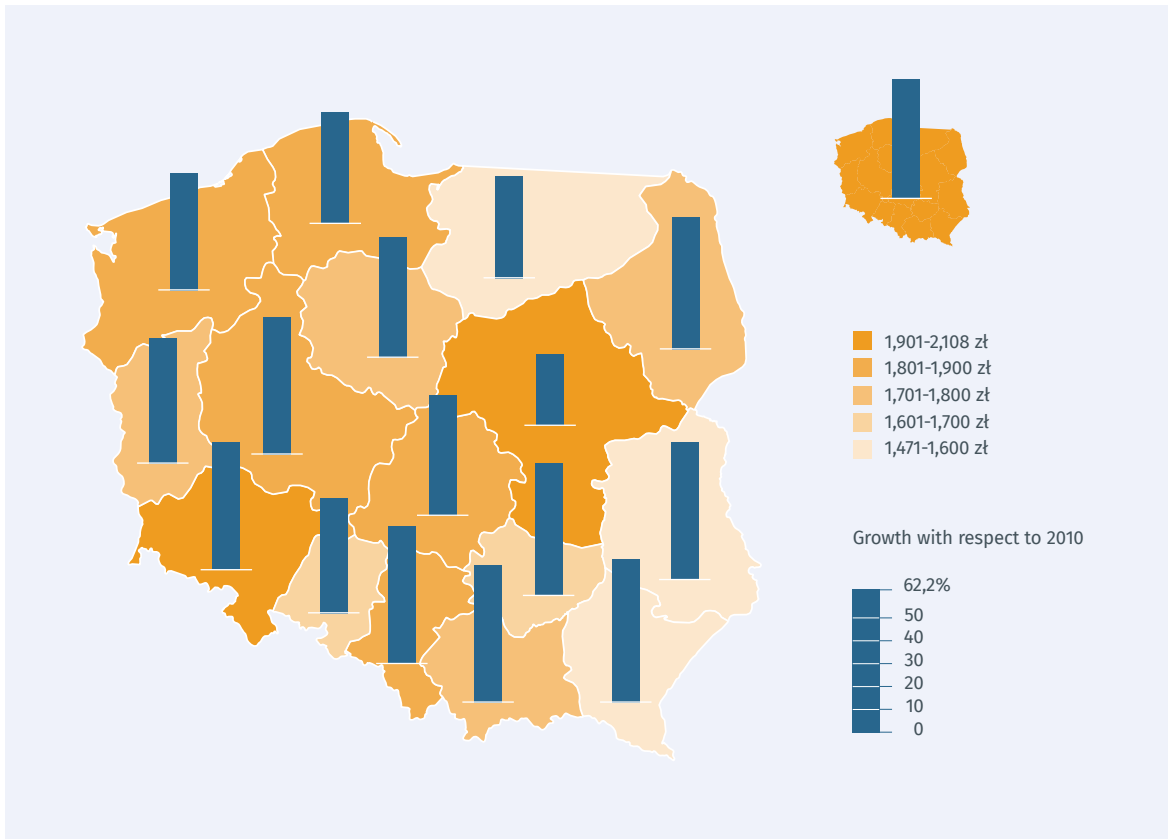
Series Name	GDP (current US\$ in billions)	Gini index (World Bank estimate)	GDP per capita (constant 2010 US\$)	GDP growth (annual %)	Unemployment with advanced education (% of total labor force with advanced education)	Unemployment with basic education (% of total labor force with basic education)	Unemployment, total (% of total labor force) (national estimate)	Life expectancy at birth (years)	Mortality rate, neonatal (per 1,000 live births)
1995	252,8	n.a.	6549.1	7.10	4.4	14.8	13.7	71.9	9.7
2000	326,94	n.a.	8545.5	4.56	5.5	21.5	16.3	73.7	5.8
2005	379,9	35.8	9954.0	3.51	7.1	27.1	17.7	75.0	4.6
2010	479,8	33.2	12613.0	3.74	5.0	17.3	9.6	76.2	3.6
2015	555,0	31.8	14610.9	4.24	4.0	16.8	7.5	77.5	2.9
2019	660,9	n.a.	17406.6	4.54	2.0	8.3	3.3	77.6	2.7

Source: World Bank data.

An indicator that lagged behind was unemployment which remained high until the second half of 2000s, and started decreasing to 9.6% in 2010, with subsequent drops to 7.5% in 2015 and 3.3% in 2019. Nevertheless, the benefits of a more favorable labor market climate were not equally distributed across Polish regions (Voivodships) and within them, across urban and rural areas. Roughly a 1/3 of the Polish territory is less urbanized, the unemployment rate is excessive, often amounting to more than 20%. Unemployment phenomenon virtually did not exist before 1989 and it deepened abruptly during the transition when Poland experienced the closure of many enterprises. The process was supposed to represent a creative destruction with an inevitable massive dose of social change. Thousands of inefficient state enterprises employed virtually the entire non-agricultural workforce. A quick transition towards high-skilled jobs left a significant part of the labor force inadequately equipped. Additionally, the reallocation of labor and capital from state run enterprises to privately run ones failed to reorganize the large inefficient companies into productive market competitors which were frequently left to fail. The growth instead was driven by establishment of new small and easily manageable businesses, which were frequently located in different areas with respect to the original labor force distribution. Workers were supposed to move from unproductive centrally run, yet secure employment, to market competition for specialized posts, frequently localized in urban areas with a significant increase of temporary contracts and limited social assistance.

A quick transition towards high-skilled jobs left a significant part of the labor force inadequately equipped.

Figure 1. Average monthly earnings per capita in households in 2019



Source: Statistics Poland (GUS, 2020).

