European Cancer Inequalities Registry

POLAND

Country Cancer Profile

2025

European Commission

OECD

BETTER POLICIES FOR BETTER LIVES

The Country Cancer Profile Series

The European Cancer Inequalities Registry is a flagship initiative of Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States, regions and population groups. The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan. The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable inputs received from national experts and comments provided by the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Data and information sources

The data and information in the Country Cancer Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database.

Additional data and information also come from the European Commission's Joint Research Centre (EC-JRC), the EU statistics on income and living conditions (EU-SILC) Survey, the World Health Organization (WHO), the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA), the European Society for Paediatric Oncology (SIOPE), the European Union Agency for Fundamental Rights (FRA LGBTIQ), the Health Behaviour in School-aged Children (HBSC) survey as well as from the 2023 Country Health and Cancer Profiles, and other national sources (independent of private or commercial interests). The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway. Mortality and incidence rates are age-standardised to the European standard population adopted by Eurostat in 2013.

Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

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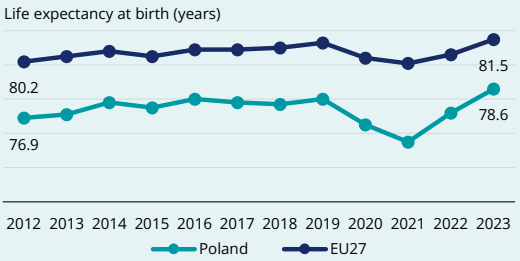
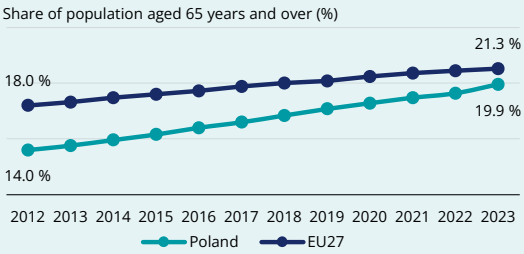
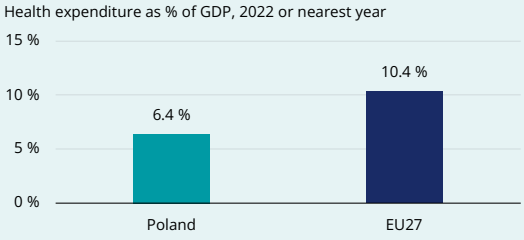
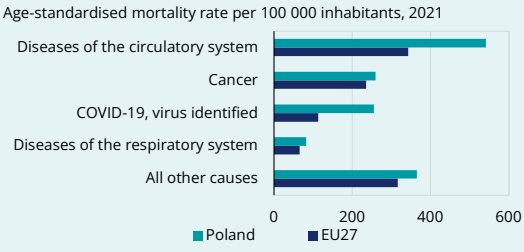


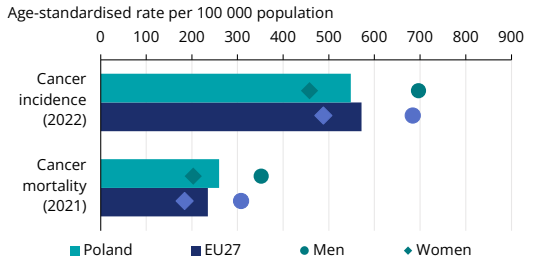






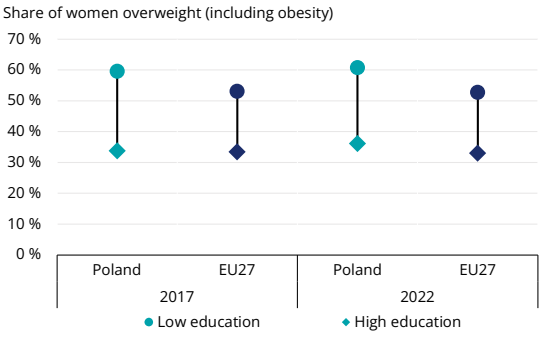
Source: Eurostat Database.

1. Highlights



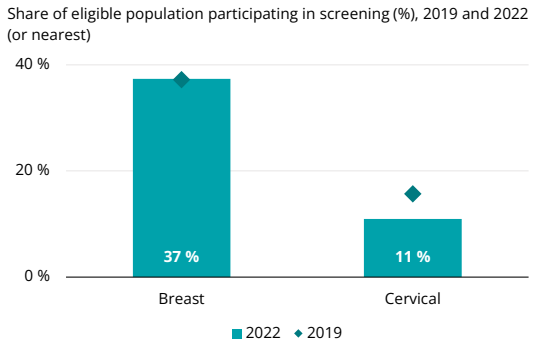
Cancer in Poland

In 2022, estimated cancer incidence in Poland was lower than the EU average, but is expected to increase more rapidly by 2040. Overall cancer mortality was above the EU average in 2021, but had decreased more rapidly than the average among Poland's economic peers, especially among men. Poland's lifetime cancer prevalence increased by 23% between 2010 and 2020.



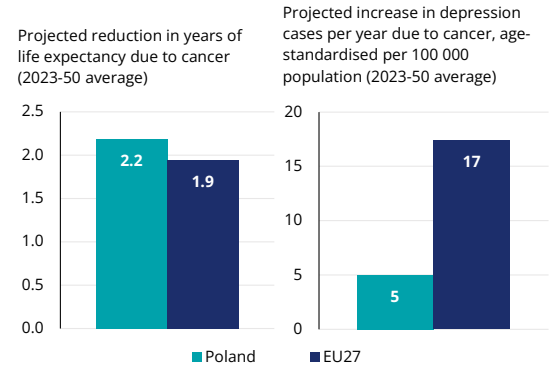
Risk factors and prevention policies

Poland has higher prevalence of cancer risk factors than other EU countries. Risk factors for which it ranks worse include air pollution, occupational exposure, overweight and obesity, but the country performs better than other EU countries on vegetable consumption and daily smoking. Socio-economic disparities in overweight and obesity among women are large compared to those in other EU countries. The National Strategy for Oncology 2020-30 focuses on prevention and reduction of cancer risk factors.



Early detection

Poland has three population-based screening programmes for breast, cervical and colorectal cancers. However, screening participation rates are relatively low. Participation in breast cancer screening has increased in recent years, while cervical cancer screening has seen a decline. Age ranges for breast and cervical cancer screening have been expanded. Pilot programmes for lung cancer screening and molecular testing for human papillomavirus as a new screening method are ongoing and pilot studies for prostate cancer early detection are planned.



Cancer care performance

Many factors limit access to cancer care in Poland, such as low density of nurses and doctors per 1 000 cancer cases and a limited supply of medical equipment. The largest initiative to improve access to and quality of cancer care in Poland is the National Oncology Network, which is expected to improve care co-ordination and quality monitoring. Between 2023-50, compared to the EU averages, Poland is projected to see a larger reduction in life expectancy due to cancer, but a lower increase in mental health disorders.

