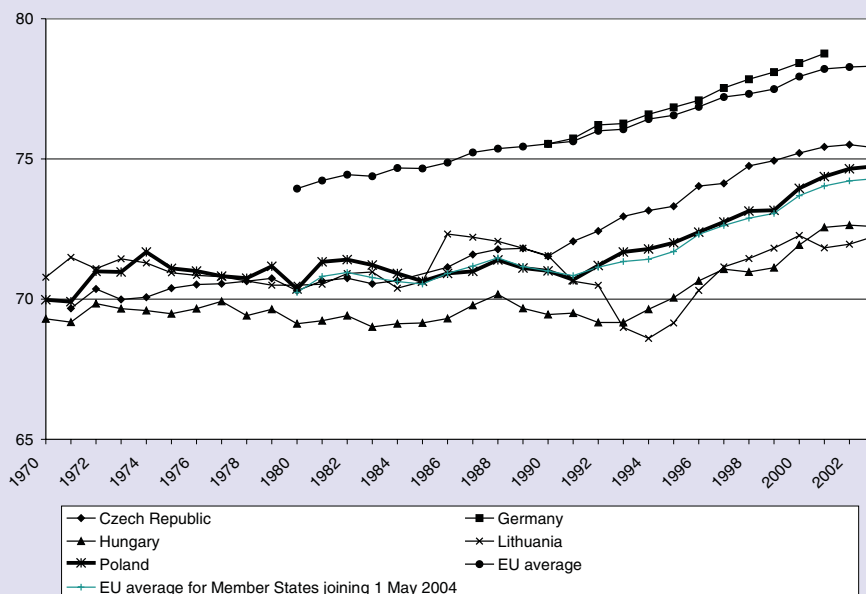


**Fig. 1** Average life expectancy at birth in Poland compared with selected countries and regional averages, 1970–2003



Source: European Health for All database, June 2005.

Note: EU: European Union.

## Overview

After the introduction of health reforms initiated in 1989, the new Law on Health Care Services Financed from Public Sources (2004) further reformed the current law in areas defining: the responsibilities of the Ministry of Health, the governance of the National Health Fund and health planning. While significant achievements, such as greater longevity, shorter hospitalization stays, improved primary health care, and a greater focus on health prevention and promotion, have been accomplished, numerous challenges, such as unfavourable demographic trends, an underfunding of the public health system and limited access to care, continue to hinder the

development of a positive attitude in the society towards the health system and health reforms.

## Health expenditure and GDP

In 2002, total expenditure on health in Poland as a percentage of GDP reached 6.1%: 2.6 percentage points lower than the average of 8.7% for countries belonging to the EU prior to May 2004,

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and 0.5 percentage points below the average of new EU Member States. Unemployment has been increasing since 1991 and was 18.1% in 2002, up 0.7% from the 2001 figures, while the inflation rate has been decreasing: it was 1.7% in 2002, down from 5.5% in 2001. Total expenditure on drugs accounts for about 2.4% of the country's gross national product (GNP) and are among the highest in Europe.

## Introduction

### Government and recent political history

The Republic of Poland is the largest country in central and south-eastern Europe (CSEE) in population and in area. In 1989, Poland was the first country among the CSEE countries to re-establish democracy after 44 years of communist rule. The parliament has a lower house (*Sejm*) and an upper house (*Senat*). The President of the Republic of Poland is elected in a general election for a five-year term. In the most recent presidential and parliamentary elections in September and October 2005, respectively, Lech Kaczyński from the nationalist-conservative Law and Justice Party (PiS) was elected president and his party won the parliamentary elections as well, winning 155 seats in the Sejm. The new PiS Prime Minister Kazimierz Marcinkiewicz leads a minority government, in which the independent Zbigniew Religas has been nominated as the new Minister of Health. Poland has been a member of the EU since May 2004. The Polish political system lacks stability, which translates into minority governments, such as the current government, and frequent strategic changes in policies. During the period 2001–2005, six different ministers headed the Ministry of Health.

### Population

In 2003, the population in Poland was estimated at 38.2 million. In recent years, the number of births has fallen below that of deaths, resulting

in negative natural population growth as in many other EU countries. It is estimated that by 2050 there will be 31.9 million inhabitants in Poland. The proportion of people over the age of 65, currently 12.9% of the population (2003) is projected to increase to 37.9% in 2025. In 2002, 62% of the total population lived in urban areas.