Figure 1 presents the current distribution of average earnings of Polish households in 2019 among single Voivodships. The territorial disparities reflect to a large extent the rural-urban divide as well as the inheritance of the mass liquidation of state enterprises which caused eventually large mobility of individuals across sectors and areas of the country.

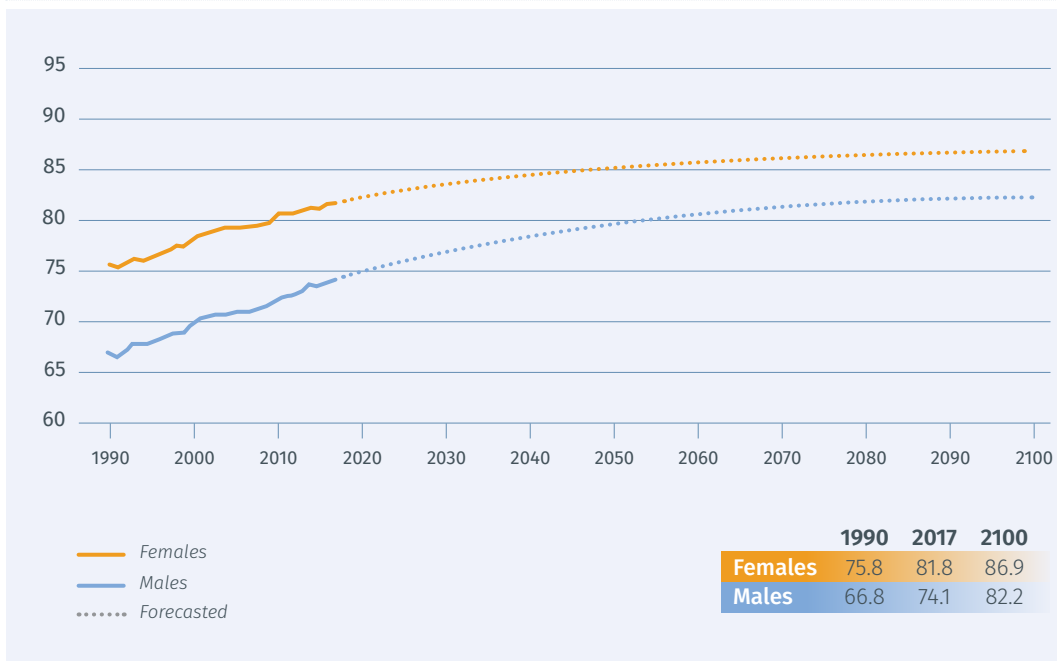
Current health status

After the First World War in 1918 the Republic of Poland was born, and in parallel the Ministry of Health, Social Care and Protection of Work, was established mainly to control communicable diseases and hygienic standards in the country. Poland was born after nearly 130 years of occupation by three major world powers at the time: Germany, Austro-Hungary and Russia. The three administrations run different social systems which gave rise to secular differences in socio-economic status across regions (Paszowska, 2004). In 1920 the first law on healthcare coverage was introduced, inspired by the German Bismarck model (Cichon and Normand, 1994). The so called Sickness Fund (“Kasa Chorych”) used payroll contributions from employers and was also limited to paid-employees, who represented a narrow share of the population. According to Paszowska (2004), the system was subsequently reformed in 1934 into Social Insurance (“Ubezpieczalnie Społeczne”), cutting down on access and services delivered and contributing to worsening of health status in Poland. The universalistic healthcare provision was gradually introduced with the influence of Soviet Union, which postulated universal access to healthcare and medical services to all citizens, financed by the state budget, with physicians and medical staff being state employees, while medical goods and services being free of charge. The full coverage was achieved in 1972 but the quality and the level of services provided was overall very low (Podstawka, 2010).

The economic transition did not face healthcare reforms until 1997, when the communist era organization was reversed back to the Sickness Fund (“Kasa Chorych”) present in the interwar period. Only in 2004 the Polish Social Health Insurance - Narodowy Fundusz Zdrowia (NFZ) was established. The NFZ system provides access to a broad scope of benefits. The NFZ offers a free public healthcare provision to every Polish and EU resident who has the right to accessible healthcare. The NFZ is financed from a mandatory contribution from Polish citizens structured as a deduction from individual income. These contributions are the main source of funding for public and free health insurance. The Ministry of Health coordinates the provision of healthcare which is very fragmented, with an important focus on hospital care. Poland has one of the lowest healthcare spending as a share of GDP, it amounts to roughly 6%, while the EU average is above 9%.

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Figure 2. Life expectancy at birth (1990-2100)