2. Cancer in Poland

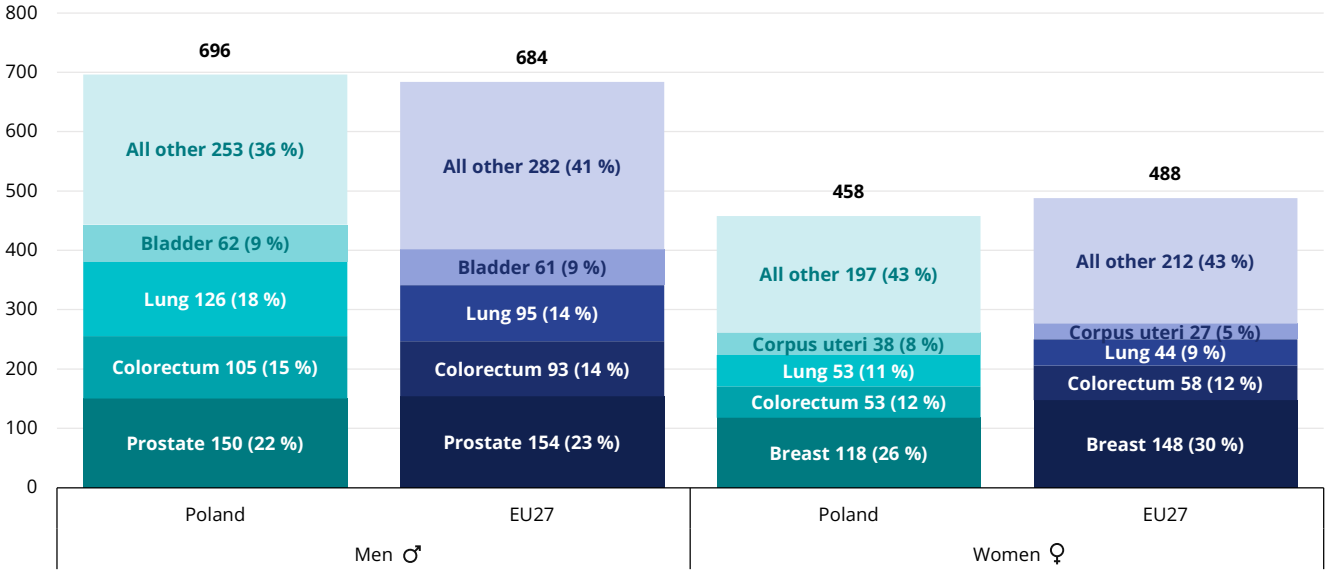
Cancer incidence is expected to be higher among men than women in Poland

According to the European Cancer Information System (ECIS) of the Joint Research Centre based on incidence trends from pre-pandemic years, 106 060 new cancer cases among Polish men and 95 977 among Polish women were expected in 2022. This represents an age-standardised incidence rate of 696 new cases per 100 000 among men and 458 per 100 000 among women, meaning that cancer incidence was 52% higher among men than women. It was also 6% lower among Polish women than the EU average but 2% higher among Polish men than the EU average.

The most common cancers among Polish men and women follow the same pattern as that seen across the EU (Figure 1). Among Polish men, prostate cancer has the highest incidence rate at 22% (compared to 23% across the EU) followed by lung[1] (18%) and colorectal (15%) cancers. Among Polish women, breast cancer has the highest incidence at 26% (compared to 30% across the EU) followed by colorectal (12%) and lung (11%) cancers.

Figure 1. The most common cancers among Polish men and women follow the same patterns as those across the EU

Age-standardised incidence rate per 100 000 population, estimates, 2022



Notes: 2022 figures are estimates based on incidence trends from previous years, and may differ from observed rates in more recent years. Includes all cancer sites except non-melanoma skin cancer. Corpus uteri does not include cancer of the cervix.
Source: European Cancer Information System (ECIS). From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024. The incidence percentage breakdown was re-computed based on age-standardised incidence rates and as such differs from the percentage breakdown of absolute numbers shown on the ECIS website.

Among women in Poland in 2021, corpus uteri (38 per 100 000), ovarian (23 per 100 000) and cervical (19 per 100 000) cancers were also common. For all these cancers, incidence rates were higher than the averages across the EU (27 per 100 000 for corpus uteri, 16 per 100 000 for ovarian and 12 per 100 000 for cervical cancers). Most cases were in the Śląskie voivodeship (the main administrative unit in Poland) (Wojciechowska et al., 2023).

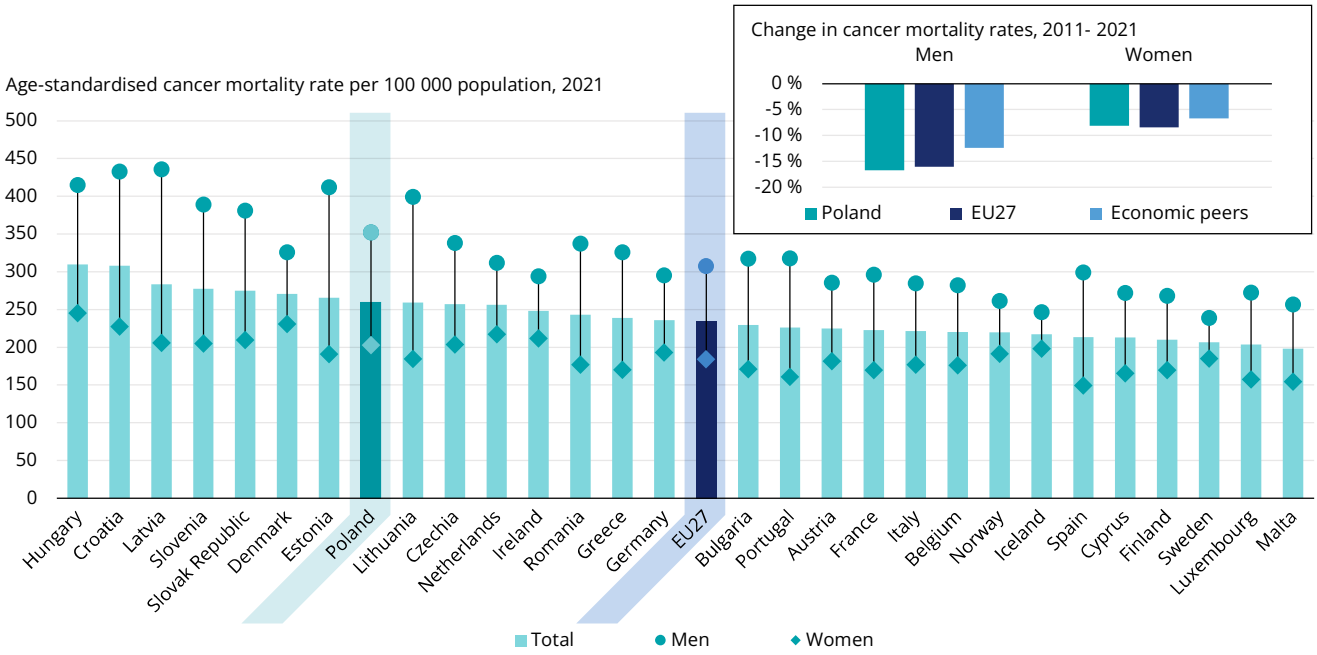
A decline in the number of cancer cases was observed in 2020 in Poland, explained in part by a postponement of diagnoses related to the COVID-19 pandemic. According to ECIS, it is estimated that cancer cases will increase by 19% in Poland by 2040.