### Average life expectancy

Following years of decline during the 1970s and 1980s, average life expectancy at birth began to increase after 1991, reaching 78.9 years for women and 70.5 years for men in 2003. This figure is expected to rise to 81.4 years for women and 72.2 years for men in 2020–2025. Nevertheless, there is still a vast life-expectancy gap between Poland and western EU countries, which has only recently started to recede; since 1991, life expectancy at birth in Poland has developed in parallel with the average of other new EU Member States.

### Leading causes of death

Cardiovascular diseases are the major cause of death in both men and women (about 50%) in Poland. They are followed by neoplasms (24%) and external causes such as injuries and poisoning (about 10% for men and 4% for women).

## Historical background of the health care system

During the period of Polish independence between 1918 and 1939, health services were expanded, and a limited Bismarckian social health insurance system, covering 7% of the population, was introduced.

The Ministry of Health was created in 1945 during communist rule and during that time, administration of the health care system was strongly centralized, albeit with differences compared to the Soviet model.

Access to health services increased during the 1950s, when coverage was extended to include all state employees. In 1972 coverage was expanded to agricultural workers.

Reforms in the 1970s centred on creating integrated networks of care for health and social services in each district. Integrated health care management units, the ZOZ (*Zespół Opieki Zdrowotnej*), were established and the Ministry of Health was renamed the Ministry of Health and Social Welfare (1960).

Health sector reforms in the 1980s aimed at decentralization. In 1983, the ZOZ were given greater political and administrative powers. This was followed by further decentralization, the strengthening of primary care and the introduction of compulsory health insurance and sickness funds in 1999. After a change of government, the sickness funds were abolished in 2002 to be replaced by a centralized National Health Fund (NHF). However, this was ruled unconstitutional by the Polish High Court and a new Law on Health Care Services Financed from Public Sources was passed in August 2004 to accommodate the court ruling.

## Organizational structure of the health care system

The stewardship, management and financing functions in the Polish health care system are divided between the Ministry of Health, the NHF and territorial self-government administrations.

The central government, represented by the Ministry of Health, is responsible for national health policy, major capital investments and medical science and education, with administrative responsibility only for those health care institutions that it directly finances. Medical academies, university hospitals and research institutes are semi-autonomous but are ultimately accountable to the Ministry of Health.

The NHF, governed by 9 members of the fund council, finances the health services provided to insured persons from social contributions

through its regional branches. The NHF contracts with service providers for the supply of health services.

Territorial self-governments are responsible for three domains: general strategy and planning based on the identified health needs in a given region, health promotion, and the management of public health care institutions. The local centres of Public Health fall under the *voivodship* self-government, county hospitals fall under the county level and the local authorities (*gminas*) are responsible for primary care services.

## Planning, regulation and management

The NHF functions as the primary payer for health care in Poland making the fund responsible for the management and planning of health services. Planning in Poland is elaborated by the NHF on the basis of National Health Plans that indicate the volume and scope of health services for the given population. These plans are approved by the Ministry of Health. The NHF contracts the delivery of health care either through competition for public funds or through negotiations. The National Health Programme is responsible for trying to improve the health status of the population and related quality of life indicators.

The state is responsible for regulation in Poland through legislation such as the Law on Health Care Institutions.

## Decentralization of the health care system

The 1997 Law on Universal Health Insurance established the framework for mandatory health insurance, including universal health insurance contributions and budgetary expenditures from the state budget, and budgets of voivodship, county and commune authorities.

The NHF has the responsibility for planning and resource allocation in the Polish health care system, carried out by the decentralized NHF branches.

## Health care financing and expenditure

Poland has a mixed system for public and private financing. Public financing comes from universal health insurance contributions, voluntary insurance premiums, budgetary expenditure from the state budget and budgets of voivodship, county and commune authorities. Private financing includes both formal and informal sources of payments as well as pre-paid plans.

Health insurance contributions are the major public source of health care financing and are mandatory; it is not possible to opt out of the system on the grounds of level of income, social group or source of means of living. The contribution rate is set at 8% of the base, which varies depending on the employment group a person belongs to, and is directly linked to personal income tax – 0.25% comes directly from personal income.