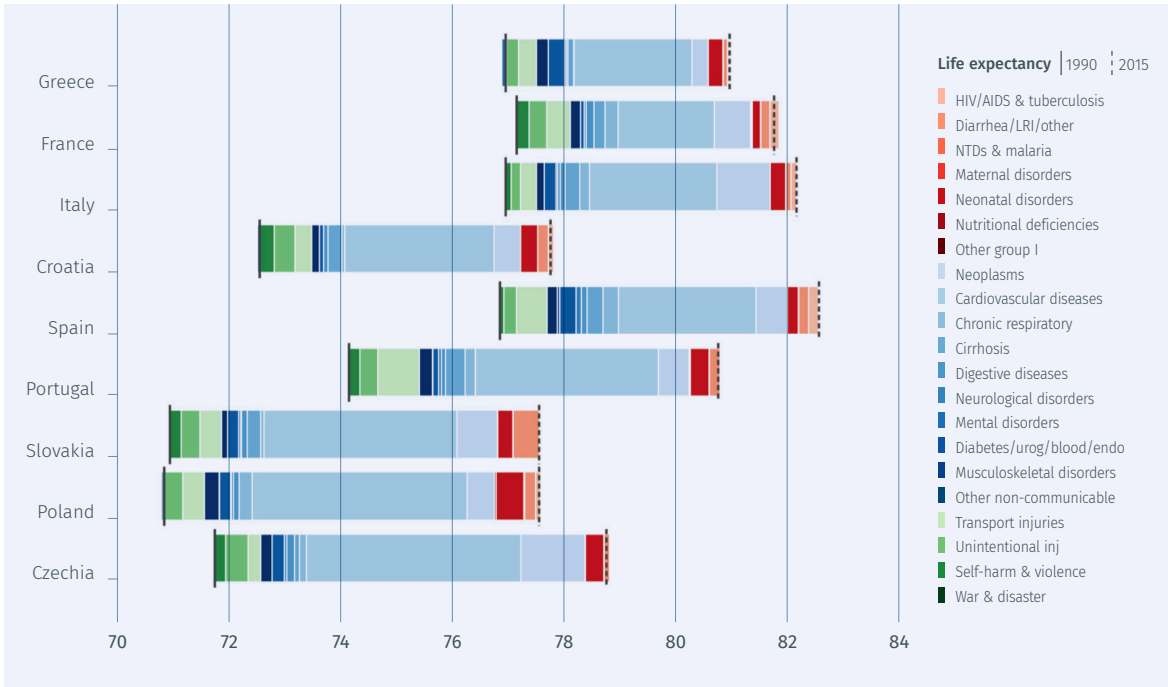
Source: Institute for Health Metrics and Evaluation, GBD.

Today Polish life expectancy at birth amounts to 78 years and is lower with respect to 81 years of the EU average. The period of economic transition of the 1990s brought around a relevant improvement in the health status of the Polish population. The important socio-economic changes that occurred promoted public healthcare provision and the reorganization of healthcare services.

As shown in [figure 2](#), life expectancy in 1990 amounted to 75.8 years for women and to 66.8 for men, increasing in 2017 to 81.8 and 74.1 respectively. The gains were wider for men, which sets the gender gap at about 8 years. The further increases to be achieved till 2100 are projected to be slower in pace, and expected to reach 86.9 and 82.2 years for women and men respectively.

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Figure 3. Change in life expectancy at birth (both sexes) between 1990 and 2015



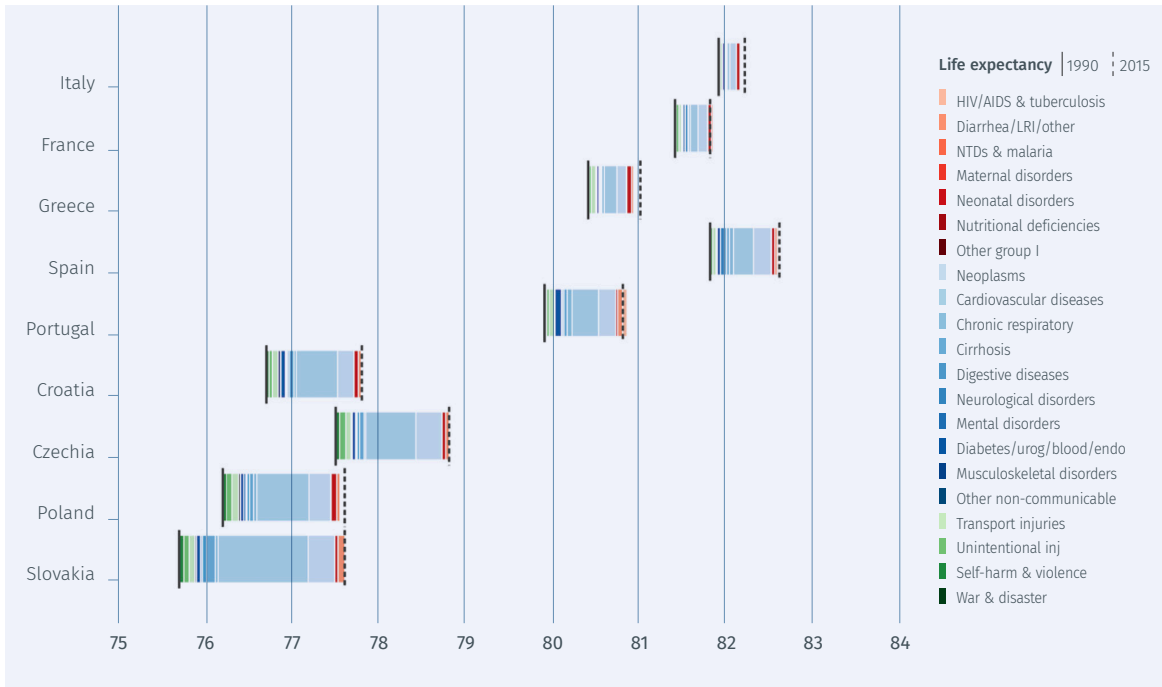
Source: Institute for Health Metrics and Evaluation, GBD.

When looking at [figure 3](#), we see that with respect to a selected group of EU member states, Poland has achieved an important life expectancy gain between 1990 and 2005, amounting to an additional 7-year life length. This increase is comparable to other similar in economic and geographic terms countries like Czechia and Slovakia. It has been driven by reductions in mortality due to cardiovascular disease, and with respect to its neighbors, to a narrower extend due to neoplasms.

When looking at the change in more recent years, between 2010 and 2015 ([figure 4](#)), we can see that the gains were less pronounced with respect to Czechia and Slovakia, leading to life expectancy at birth in 2015 being almost equal to that of Czechia in 2010. The distance between EU countries with the highest longevity remains vast, as Spain and Italy achieve at birth life expectancy of more than 82 years.