1 *Lung cancer also refers to trachea and bronchus cancers.*

The cancer mortality rate in Poland declined faster than the average among the country's economic peers

In Poland, the age-standardised mortality rate was 260 per 100 000 population in 2021, which is higher than the EU average (235 per 100 000) (Figure 2). As in all EU+2 countries[2], men had significantly higher mortality rates (352 cancer deaths per 100 000) than women (203 per 100 000). Mortality rates decreased significantly between 2011 and 2021 among both men (by 17%) and women (by 8%). The reductions were larger than the averages among Poland's economic peers[3] – especially for men.

Figure 2. Cancer mortality rates in Poland have declined but remain higher than the EU average



Notes: Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for PL include BG, EE, EL, HR, HU, LV, PT, RO and SK.
Source: Eurostat Database.

Cancer mortality rates vary considerably by region within Poland. In 2020, the highest rates were observed in the western part of Poland and the lowest in south-eastern area (Wojciechowska et al., 2023).

Lung, colorectal and breast cancers were the three leading causes of cancer death in Poland in 2021. Lung cancer mortality accounted for 26% of all cancer deaths among men and 18% among women. Breast cancer accounted for 15% of all cancer deaths among women, and colorectal cancer accounted for 13% among men and 12% among women (Didkowska et al., 2023).

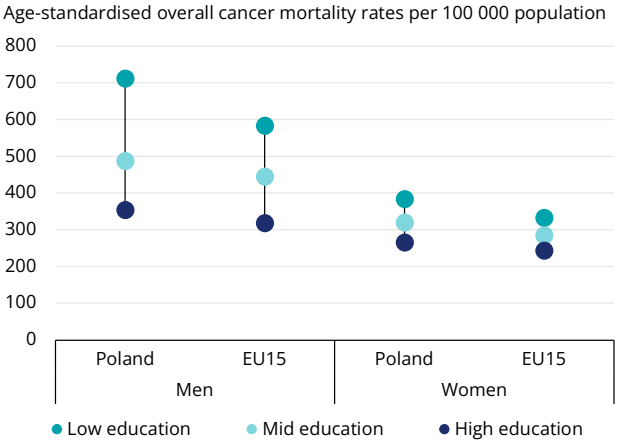
Polish men with lower education levels are twice as likely to die from cancer as those with higher education levels

Age-standardised overall cancer mortality rates in Poland are higher among individuals with lower than higher education levels (Figure 3). Among men, this gap (a difference of 357 per 100 000 population) is wider than that among women (119 per 100 000).

2 *EU+2 countries include 27 EU Member States (EU27), plus Iceland and Norway.*

3 *Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for PL include BG, EE, EL, HR, HU, LV, PT, RO and SK.*

Figure 3. The mortality gap between individuals with higher and lower education levels is wider among men than women



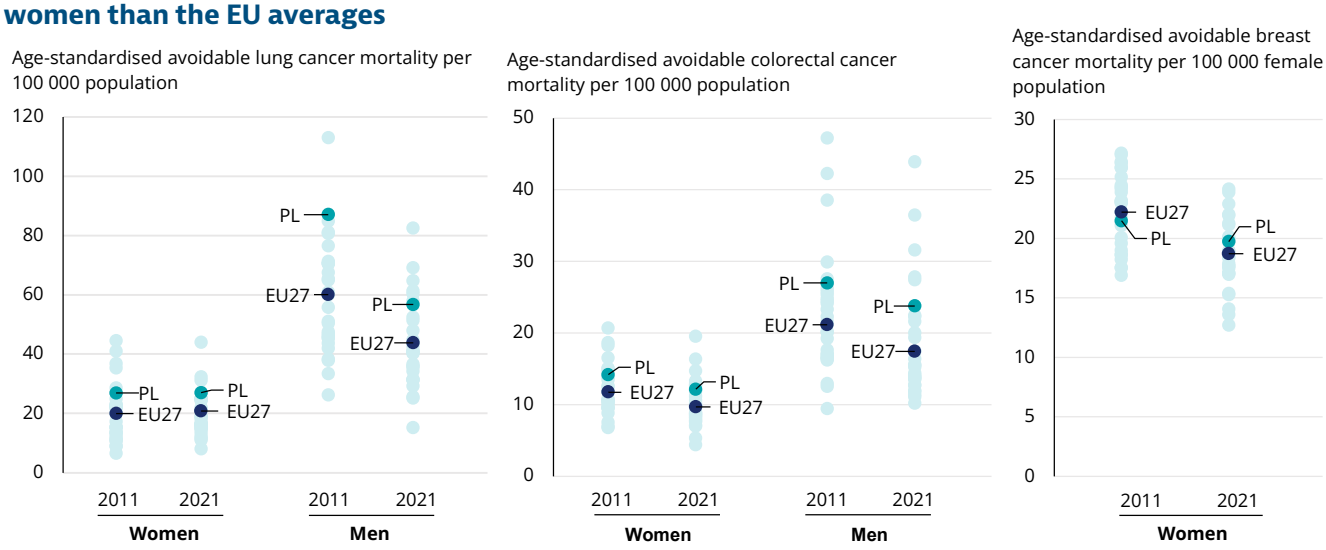
Notes: Data come from the EU-CanIneq study and refer to 2015-19. EU15 refers to unweighted average of 14 EU countries and Norway.
Source: European Commission/IARC/ERASMUS MC (2024), Mapping socio-economic inequalities in cancer mortality across European countries. ECIR Inequalities factsheet.

Avoidable mortality from several cancers decreased between 2011 and 2021, especially among men

Thanks to improved prevention strategies and advances in treatment options, a significant proportion of cancer deaths among people aged under 75 are considered avoidable.[4] In 2021, avoidable mortality from lung cancer (mostly preventable) in Poland was 27 per 100 000 women (30% higher than the EU average) and 57 per 100 000 men (29% higher than the EU average) (Figure 4). Between 2011 and 2021, the rate increased by 0.6% among women and decreased by 35% among men (outpacing the average decline across the EU). This reflects the positive impact of tobacco control policies in recent decades.

On the other hand, the mortality rate from breast cancer (mostly treatable) in Poland was 20 per 100 000 women, which is 5% higher than the EU average. Since 2011, the rate has decreased by 8% in Poland, while the EU average has decreased by 16%. The colorectal cancer mortality rate has decreased by 14% among women and by 11% among men compared to 2011 in Poland. Improved uptake of screening and early diagnosis initiatives could lower these mortality rates.

Figure 4. Avoidable mortality from colorectal and lung cancers was higher among Polish men and women than the EU averages



Note: Avoidable mortality figures relate to deaths of people aged under 75.
Source: Eurostat Database.