The base for calculating farmers' health insurance contributions is the price of 0.5 quintal of rye from each standard hectare of cropland on a given farm. The base for calculating health insurance contributions for the self-employed is their income, but the base cannot be lower than 75% of the average salary in the enterprise sector. In regard to insured persons who receive social security benefits, the base for calculating health insurance contributions is the gross amount of those benefits (retirement pay and pensions, social welfare allowances). In most instances, contributions are calculated, collected and transferred by payers, namely by employers or institutions responsible for providing benefits, not by the insured persons themselves. For these activities, payers get a 0.1% commission on paid contributions. All social health insurance contributions in Poland are tax-deductible.

The state budget plays a limited role in public health care financing. The state finances public health targets, health insurance contributions for

specific groups of the population (the unemployed receiving social security benefits, those receiving social pensions, farmers, war veterans and others), and investments in public health care institutions. The major part of funds allocated for the implementation of health programmes is transferred to the National Health Fund. Funds from the state budget are also used to cover health services provided in life-threatening situations, in case of accidents, or during childbirth to persons who are not insured and thus do not pay health insurance contributions.

Revenues generated from the contributions are pooled at the NHF. The NHF is the main payer for health services, contributing 80% of total public spending on health while the state budget contribution is around 10%. The NHF's budget for the year 2004 was PLN 30.4 billion (about €7.5 billion); however, purchasing of health services still remains a serious challenge for the NHF.

### Health care benefits and rationing

Universal coverage is a feature of the Polish health care system and there is a defined benefit package to which people covered are entitled. Health services such as alternative therapies, cosmetic surgery, non-standard treatments and/or vaccinations and non-disease-related treatments in health resorts (spas) are excluded from coverage. These excluded services are determined in a list issued by a decree of the Minister of Health. However, the limited range of exclusions has not undergone reform in recent years. There is also an approved list for pharmaceuticals.

Long queues, waiting lists, lack of specialists and limited referrals to specialists are prevalent in the public sector; waiting lists for some conditions, notably cancer operations, are long, seasonal and detrimental to the health of the individuals concerned. This leads to limited access to services provided as part of the entitled benefits and imposes extra expenses on patients who have to purchase services in the private or public sector.

## Complementary sources of financing

Complementary sources of financing include out-of-pocket payments (formal and informal) as well as pre-payment schemes. Between 1998 and 2002, private expenditures increased by 32.6%, due to a 66.4% rise in the spending for pharmaceuticals and medical devices.

Out-of-pocket expenditures on drugs and aids and medical devices represent 60% of all private expenditures on health care. Direct expenditures on health services range between 20% and 25% of all out-of-pocket payments; a substantial part of these expenditures, especially those on hospital care (mainly in public hospitals) are informal (i.e. “gratuities” in kind to physicians and other personnel). The share of primary health care in these expenditures is very small.

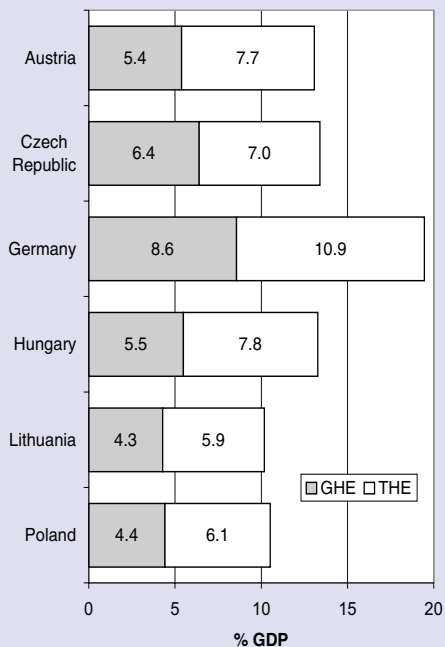
Formal charges exist for food, pharmaceutical consumption, transport costs and medical devices and aids. The level of co-payment is limited and depends on the incomes of insured persons.

With regards to pre-payment schemes, in 2004, 30 companies offered private accident insurances, 23 companies offered full health insurance plans, and 32 companies offered additional accident and health insurance packages. The total amount of premiums paid in additional insurances was PLN 2000 million in 2003, of which accident insurance premiums amounted to PLN 631 million and health insurance premiums to PLN 145 million.

The number of persons with medical subscription coverage is around 1 million. They are mainly employees who are offered extended packages of health services by their employers. Subscriptions mostly cover outpatient health services.

The development of a system of supplementary health insurance, offering a wider range of health services, is still at an early stage. Currently it is offered by a limited number of insurance companies; the number of beneficiaries is estimated at approximately 10 thousand.