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Figure 4. Change in life expectancy at birth (both sexes) between 2010 and 2015

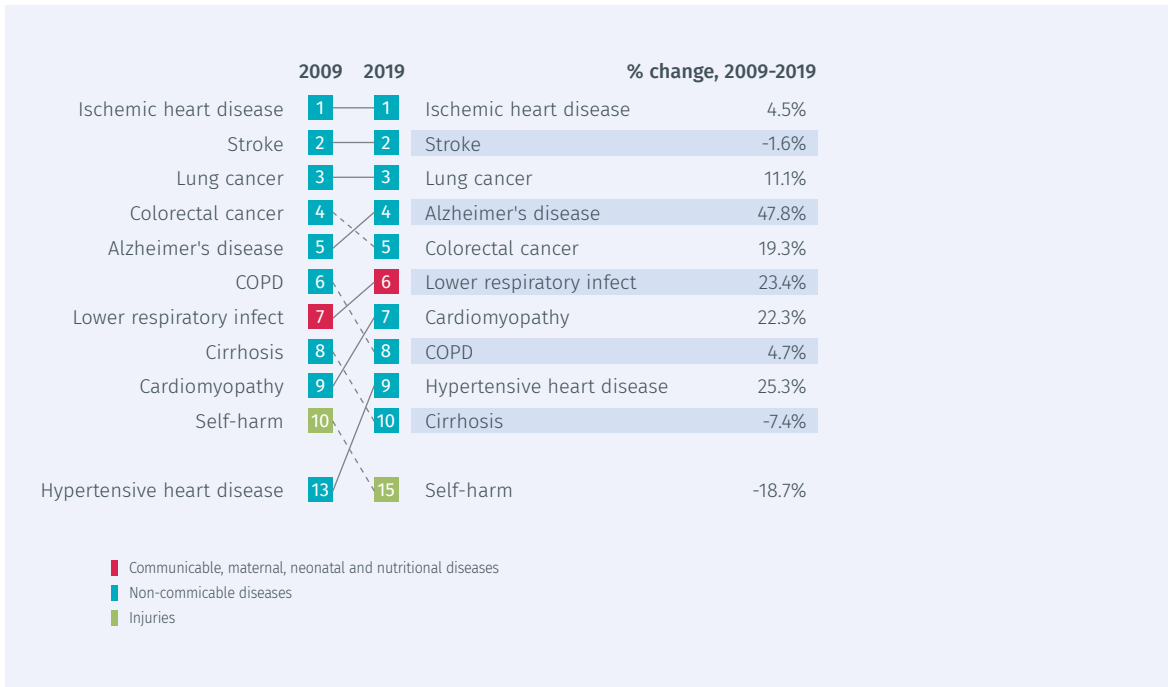


Source: Institute for Health Metrics and Evaluation, GBD.

The most frequent causes of mortality in Poland are represented by non-communicable diseases, with Ischemic heart disease on the first place since 2009 (see figure 5). This most deadly health issue has also been on the rise since that year, increasing by additional 4.5%. The second and third position is occupied by Stroke and Lung cancer respectively, with the former one seeing an important increase of 11.1% since 2009. In the last decade, improvements have been achieved in mortality of Colorectal cancer, COPD, Cirrhosis and Self-harm. Conversely, Alzheimer's disease, Lower respiratory infections, Cardiomyopathy and Hypertensive heart disease have been on the rise.

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Figure 5. Most frequent causes of death (2009-2019)



Source: Institute for Health Metrics and Evaluation, GBD.

Inequalities in health

In the recent years, health inequalities have become a major public health issue. Health inequalities are driven by factors which belong frequently to socio-economic characteristics that determine health. Income levels, education attainment, occupation, territorial features, are all likely to shape the population health profile. All these aspects impact the evolution of health indicators in both short and long term, including disease incidence, disability, mortality and life expectancy.

When inequalities pervade societies, distinct subgroups of it are destined to benefit from different level of privileges, occupy different socio-economic roles, and as a consequence, have access to different types of goods. The access may be delimited or the individuals themselves might seek different types of access, where due to the so-called “market failures”, asymmetric information enables different types of individuals to internalize differently cost and benefits of investing in certain types of goods. One of such goods is healthcare.

Inequalities in health are particularly pernicious, as health endowment is likely to be transmitted across generations, hence bad health of an individual is likely to be transmitted to her offspring, reinforcing the inequality propagation chain.

The World Health Organization (WHO) defines health inequalities as “potentially avoidable differences in health between groups of people who are more or less privileged”. Generally speaking, health inequalities systematically prevent disadvantaged groups from achieving better health and make them more likely to be exposed at risk factors and other external impacts that are harmful and potentially avoidable.

Most individuals in the world do not benefit from the full health that is biologically possible (WHO, 2008). As evidenced in a seminal paper by Mackenbach et al. (1997), those who are socially and economically disadvantaged, are more likely to experience much worse health outcomes. One of the strongest socio-economic predictor of health is income and educational attainment. The two are closely related to a number of health status measures, like obesity, disability, mortality and life expectancy. It is thus clear that health status can be seen in a life-cycle perspective, as events and the accumulation of various factors that occur during prenatal life, early childhood and adolescence may affect later health status. The two concepts themselves are subject to the phenomenon of inequality, meaning that, depending on the type of society and the degree of social mobility it features, it is difficult to overcome the endowment inherited from the family background.