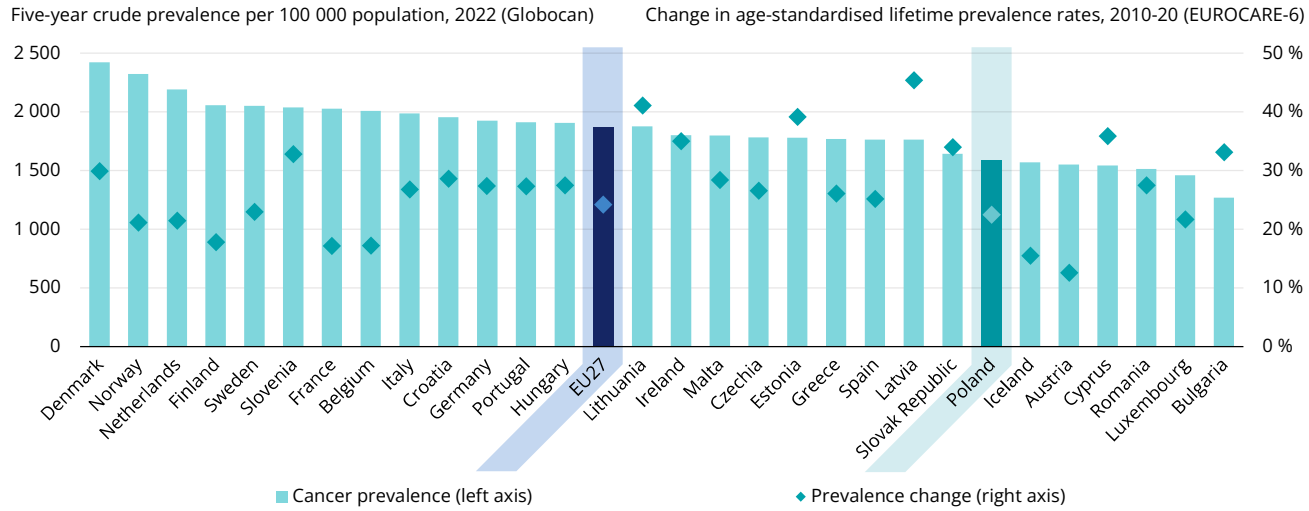
In 2021, 90 126 people died in Poland as a result of the COVID-19 pandemic, of which 11 640 were people with cancer (13%) (Didkowska et al., 2023). Among people with cancer who died from COVID-19 in 2021, 58% were men. A clear decline in cancer mortality among women and men in 2020-21 can be explained by the impact of the pandemic on the Polish population (Didkowska et al., 2023) and the way these death were recorded.

4 *Avoidable mortality includes both preventable deaths that can be avoided through effective public health and prevention interventions, and treatable deaths that can be avoided through timely and effective healthcare interventions.*

Five-year cancer prevalence in Poland is much lower than the EU average

According to GLOBOCAN estimates by the International Agency for Research on Cancer (IARC), in 2022, five-year cancer prevalence[5] in Poland was the seventh lowest among EU+2 countries, with 1 585 cancer cases per 100 000 people who were diagnosed in the last five years and were still alive – a rate below the EU average of 1 876 cases per 100 000 (Figure 5). Between 2010 and 2020, cancer prevalence in Poland increased by 23%, which is slightly lower than the increase across the EU (24%). This rise highlights the growing importance of focusing on quality of life and survivorship, as people are living longer with cancer and more people have a history of the disease (Section 5.4).

Figure 5. Poland's five-year cancer prevalence was much lower than the EU average



Sources: IARC Globocan Database 2024; EUROCARE-6 study (De Angelis et al., 2024).

The National Strategy for Oncology 2020-30 has an important focus on preventive programmes

The National Strategy for Oncology (NSO) includes a number of actions planned for 2020-30, which are focused around six key areas of investment in the cancer care system (Ministry of Health, 2023). It also supports collection of data through the National Cancer Registry, in line with Europe's Beating Cancer Plan (Box 1).

As part of the NSO, many programmes are being launched, including a lung cancer screening programme for 2021-23, and care programmes for families with high hereditary risk of developing selected malignancies (such as breast, ovarian, colorectal and corpus uteri cancers, and retinoblastoma or von Hippel-Lindau disease).

A pilot application of molecular testing for high-risk human papillomavirus (HPV) as a new screening test in the Cervical Cancer Prevention Programme has also been implemented.

A social campaign called "I am planning a long life", focusing on providing health education and promoting healthy lifestyles, has also been launched. This is dedicated to lung cancer, colorectal cancer, malignant skin cancer, breast cancer, cervical cancer and prostate cancer, and is disseminated through television, radio and the internet. In 2021-24, the "Prevention 40 plus" Programme also offered preventive diagnostic tests to people aged over 40 for the most common health problems.

5 *Cancer prevalence refers to the proportion of the population who have been diagnosed with cancer and are still alive, including those currently undergoing treatment for cancer and those who have completed treatment. Five-year cancer prevalence includes people who have been diagnosed within the previous five years, while lifetime prevalence considers those who have ever received a cancer diagnosis.*

Box 1. Poland's National Strategy for Oncology 2020-30 aligns with Europe's Beating Cancer Plan

The NSO aims to focus on investments in six key areas: human resources (improving workforce numbers and education of medical staff); prevention (educating adults and children to take care of their health to reduce the risk of cancer, supporting healthy eating and reducing use of tobacco products); science and innovation (increasing participation of oncology patients in clinical trials and facilitating access to innovative cancer therapies); early detection (introducing new screening tests); and the cancer care system (optimising the treatment process and providing hospitals with modern medical equipment and infrastructure). The NSO also prioritises all three transversal themes of Europe's Beating Cancer Plan, aiming to improve access to high-quality cancer care across regions, enhance care co-ordination and implement better-quality monitoring (Table 1). It emphasises enhancing investment, improving care quality, promoting early diagnosis and providing psychological support for children with cancer. To advance research and innovation, it plans to develop medical registries, increase patient participation in clinical trials conducted in Poland, establish clinical trial support centres, and expand access to reimbursed oncology drugs.

Table 1. Poland's National Strategy for Oncology 2020-30 aligns with Europe's Beating Cancer Plan

Pillars of EBCP				Transversal themes of EBCP		
Prevention	Early Detection	Diagnosis and treatment	Quality of life	Cancer inequalities	Paediatric cancer	Research and innovation
●	●	●	●	●	●	●

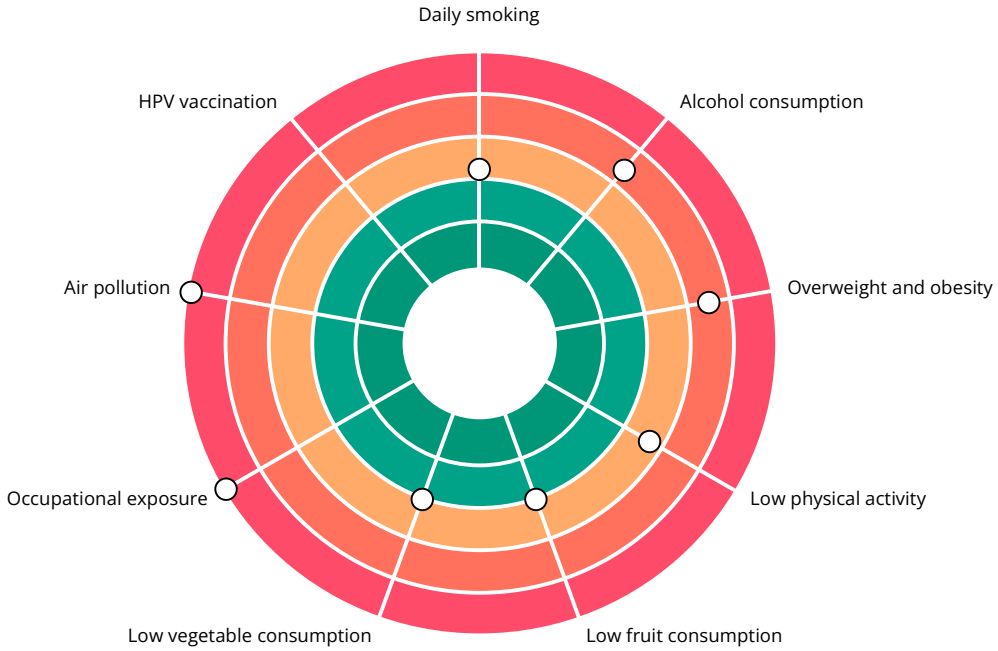
Notes: EBCP = Europe's Beating Cancer Plan. Blue indicates that the NSO includes a specific section on the topic; orange indicates that the topic is covered in one of the NSO's sections without being the only focus; and pink indicates that this topic is not covered in the NSO.
Source: Adapted from "Study on mapping and evaluating the implementation of Europe's Beating Cancer Plan" (not yet published).