**Fig. 2** Proportion of total government health expenditure (GHE) to total health expenditure (THE) as a % of GDP in Poland and selected countries, 2002



Source: WHO. Core Health Indicators in the WHO European Region 2005.

## Health care expenditure

Poland's health expenditure grew by 55% between 1995 and 2002, similar to Great Britain, Portugal and Hungary. Private expenditures accounted for 28–30% of total expenditure on health care, thus Poland spends more on private health care than any other country in central and south-eastern Europe.

While public expenditure in health for Poland increased in nominal terms from US\$ 23.2 billion (1998) to US\$ 34.1 billion (2002), when taking inflation into account the increase in public health care expenditure has been very small, from US\$ 27 billion in 1999 to US\$ 28.7 billion in 2002 (1999 as base year), so the growth in health care expenditure has been mainly due to an increase in private expenditure for health. Public

expenditure has not increased in line with total expenditure in Poland, the Czech Republic and Slovakia. However, some countries in western Europe such as the Netherlands, Switzerland and Greece finance even higher proportions of their health care systems from private sources.

In 2003, hospital care predominated in the structure of expenditures for health services (41.9% of total expenditure) followed by drug reimbursement for insured persons (21.8%), primary health care (11.6%) and outpatient specialized care (6.4%). These four areas of services consume over 90% of all financial resources for health care.

## Health delivery system

### Primary health care

Primary care and family medicine are relatively new concepts in Poland and were relatively undervalued until 1991 when a strategy to improve the status and quality of primary care was developed under the name of “family medicine”. This was followed by the creation of the College of Family Physicians in Warsaw in 1992 and the introduction of postgraduate specialist training in family medicine. As of 2004, 7000 doctors obtained a specialist degree in family medicine, falling short of the 15 000 family medicine specialists needed. This shortage is covered by the former primary care physicians, most of whom have a specialist degree in internal medicine. Also, 5000 paediatricians and 3000 gynaecologists deliver health care services in primary care according to their specialty areas.

All primary health care physicians are obliged to ensure services at patients’ homes in instances when emergency ambulance services are not required. With 5.5 outpatient contacts per person per year in 2001, Poland’s outpatient services intensity was somewhat lower than the average of 6.2 for countries belonging to the EU prior to May 2004 and substantially lower than the average of new Member States with 8.3 outpatient contacts per person per year.

### Secondary and tertiary care

There is a strict separation between outpatient specialized care and inpatient care in Poland. Specialists working in inpatient health care on the basis of employment contracts with purchasers are not allowed to work in outpatient health care. The outpatient specialized sector is mostly based on private medical practices, except in large cities, where outpatient specialized care has developed on the basis of the former specialized health care centres, which now operate as independent health care institutions.

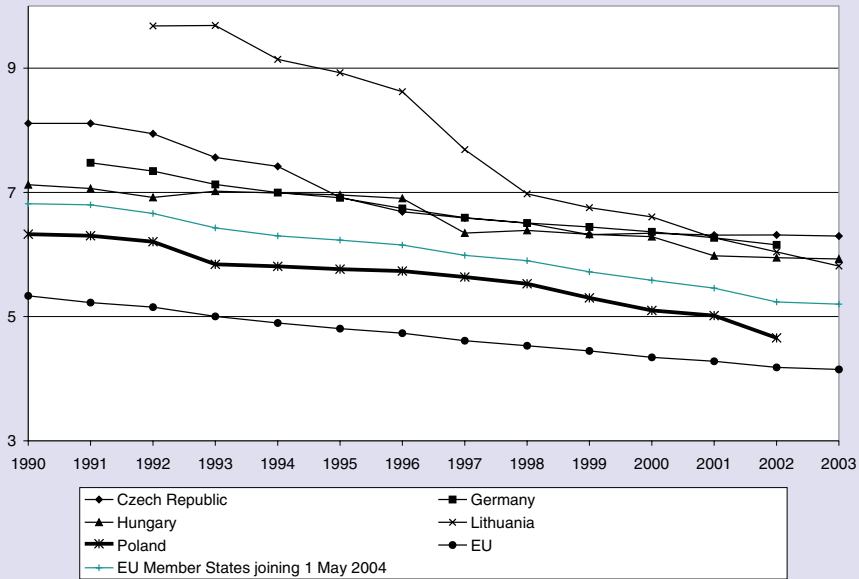
In 2003 there were 732 public hospitals in Poland. Until 2005 hospitals were categorized by reference level. A new classification system is currently being developed. The first reference level hospitals are mainly established by county self-governments and provide services in internal medicine, surgery, obstetrics and gynaecology, and paediatrics. The second reference level hospitals, mostly established by voivodship self-governments, provide services in other specializations: cardiology, dermatology, oncology, urology and/or neurology. The third reference level hospitals, mostly clinical, university or ministerial hospitals, provide highly specialized medical care by top medical specialists, e.g. the National Institute of Cardiology, the Maria Skłodowska-Curie Memorial Cancer Centre and Institute of Oncology and the National Mother and Child Institute. The number of hospitals in private, confessional or NGO ownership in Poland is low. In 2003 there were 72 non-public hospitals in total.