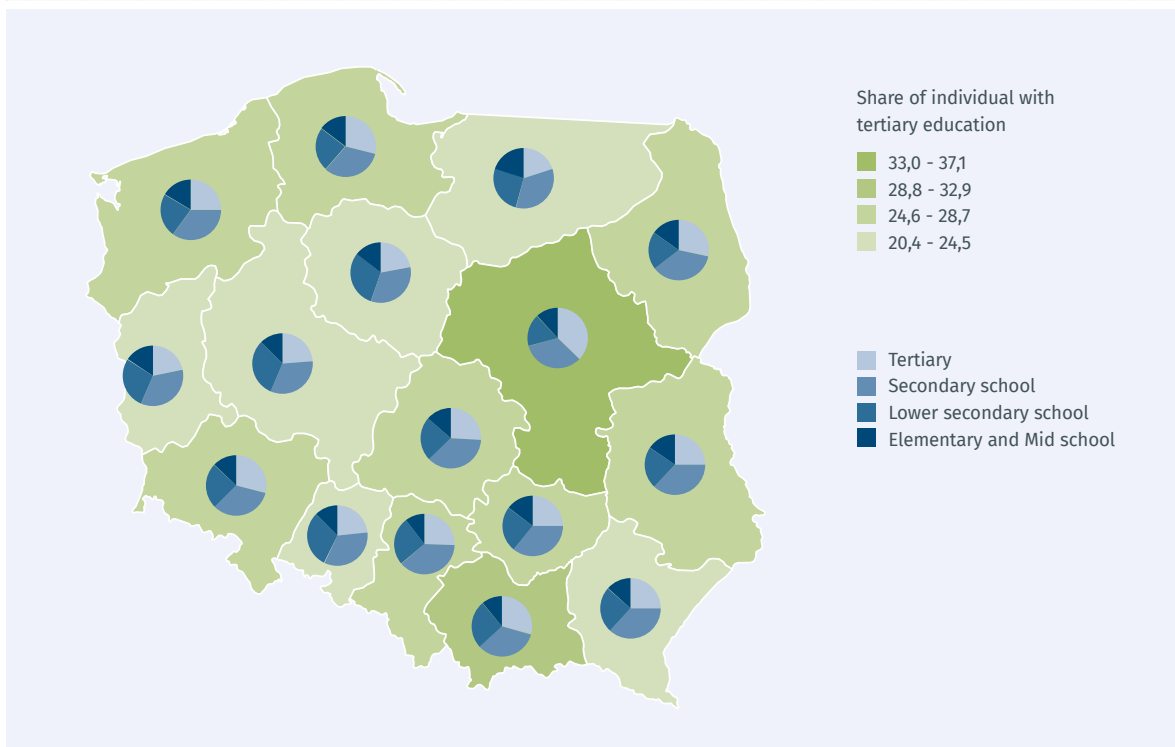
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A number of studies show how socio-economic conditions occurring in early life have an impact on later health and quality of life and how education and income are likely to mitigate this negative effect (Currie and Almond, 2012). In their paper, Mirowsky and Ross (2003) suggest that, education provides general and cognitive skills, which are the most important drivers of the relationship between health and socio-economic characteristics. In this paper, the authors suggest that education influences health through a direct and an indirect channel. They argue that education delivers productive abilities and fosters the sense of control throughout life, developing habits of preventing and solving problems. According to the literature, education teaches us how to communicate, read, write, inquire, research, interpret, experiment, and synthesize ideas. Ruhm (2012) underlines the role of individual deliberative abilities, rooted in cognitive functioning, which enable individuals to evaluate the long-run implications of their lifestyle choices. Also Kenkel et al. (2006), alluding to the seminal work of Grossman (1972), explains how schooling increases individual productive efficiency. The author finds that better-educated individuals obtain better health outcomes from the same set of inputs due to the abilities and information to make better choices for their lifestyles.

When it comes to education, the level of schooling in Poland has been constantly increasing in the last decades. Nevertheless, there are still important disparities in its attainment across the country. *Figure 6* shows how different the shares of tertiary education among different Voivodships are, with the most pronounced levels of highest educational attainment in the Mazovian Voivodeship, region surrounding Warsaw.

Education provides general and cognitive skills, which are the most important drivers of the relationship between health and socio-economic characteristics.

Figure 6. Individuals 15-64 according to level of education in 2018



Source: Statistics Poland (GUS, 2019).

Another important factor, closely related to education and health is income. According to [figure 7](#), inequalities in self-reported health according to income level, based on EU-SILC 2017 data are substantial in Poland. The Voivodship differentiation in the level of poverty is also visible in Poland ([figure 1](#)).

Figure 7. Inequalities in self reported health by income level



Source: European Commission Poland Country Profile (2019).

One of the most worrying panorama is the Lodzkie Voivodship, where severe poverty and its intergenerational transmission strengthens the relative disadvantage that the area accumulates over time in terms of income, education and health.

Risk factors

According to Mirowsky and Ross (1989), education indirectly facilitates individual development and interpersonal relationships, enabling people to pursue personal and professional success, which has a positive impact on health. In their work, Rosenzweig and Schultz (1983) argued that better education indirectly increases individual allocative efficiency, enabling individuals to allocate more inputs in health. Finally, again Ross and Mirowsky (1999) show how individuals with high levels of perceived control and social support are likely to invest more in health, and hence drink alcohol and smoke tobacco less while choosing balanced diets and active lifestyles—thereby reducing their chances of being overweight or obese.

Behavioral risk factors account for almost half of all deaths in Poland, which according to the European Commission Poland Country profile amount to 47%. The most severe risk factors pervading the Polish society are dietary risks, tobacco smoking, alcohol consumption and low physical activity. On average, mortality attributable to behavioral risk factors in the EU countries is lower and amounts to 39%.