3. Risk factors and prevention policies

Poland performs worse than other EU countries on most risk factors for cancer

For all cancer risk factors, Poland performs worse than other EU countries. Rates of prevalence of air pollution, occupational exposure, overweight or obesity and alcohol consumption are higher for Poland than other EU countries (Figure 6). The risk factors on which it ranks worst are occupational exposure and air pollution, but Poland ranks better than most EU countries on daily smoking, physical activity, vegetable and fruit consumption.

Figure 6. Poland ranks below most other EU countries on air pollution, occupational exposure, and overweight and obesity



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas. Air pollution is measured as particulate matter with a diameter less than 2.5 micrometres ($PM_{2.5}$). Data for HPV vaccination is not available.
Sources: OECD calculations based on 2022 EU-SILC Survey for overweight, obesity, physical activity, fruit and vegetable consumption (in adults); Eurofound Survey for occupational exposure; OECD Health Statistics for smoking, alcohol consumption (in adults) and air pollution; and WHO for HPV vaccination (15-year-old girls).

Expenditure on prevention in Poland is low, and amounted to 2% of all health expenditure in 2021, although it remained constant over time despite the COVID-19 pandemic[6]. The National Health Programme 2021-25 included goals to reduce the risk of cancer, including preventing overweight and obesity, healthy ageing, addiction prevention, and reducing health risks resulting from environmental factors. Under the umbrella of the NSO, the Ministry of Health finances an educational campaign called "I am planning a long life" (see Section 2), and since 2023, free HPV vaccinations are being rolled out for girls and boys aged 12-13 (Box 2).

6 *Prevention expenditures as reported in health accounts should include activities outside of national programmes (e.g. opportunistic cancer screening or counselling for smoking cessation during a routine physician contact), however in practice countries may have difficulty in identifying prevention spending outside of such programmes.*

Box 2. Since 2023, human papillomavirus vaccination is publicly funded in Poland

From June 2023, HPV vaccinations are financed for boys and girls as part of the recommended preventive vaccination programme, which is part of the NSO. Since September 2024, boys and girls aged 9-14 are eligible for the Programme. Children are allowed to have two doses (at an interval of 6-12 months) of two types of HPV vaccine: 2-valent and 9-valent vaccines. In addition, the 2-valent vaccine can be purchased via the pharmacy, at 100% reimbursement for children up to age 18 years and 50% for people over 18. A nationwide campaign on HPV was also conducted in 2024.

Men in Poland smoke cigarettes and drink alcohol more often than women

In Poland in 2019, 17% of people smoked daily, which is slightly lower than the EU average (18%). However, the average number of cigarettes per smoker per day was higher in Poland (15) than across the EU (13). Differences by gender and education level were visible in 2022 among the population aged 20 and over: men (30%) smoked more than women (17%), and people with lower education levels smoked more (28% among men and 20% among women) than people with higher education levels (20% among men and 16% among women) (Wojtyniak & Goryński, 2022). In 2021, alcohol consumption per capita among people aged 15 and over was 11 litres, which is slightly higher than the EU average (about 10 litres).

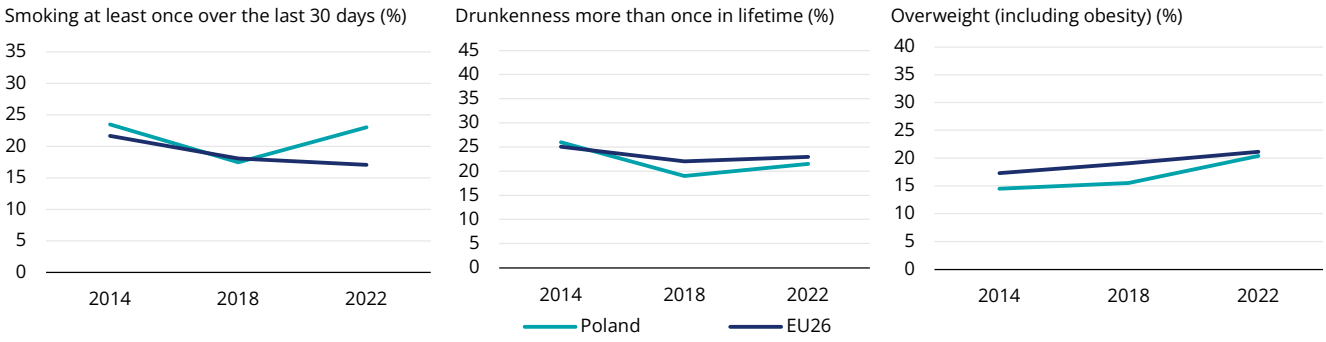
Poland has strengthened tobacco control policies over recent decades. Since 2011, smoking is banned in all workplaces, on public transportation, and in bars and restaurants. Health warnings on cigarette packs were introduced in 2017, in line with the EU Tobacco Product Directive. On alcohol policies, while the minimum legal age for purchasing alcohol in Poland is 18, there are no restrictions on density of alcohol outlets or on sales by premises type. There are also no health warning labels or guidelines for school-based prevention. An additional fee on alcohol sold in small bottles of up to 300 ml was introduced in 2021, called the "Monkey tax".

Prevalence of tobacco smoking among adolescents is higher in Poland than the EU average

From 2018, an increase can be seen in the percentage of teenagers smoking and drinking alcohol (Figure 7). In 2022, the percentage of 15-years-olds who smoked (23%) remained 6 percentage points higher than the EU average (17%), and the percentage who had experienced drunkenness more than once in their lifetime (22%) has increased by 3 percentage points since 2018. Use of e-cigarettes among teenagers is also very common in Poland. Over 30% of teenagers had used e-cigarettes at least once over the last 30 days in 2022. This places Poland fourth among EU countries for teenage e-cigarette use.

However, prevalence of other risk factors (low levels of physical activity, overweight and obesity) is similar to the EU average. For example, overweight and obesity increased in Poland by 6 percentage points over eight years to 2022, but is still 1 percentage points lower than the EU average. Overweight and obesity are more concentrated among children whose family background is disadvantaged. In Poland, 11- to 15-year-olds in the bottom 20% of family affluence based on the Family Affluence Score are 8 percentage points more likely to be overweight (28%) than those in the top 20% of family affluence (20%).