Like many other European countries Poland has decreased its total hospital bed capacity substantially in the last decade to 4.7 per 1000 people in 2002, down from 6.6 per 1000 people in 1990. The average hospital stay in general hospitals has decreased from 9.3 days in 1999 to 7.9 days in 2002. The occupancy rate of hospital beds was 74.5% in 2001 and was thus similar to many other European countries.

In Poland, the emergency medical service has always been independent. Its organization is territory-based. A national network of 270



**Fig. 3 Beds in acute hospitals per 1000 people in Poland, selected countries and regional averages, 1990–2003**



Source: European Health for All database, June 2005.

Note: EU: European Union.

hospital emergency departments throughout the country is planned to be operational by the end of 2005.

Health resort treatment is provided under contracts with the NHF concluded on terms defined in the Law on Universal Health Insurance.

### Social care

There is very little state provision of community care services in Poland and insufficient beds and nursing homes to care for dependent people. Since community services and residential care are still not well developed, many patients are cared for in hospitals. Nongovernmental organizations are playing a larger role as providers of nursing homes, hospices and rehabilitation services and as providers of long-term residential care and care in the community, but these services are still scarce. There is currently a debate in parliament about a possible role for mutual insurances for health

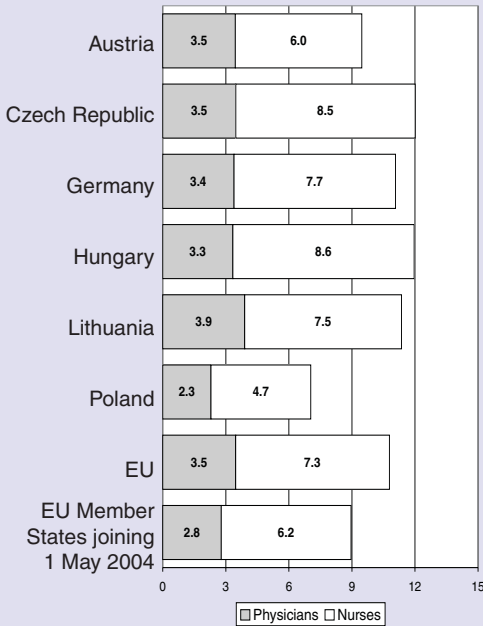
and social care and for a separate insurance for nursing or long-term care for the elderly.

### Human resources and training

The number of doctors, nurses and other health care staff per capita in Poland is lower than that in most western European countries. Poland had 2.2 doctors per 1000 people in 2001, which is about one third below the average of 3.5 for countries belonging to the EU before May 2004 and lower than most CSEE countries and the new EU Member States (2.8 doctors per 1000 people). Despite the new development of family medicine, Poland is still regarded as having too many specialists with more than three specialists for every primary care doctor.

In Poland, there are 24 Regional Chambers and one Military Chamber of Physicians and Dentists. There are also eleven Medical Academies, which graduated 2387 physicians and 753 dentists in 2004.

**Fig. 4 Ratio of physicians to nurses per 1000 people in Poland, selected countries and regional averages, 2004 or latest available year**



Source: European Health for All database, June 2005.  
Note: EU: European Union.

Training for physicians includes a compulsory one-year internship and a biannual multiple-choice examination. If passed, this exam allows for further specialization. In Poland around 800 physicians begin their specialization with resident status. Training for nurses and midwives is currently undergoing transformation. The duties and responsibilities have expanded and as a result there is a possibility of a 2-year Master's programme post-licentiate degree for these professions. Currently, out of the 200 000 employed nurses and midwives, only 4000 are higher-education graduates.