Dietary risks constituted 25% of the risks in 2017 (EC, 2019) and range from low fiber (fruits and vegetables) intake, to high salt and sugar consumption. Also smoking represents a meaningful threat. Although smoking rates have decreased, they remain higher than the EU average. Both direct and second-hand smoking accounted for another 20% of the risks (EC, 2019). A prominent problem, also inherited from the pre-transition period, is alcohol consumption. Although Poland has made important progress in delimiting the issue of drinking, 7% of deaths can be attributed to alcohol consumption (EC, 2019). Additionally, binge drinking is rising also among teenagers. The obesity rate, and in particular obesity among children and teenagers, is higher than the EU average and constantly on the rise since 2001. In particular, the obesity rate in children has more than doubled since 2001.

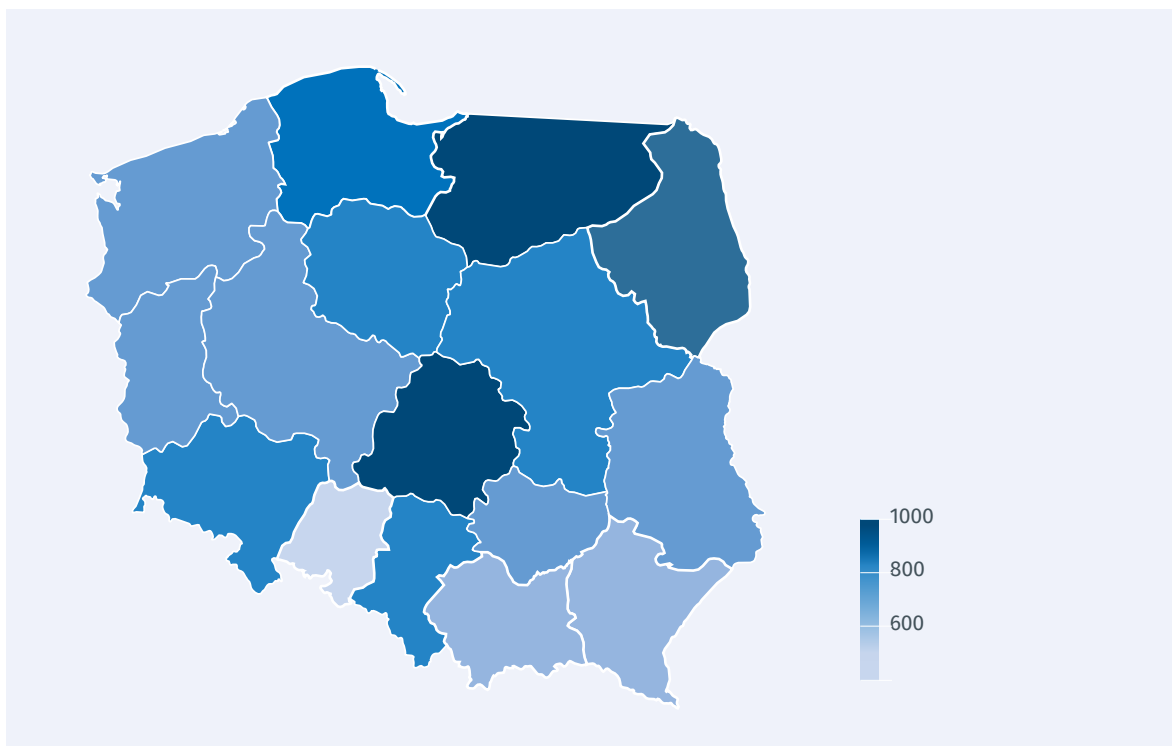
It is important to highlight that there are significant inequalities in how the risk factors are distributed in the Polish society, where in particular smoking, alcohol abuse and obesity, are more common among people with lower education or income. According to EC, 2019, in 2014, 19% of adults who had not completed secondary education smoked daily, compared to only 12% with tertiary education. This difference appears to be magnified between income groups, where 31% of people in the lowest income quintile were found to be smokers, while the same was true for only 18% in the highest quintile.

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According to Wojtyniak and Goryński (2018), a similar pattern emerges for obesity, where 18% of people without secondary education were obese in 2014, compared to 10% with higher education.

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Figure 8. DALY per 100,000 population, age-standardized 2019, alcohol use disorders



Source: European Commission Poland Country Profile (2019).

When it comes to alcohol use, [figure 8](#) represents the distribution of disability-adjusted life years (DALYs), a measure of overall disease burden, expressed as the number of years lost due to a particular health issue, in this case due to alcohol use disorders. The number of DALYs devoted to alcohol abuse seems to be of particular concern for the Voivodships

of Warmia-Masuria, Podlaskie and Lodz. The first two also happen to be those with lowest GDP per capita levels, while Lodz, as already discussed, suffers important problems of severe poverty rates.

According to *figure 9*, in spite of the decrease in smoking rates between 2009 and 2019 of 3.8%, tobacco remains the top risk factor and the top behavioral risk factor. It is immediately followed by hypertension, which has undergone a 15% decline in the recent years. Conversely, high body-mass index increased by 6.9% between 2009 and 2019. An important increase has also been found for glucose level (+19.7%) and occupational risks (+6.3%).