Figure 7. In Poland, unlike the EU average, there has been a visible increase in rates of smoking and drunkenness among adolescents



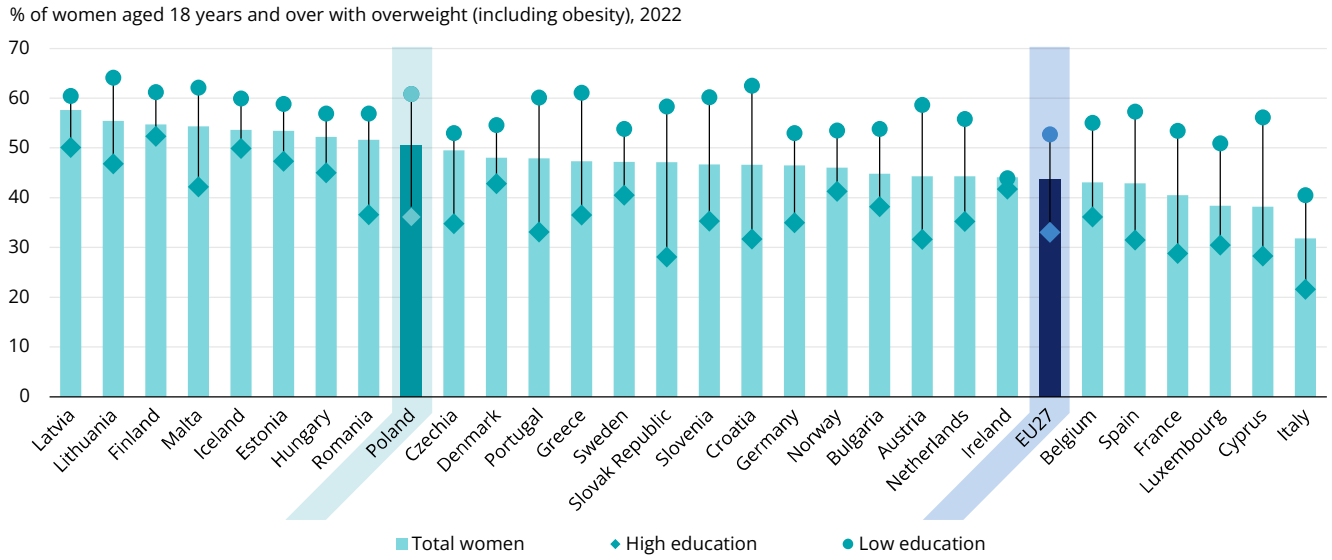
Notes: The EU average is unweighted. Data refer to 2022, and are based on children aged 15 years. EU26 for smoking and drunkenness; EU25 for overweight.
Source: Health Behaviour in School-aged Children Survey.

People with lower education levels are more often overweight or obese

The share of Polish people aged 18 and over who were overweight and obese increased between 2017 and 2022 to reach 58%, including 19% who were obese. The rate was higher among men (68%) than women (51%), and among people with lower (60%) than with higher (47%) education levels. The gender gap is slightly larger than the difference across the EU, while the socio-economic gap is slightly narrower than the difference across the EU.

In Poland, more than half (51%) of adult women were overweight (including obesity) in 2022 – a higher rate than the EU average (44%) (Figure 8). As in most countries, rates of overweight were significantly higher among women with lower (61%) than higher education levels (36%). Between 2017 and 2022, prevalence of overweight increased slightly among women with lower education levels (by 1 percentage point), and it increased more among those with higher education levels (by 2 percentage points). The socio-economic gap for overweight decreased slightly over time in Poland. This is not the case in the EU as the EU averages for both groups decreased slightly during 2017-22.

Figure 8. The overweight rate among Polish women is well above the EU average



Note: Overweight (including obesity) includes those with a body mass index (BMI) above 25.
Source: Eurostat Database.

Poor nutrition and lack of physical activity contribute to overweight and obesity. In 2022, 44% of adults consumed fruit (compared to 39% in the EU) and 41% consumed vegetables (compared to 40% in the EU) less than once daily. In addition, only 30% of people aged over 15 engaged in physical activity at least three times per week – slightly lower the EU average (31%).

Among 15-year-olds in Poland, 27% consumed fruit daily (compared to 30% in the EU on average) and 32% consumed vegetables daily (compared to 34% in the EU). The share of 15-year-olds engaging in 60 minutes of physical activity daily in Poland is quite low – at 15%.

In relation to healthy eating programmes, limits or reduction targets on salt, sugar and total fat have been set for a specified range of products in Poland. A tax on sugar-sweetened beverages was imposed in 2021, and a regulation on direct advertising to young people was introduced in 2015. Additionally, since 2020 the National Health Fund co-ordinates an "8 weeks to health" online training programme free of charge to encourage healthy lifestyles and regular physical activity.

High rates of air pollution and occupational exposure are causes for concern in Poland

According to WHO, 36 of the 50 cities in Europe with the most polluted air are in Poland (Karver, Badiani-Magnusson & Carroll, 2022). In 2020, Poland had the highest mean population exposure to $PM_{2.5}$ at 18 µg/m³. Additionally, the premature death rate due to exposure to $PM_{2.5}$ in Poland (128 per 100 000) was the second highest in the EU, just behind Bulgaria (166 per 100 000) and twice the EU average (57 per 100 000). Only Hungary and Poland failed to meet country-specific $PM_{2.5}$ reduction targets set by National Emission Ceiling Directive by 2021, and Poland needs to cut its $PM_{2.5}$ emissions by more than half to reach the target. Poland has a programme to upgrade residential heating

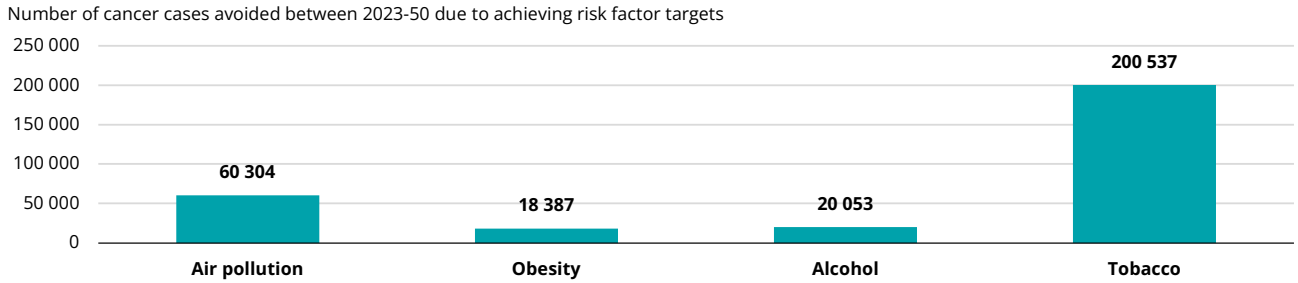
systems, which includes subsidies for low-income households of up to 90%, better outreach to individuals on low incomes, an easier application process, and greater technical and implementation assistance. Furthermore, the National Fund for Environmental Protection and Water Management carried out a national programme for safe removal of asbestos, and hosted an asbestos database for 2019-24.