Pay levels, working conditions and morale remain problematic among health care personnel in Poland. Wages for health sector workers in the former socialist states were historically lower than the workforce average and this has remained the case in Poland. In 2003, the average monthly

pre-tax salary of a doctor in the public health sector was €750; the salary of a nurse was €400. This low salary has been compensated by an increase in informal "envelope" payments and a rise in medical staff migration. In the 12 months following Poland's accession to the EU in May 2004, an estimated 2500 doctors left the country to take up work in Western Europe.

According to the General Medical Council of the United Kingdom, 1211 doctors with a Polish primary medical qualification were registered in the United Kingdom alone in August 2005.

### Pharmaceuticals and health care technology assessment

The Polish pharmaceutical industry consists of 238 enterprises, including 15 leading ones with over 1% of the market share. The Polish pharmaceutical market occupies the nineteenth place in world rank in terms of revenue (IMS data). The largest Polish domestic pharmaceutical enterprises are: Polfarma – Starogard, Polfa – Warszawa, Polfa – Tarchomin, and Polfa – Pabianice. GSK Pharma, Servier, Novartis, and Eli Lilly lead the market among foreign pharmaceutical companies in terms of revenue.

The Polish pharmaceutical market can be split into three major segments, according to turnover, with the following value shares: general access pharmacies (80%), hospital pharmacies (15%), and other retail outlets (5%). In 2002, 10 200 general access pharmacies and 668 hospital pharmacies operated in Poland. The former are almost entirely in private ownership. On average in Poland there are 3700 inhabitants per pharmacy, placing Poland among EU countries with the densest network of pharmacies. The number of inhabitants per pharmacy varies from 1000 inhabitants in one district to over 5000 in another.

In Poland the pharmaceutical industry is responsible for supplying drugs and medical devices, and is regulated by the following 2001 legalizations aimed at harmonizing Polish legislation with EU requirements: the Pharmaceutical Law, the Law on the Office



of Medicinal Products, Medical Devices and Biocides, the Law on Medical Devices and the Law on Prices.

The decision to register a drug is issued by the Minister of Health. Safety, quality and efficacy are the three basic criteria taken into account in the process of registration and marketing approval of medicinal products and medical devices. Currently around 15 000 pharmaceuticals have been registered and have been given marketing approval in Poland. To meet EU requirements, over 8000 Polish drugs have to be subjected to repeated investigations.

Reimbursed drugs are divided into two major categories: A. drugs available to all insured persons, and B. drugs available to patients with specified chronic disorders. Each has defined levels of co-payments.

Once the lists of drugs are determined, drug producers submit price proposals with their justification and the Drug Management Team then arrives at a statutory retail and wholesale price per package of each drug included in individual lists. Lists of reimbursed drugs and prices are agreed in consultation with relevant governmental bodies and representatives of physicians and pharmacists, and with drug producers. The prices determine the scale of expenditure on drug reimbursement provided by the NHF. If price limits are lower than statutory ones then patients pay the difference, and thus the patient's share in the expenditure (co-payment) becomes higher than the level determined on the lists of reimbursed drugs.

There are two kinds of reference prices. The first is most frequently applied to preparations containing the same active substance converted into a specified amount of a given substance, taking account of its different pharmaceutical forms. The use of a group limit is rather rare. The fixed limit price corresponds to the daily therapy costs for the cheapest drug of a given group with allowance made for the amount of the defined daily dose (DDD) published by WHO. Over the last three years, the consumption of all drugs measured in DDD has decreased to a level

of about 1300 DDD/1000 inhabitants/day. In 2002, drugs in group C (the circulation system) made up the largest proportion (25.6%). They were followed by drugs in group A (the digestive system and metabolic diseases) (23.7%), and drugs in group N (the nervous system) (8.1%).

## **Financial resource allocation**

The NHF is the main payer for health services in Poland. In order for providers to contract with the NHF, health care institutions need to have the status of independent institutions. In 2003, the NHF developed terms for entering into contracts with service providers, including general and final provisions of contracts, as well as specified requirements for individual categories of services (e.g. primary health care, outpatient specialized care, long-term care, etc.).

### **Payment of hospitals**

Currently the NHF is the main payer for hospital services. Reimbursement is based on a uniform classification (embracing over 1000 categories) of hospital services, mainly based on defining individual groups of procedures and prices for basic units. However, increasing hospital debts and limited financial resources still remain a problem.