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Figure 9. Factors that drive the most death and disability combined (2009-2019)

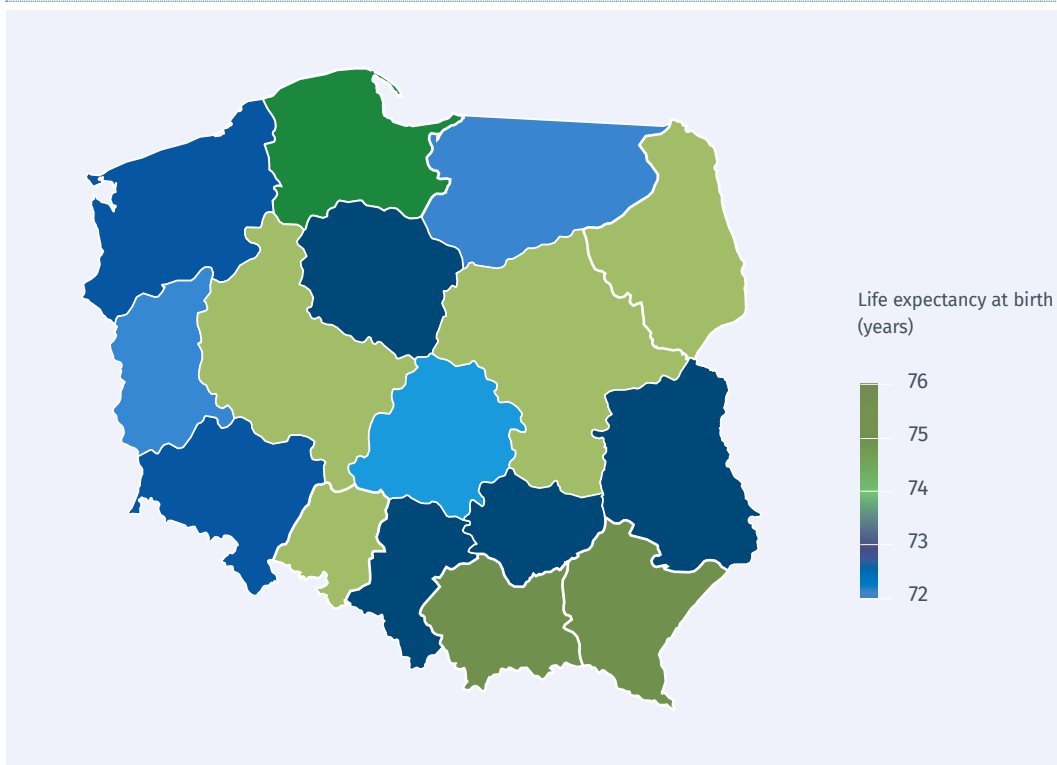


Source: Institute for Health Metrics and Evaluation, GBD.

The risk factors enlisted are likely to contribute to greater incidence of cardiovascular disease, the most life threatening disease group in Poland. In fact, these differences in the prevalence of risk factors contribute importantly to inequalities in health and life expectancy. When seen in

a cross-voivodeship setting, life expectancy among Polish populations bears important differences too (figure 10).

Figure 10. Life expectancy at birth (both sexes) in 2019



Source: Healthcare Needs Maps, (MPZ, 2020)

The Voivodeship of Warmia-Mazuria and Lodz present the lowest average life expectancy near to 72 years, while the longest life expectancy is featured by the residents of Lesser Poland (Małopolska). Lodzkie Voivodeship is the most penalized region in terms of inequalities in life expectancy, and this differential is likely to be driven by the unsuccessful economic transition it went through, where large workplaces operating under the previous regime were liquidated or collapsed. Inequalities, are thus greatest where social cohesion was the weakest and affected regions and social groups, where the transformation took away their previous forms of work and life, and where, in return, no aid programs were introduced.

Inequalities in access to healthcare

Although NFZ grants all Poles equal access to care as part of guaranteed services, it turns out that important inequities in this access affect the Polish population, across both geographical regions and socioeconomic groups. The uneven distribution of medical services and admission limits imposed by the NFZ, are accompanied by diversified level of wealth, which results in limited access to private services. In addition, financial outlays that are missing or ineffectively spent in the healthcare system slow down the progress of medical technologies, impeding faster diagnosis and treatment. As for the health status, the problem of inequality in healthcare access is related also to socio-economic characteristics.

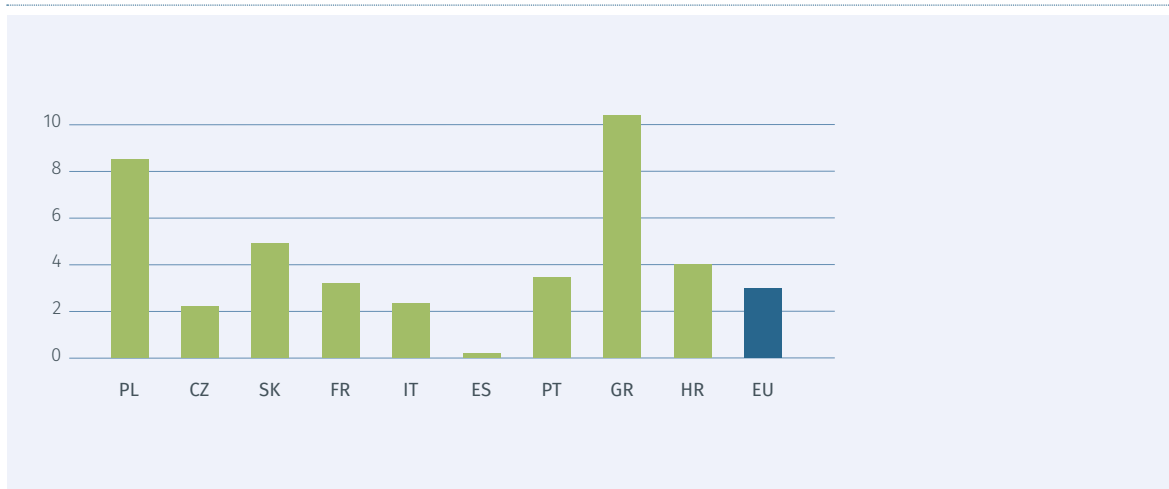
These differences are more significant in the case of specialist outpatient services compared with primary and hospital care (Sowa-Kofta, Rabczenko and Wojtyniak, 2017). For example, looking at cardiology, which is relatively well developed in Poland, differences in per capita spending by the NFZ branches range from PLN 48.8 to PLN 94.3 and the number of cardiologists per million inhabitants ranges from 53 to 122 (NFZ, 2017). Areas with the lowest level of income and education are also found to feature lower number of specialists clinics. In fact, the waiting times seem to be a particularly heavy problem in healthcare provision. To benchmark and contextualize these claims, *figure 11* shows the percentages of individuals who report having had an unmet need for medical examination or treatment, based on Eurostat (2018) data for selected EU countries. The data seem to be particularly alarming for Poland (next to Greece), whose percentage of unmet needs is almost triple with respect to the EU average. Unmet medical needs arise mainly due to long waiting times, but also costs. Outpatient medicines constitute a major coverage gap, which often results in catastrophic spending, particularly for low-income households. Overly long waiting lists for screening tests may lead some patients to visit specialists and diagnostic centres in the private sector, paying out-of-pocket fees for these services. Fully paid commercial services in private entities are provided at a high quality and due to public healthcare underfunding (resulting in patients' low satisfaction and long queues for receiving the treatment) the financing of private healthcare services is becoming more popular every year among wealthier population groups. Hence those with low incomes are forced to face long waiting times, and this applies in particular to scheduled operations, medical treatments and visits to specialists.