Poland was also the country with the highest percentage of people (37%) who reported exposure to chemical products or substances among all EU countries in 2021 according to the European Working Condition Survey. Men (40%) experience occupational exposure more often than women (32%), and the rates were higher than the EU averages for both men (44% higher) and women (32% higher).

Achieving risk factor reduction targets would prevent hundreds of thousands of new cancer cases between 2023 and 2050

Like all countries in Europe, Poland has a substantial opportunity to reduce new cancer cases in the country by focusing on primary prevention. According to OECD Strategic Public Health Planning (SPHeP) modelling work, the biggest potential – of 200 537 cancer cases between 2023 and 2050 – is achievable if tobacco reduction targets are met (Figure 9). If Poland meets the air pollution target, 60 304 new cancer cases could be prevented over the same period; an additional 20 053 cancer cases could be prevented if alcohol targets were met, and 18 387 cancer cases if obesity targets were met.

Figure 9. Poland could prevent more than 200 000 new cancer cases by achieving tobacco reduction targets between 2023-50



Notes: The target for tobacco is a 30% reduction in tobacco use between 2010 and 2025, and less than 5% of the population using tobacco by 2040. For alcohol, the target is a reduction of at least 20% in overall alcohol consumption and a 20% reduction in heavy drinking (six or more alcoholic drinks on a single occasion for adults) between 2010 and 2030. For air pollution, it is an annual average $PM_{2.5}$ level capped at 10 µg/m³ by 2030 and at 5 µg/m³ by 2050. For obesity, the target is a reduction to the 2010 obesity level by 2025.
Source: OECD (2024b), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

4. Early detection

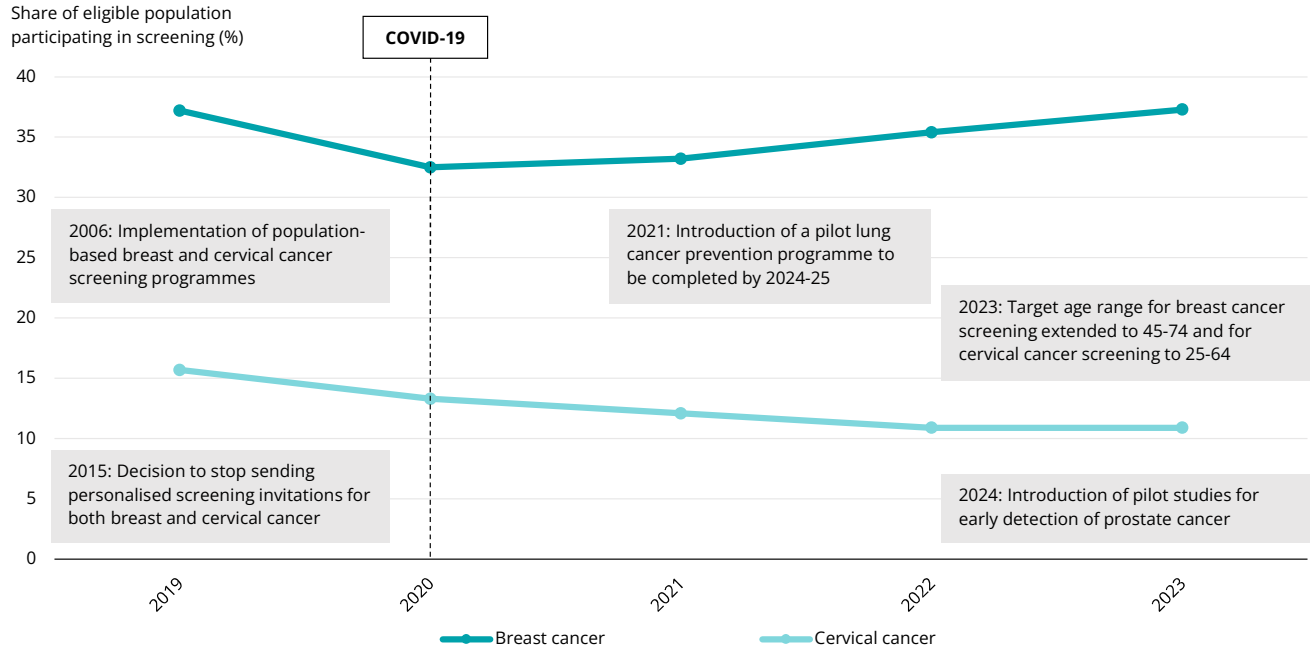
Breast cancer screening rates in Poland are among the lowest in the EU

Population-based breast cancer screening in Poland includes mammography every two years. It is available for women aged 45-74 following an expansion in 2023 from the age range 50-69 to improve consistency with the updated Council recommendation of 2022. Since 2022, notifications are sent through the national internet patient account (IKP) to women who have not undergone mammography in the past two years and those who fulfil criteria for a repeat mammography after 12 months due to family history of breast cancer or mutations in the BRCA1 or BRCA2 genes.

In 2023, based on programme data, participation in breast cancer screening was low in Poland (37%). Between 2019 and 2021 (based on programme data), there was a slight decline in the percentage of women participating in the programme of around 10%. A slow increase can be noted thereafter, as participation grew by 12% between 2021 and 2023 (Figure 10). Women with lower socio-economic status are less likely to participate in breast cancer screening. For Poland, the difference between women with high and low education levels is larger than in other EU countries (OECD, 2024a). In Poland, the likelihood of having received a mammogram in 2021 was 35% among women with lower education levels compared to 54% among women with higher education levels.

To improve the reach of the breast cancer screening programme, Poland uses delivery models such as mobile breast cancer programmes. “Mammobus” is mobile cancer screening programme that allows women to have a mammogram performed close to their place of residence or work. The programme was paused during the COVID-19 pandemic, but was relaunched in the summer of 2020.

Figure 10. Based on programme data, breast and cervical cancer screening uptake rates are low in Poland



Notes: Data refer to mammography screening among women aged 50-69 within the past two years and cervical cancer screening among women aged 25-59 within the past three years. Figure refers to programme data, which are collected from national/regional cancer databases/registries.
Source: OECD Health Statistics 2024.

Uptake of cervical cancer screening in Poland via the population-based programme is the lowest in the EU

Since 2023, the population-based cervical cancer screening programme is based on performing cervical cytology every three years among women aged 25-64 (previously among women aged 25-59). Unlike in many EU countries, it does not include HPV testing. As part of the NSO, a pilot application of molecular testing for high-risk HPV is being carried out as a new screening tool to aid cervical cancer prevention.

Based on programme data, only 11% of women participated in cervical cancer screening in Poland in 2023. Based on the 2019 European Health Interview Survey however, the proportion of women aged 20-69 who had been screened for cervical cancer is much higher at 73%, reflecting the important role of opportunistic screening for cervical cancer in Poland.

Among LGBTIQ people, participation in breast cancer screening is lower compared to the EU average, while participation in cervical cancer screening is higher

According to the EU LGBTIQ Survey III, participation in cervical cancer screening among relevant LGBTIQ persons is higher in Poland than in other EU countries (Figure 11). In 2023, 69% of LGBTIQ cisgender females, trans women and intersex population aged 25-39 in Poland reported having had a smear test in the previous 5 years (higher than the 64% in the EU), while 74% of those aged 40-55 in Poland reported a smear test (similar to the EU average). In contrast, for breast cancer screening, only 16% of relevant LGBTIQ people aged 40-54 years reported having had a mammogram in the previous 12 months, much lower than the EU average of 28%.