### **Payment of physicians**

The National Health Fund finances physicians per capita on the basis of patients' lists (capitation). A basic rate is usually adopted and differentiated by age for three age groups (0–6 years, 7–64 years, 65 years and older) with different benefits (for nurses and community midwives, school children and pensioners of social welfare homes or children's homes). The capitation amount has been low and unchanging, leading to a mass protest by primary health care physicians, which ended in agreement to increase the capitation rates. Currently these capitation rates still lack uniformity and vary throughout the country.

## Health care reforms

The reform agenda in 2003 provided another opportunity to modernize the health care financing mechanism in Poland. A new Law on Financing Health Services from Public Resources, passed by the parliament in August 2004, set up new rules for the contracting of health services. The NHF is now responsible for gathering, monitoring, supervising and making data from waiting lists accessible to the public at large, and has made it possible to decentralize responsibility for financial and service plan realization to voivodship NHF branches. Preparatory studies on the role of a supplementary insurance system and the change in status of independent public health care organization units into legal entities are also being examined. The main target of these changes is to improve financial management of hospitals and, it is expected, the limitation of further liabilities.

In order to limit spending on drugs, a return to a fully electronic registration of all health services, especially prescriptions, is expected. The Government also accepted the National Drug Policy, which is aimed at transferring market share from branded to generic drugs.

Other health policy reforms include the Insurance Law that mandates that the insurance contribution is to be increased from 8.25% in 2004 to 9% in 2007, and hospital restructuring, aimed at decreasing the total number of beds and helping to maintain the balance between short- and long-term care beds. Changes in the number and structure of hospital beds have been accompanied by a gradual development in new forms of service delivery, day-care treatments and home care, among others.

To address demographical challenges, further development in rehabilitative care and nursing services in the hospital sector is expected as well as the strengthening and development of the national networks of hospitals. Hospitals within a hospital network will have to fulfil defined conditions and will form the basis for providing emergency health care services, care during disasters, epidemics and/or for taking over

duties of other health care institutions should the need arise. However as of October 2005, no decision has been made to introduce the hospital network.

Increasing hospital debts have also been the cause of particular concern in Poland. Public hospital debts have reached the level of PLN 5.5 billion. Currently 65% of all public health care institutions are indebted, and these debts vary across regions. Some 31% of these debts are owed to the public sector, mostly for local taxes, real estate taxes, and social insurance contributions on behalf of the employees. New legislation, the Law on Public Help and Restructurization of Public Health Care Institutions, has been approved to create the mechanisms that will enable restructuring of the hospital debts, through financial restructuring of public health management units. Hospitals will receive low-interest long-term loans (3% for 10 years) and on completion of the restructuring programme, half of the loan will be cleared. Currently hospital debts amount to about 30% of local government's budgets.

## Conclusion

The health care reforms, initiated in 1989, developed in parallel with reforms in the national economy. However, levels of public funding for health care have not kept pace with GDP growth, falling slightly as a proportion of GDP since 1995, accompanied by high rates of unemployment. A 4-year increase in life expectancy during this period, together with a birth rate which fell below the reproduction level and the continuous increase in expenditure on pharmaceuticals and medical technologies contribute to an increasing financial burden imposed on health care institutions. The symptoms of underfunding in the public health system, such as waiting lists, avoidable deaths and informal payments to health professionals, have ultimately led to a widespread dissatisfaction with health services among Polish citizens.

## HiT Summary

## Poland

Some positive effects of the reforms are manifested, among others, by a restructuring of hospitals, including a decrease in the number of hospital beds, shorter hospitalizations, the strengthened role of family medicine and a new focus on health prevention and promotion with the National Health Programme. Low salaries in the public health care system remain a major issue, and – related to this – informal payments for health services and the emigration of health professionals to western European countries.

Currently, measures to raise the revenue from out-of-pocket payments, and from supplementary

insurance, such as those provided by mutual societies or long-term care insurance, are being discussed. Another focus of attention is the continuing effort to improve control over health expenditure, notably on pharmaceuticals, and to define specific benefit packages for certain population groups, such as the elderly, and for screening, rehabilitation services and social care. The improvement of the health information system is again under discussion in order to make data- and evidence-based contracting of services feasible, with the aim of increasing the efficiency and equity of health services in Poland.

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The Health Systems in Transition profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.