According to the data of the NFZ (2017), in 2016 as much as 83% of residents of the Lodzkie Voivodship took advantage of at least one benefit financed from public funds, which is much less than, for example, in the Opolskie Voivodship, where it is 74%. Also in terms of the average values of reimbursed benefits, in the richest Voivodship of Mazowieckie,

The uneven distribution of medical services and admission limits imposed by the NFZ, are accompanied by diversified level of wealth, which results in limited access to private services.

it amounted to PLN 2,900, while in the poorest, Warmia and Mazury, it was PLN 500 less. Access limitations are also felt in rural versus urban agglomerations, where medical staff frequently emigrates in search of better working conditions and pay.

Figure 11. Percentages of individuals who report to have had an unmet need for medical examination or treatment



Source: Eurostat health data (2018).

Another symptom of healthcare access barriers is the pattern in which patients visit the hospital instead of a primary care physician. In the case of Poland, according to Sagan et al., (2016), the emergency departments were found to treat patients that did not require emergency care, with the share of such patients accounting for 30-80% of all urgent admissions. The authors explain that the reason for such pattern is likely rooted in poor access to ambulatory care in particular in the evenings or at weekends, and this is of course more problematic for those who rely on the sole public provision of services.

Conclusions

If health inequalities reflect unfair, unnecessary and avoidable health gaps, their reduction should represent an ethical imperative for modern societies. In this context, state policy should focus not only on creating conditions for households to achieve higher incomes, but also on providing direct support to low-income households, reinforcing employment policies which are efficient in leveling of inequalities in the long-term perspective. In the recent decades the level of education in the Polish society has systematically improved, which is likely to promote correct health-related behaviors and alleviate the education-driven inequalities in various determinants of health.

However, health challenges remain. These include socioeconomic health inequalities, high rates of overweight and obesity, rising burden of mental disorders (and a very high suicide rate – with more people dying due to suicides than due to road accidents and with men accounting for almost 90% of suicides) and population ageing. Since older people have on average more chronic and complex health needs, more limitations in activities of daily life and worse health status compared with younger age groups, this is likely to lead to a growing demand for care and necessitate changes in the structure of healthcare and social care provision.

Non-communicable diseases are the leading cause of mortality and disability in Poland as in other EU member countries. Most of them are caused by risk factors that are largely avoidable like high blood pressure, smoking, alcohol drinking, hypercholesterolemia, obesity and bad diets. Many of these risk factors are closely related to social inequality. Effective addressing of these inequalities should embrace actions directed towards populations that are the most likely to develop such diseases. It is necessary also in the context of inequalities in the health of children and youth, which should be prevented from being transmitted across generations causing the most in need to have a bad start in terms of the health endowment from the earliest ages.

Paying attention to inequalities in health outcomes and access should be fundamental in any NFZ reform design, making sure that these inequalities are reduced or, at the very least, not exacerbated any further. In fact, the strategic goals of the NFZ expressed in the National Health Program (Narodowy Program Zdrowia, NPZ) for the 2016-2020 were to extend life expectancy, improve health-related quality of life, and reduce health inequalities. The NPZ indeed acknowledged that issues hampering the progress towards health inequalities reduction evolved around improving nutrition, reducing problems associated with addiction and risky behaviors and improving mental health. It was also recognized that the success of any efforts is warranted upon efficient family medicine and primary care, capable of improving care coordination. For this purpose a

series of pilot programs were introduced where primary care teams were formed, composed of different professional figures covering the same group of patients and providing primary care services, including health promotion and prophylaxis, in cooperation with hospitals, ambulatory specialist care, schools and kindergartens. Additionally, several prevention programs were introduced with the aim of access to prevention. Under one of such programs, in summer 2018 influenza vaccines were added to the statutory reimbursement lists, widening epidemiological prevention in Poland.

A fundamental problem that the NFZ has to face remains however the alarmingly low healthcare spending. While theoretically speaking statutory health coverage is universal, the universal access continues to feature severe shortcomings, due to long waiting times and high share of unmet health needs, which all setback reduction of health inequalities. In a wave of protests, junior doctors undertook a hunger strike in October 2017 demanding higher healthcare spending from public sources, reduced bureaucracy, rise in the number of medical staff and their salaries and shorter waiting lists for patients. The government promised it would gradually rise healthcare funding to over 6% of GDP by 2024, with an annual growth of about 0.2% of GDP. While the proposal sounds like a hopeful cure, in the COVID era it will depend on whether the government will be able to keep the promise, given the looming economic uncertainty, and on whether the pandemic is not going downplay the entity of this proposal.

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