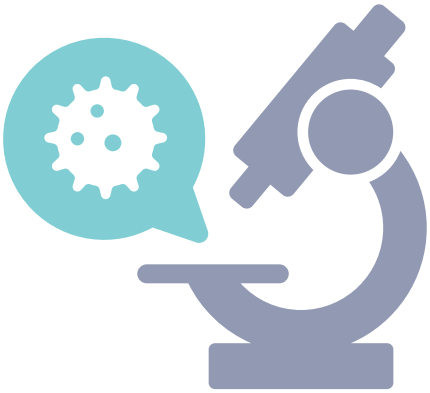
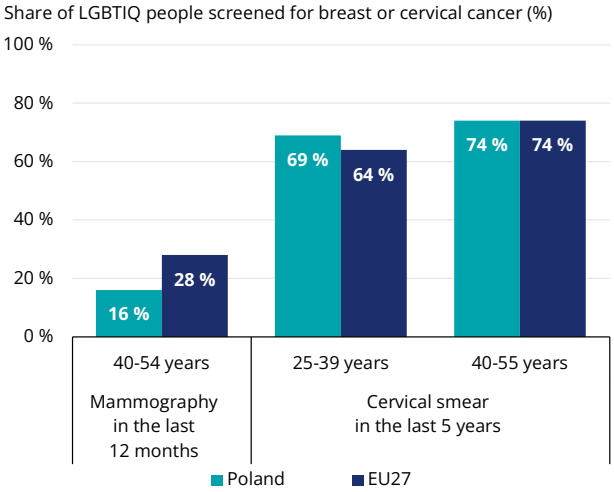


Figure 11. LGBTIQ persons in Poland participate less in breast and more in cervical cancer screening than their counterparts in the EU



Note: LGBTIQ survey results refer to age groups and/or screening intervals that do not align with the population screening approach in EU countries, and should not be compared.
Source: The European Union Agency for Fundamental Rights (EU LGBTIQ Survey III).

Availability of colorectal cancer screening centres varies across regions

In Poland, the population-based colorectal cancer screening programme includes colonoscopy once in a lifetime for people aged 50-64. Introduction of faecal immunochemical testing, which is already in use in most EU countries, is also being considered. Since 2022, personal electronic invitations to participate in the screening programme are sent to eligible candidates through the IKP. The number of centres offering colonoscopy varies widely by geographical region. Some voivodeships have plenty of centres, such as Śląskie with 33, Mazowieckie with 38 and Małopolskie with 30. However, others have few: Warmińsko-Mazurskie has 4, Lubuskie has 5 and Kujawsko-Pomorskie has 6.

Internet patient accounts and fast-track pathways are available in Poland to improve access to cancer screening

In recent years, Poland has developed strategies to improve cancer awareness (knowledge about cancer and positive belief in the benefits of screening) with the aim of improving participation in cancer screening programmes. For example, media campaigns and information leaflets designed to increase awareness among the population are financed under the NSO educational campaign "I am planning a long life". However, no campaigns are dedicated specifically to groups with low cancer awareness, such as people with low socio-economic status or lower education levels, or those in older

age groups or from ethnic minority backgrounds. To monitor inequalities in cancer screening participation rates, Poland collects variables such as age, sex, geography and migration status of participants. Information on geographical diversity is published on the website of the National Health Fund.

Although primary healthcare does not have a key role in delivering cancer screening activities in Poland, the Ministry of Health launched the IKP in 2018 and "my IKP" – a free mobile phone application that gives access to the most important functionalities of the IKP – in 2021. These two initiatives are used to invite patients to participate in cancer screening. In 2022, sending of push notifications to users through "my IKP" was initiated, along with a link to detailed information on the government health website. Approximately 47 000 screening notifications for breast cancer, 332 000 for prostate cancer and 664 000 for colorectal cancer were sent through "my IKP".

In recent years, various changes have been introduced in Poland regarding screening programmes and early detection (Box 3).

Box 3. There are innovations in screening programmes and early detection in Poland

- The age range for breast cancer screening was extended to 45-74 and for cervical cancer screening to 25-64 in 2023.
- A pilot lung cancer prevention programme was introduced in 2021-23. It targets high-risk heavy smokers aged 50-74, who have smoked a pack of cigarettes per day for 20 years or have other risk factors for lung cancer (for example, a family history of lung cancer). Lung imaging with a low-dose computed tomography (CT) scan was conducted within the programme in 31 units in nine voivodeships (most in Dolnośląskie voivodeship). The programme was financed by European Social Fund. It is planned to continue the programme in 2025 with national funds.
- Pilot studies for early detection of prostate cancer (within Prostate cancer awareness and initiative for screening in the European Union (PRAISE-U) project will take place in Poland.

5. Cancer care performance

5.1 Accessibility

A new model for organising and managing oncological care is being introduced with the National Oncology Network

The National Oncological Network is an initiative of the NSO. A pilot programme was conducted in 2019-23 in the Dolnośląskie, Podlaskie, Pomorskie and Świętokrzyskie voivodeships among patients diagnosed with prostate, ovarian, colon, breast or lung cancer. The Network will be implemented throughout Poland in April 2025, co-ordinated and managed by the National Council of Oncology (Dziennik Ustaw, 2023). It is introducing a new model for organising and managing oncological care. Its priority is to provide every patient, regardless of their place of residence, with comprehensive and high-quality care based on the same standards. The Network will consist of specialised oncological treatment centres (SOLOs) organised into three levels and co-operative centres. The most complex medical services will be provided at the highly specialised level (SOLO III), complex level (SOLO II) and basic level (SOLO I). Qualification for the level of oncological care provided by the National Oncological Network will be based on objective criteria including, among others, the volume and qualifications of medical staff, diagnostic and therapeutic potential, and quality assurance mechanisms in place to ensure patient safety.

Waiting times remain an issue in Poland despite the introduction of fast-track pathways

Fast-track pathways in Poland help to reduce the time between cancer suspicion, cancer diagnosis and initiation of treatment. The Rapid Oncology Therapy Package was introduced in 2015, through which a primary care doctor issues a treatment card with the cancer diagnosis if cancer has been confirmed. The treatment card ensures delivery of services within the specified maximum waiting time limits: 28 days from visiting the primary care doctor to basic diagnostics; 21 days from specialist consultation to in-depth diagnostics; and 14 days from multidisciplinary team meeting to the start of treatment. All the treatments are covered by the Rapid Oncology Therapy Package. Unfortunately, the introduction of the Package resulted in a minimal reduction in the waiting time for services covered; it also led to lengthening of waiting times for services not covered and for follow-up cancer care. Additionally, many problems were encountered when gathering the appropriate team members for multidisciplinary boards – especially for the co-ordinator role, which is hugely important during the diagnostic phase and for improvement of overall oncological care (Sagan et al., 2022).

In addition, there are significant regional disparities in access to key lung cancer treatments across Poland's voivodeships. These differences arise from unequal availability of treatment options between regions. The northwestern part of Poland has the highest incidence of lung cancer cases per 100 000 population, yet novel treatments like immunotherapy and targeted therapy are more commonly used in the southeastern regions. Additionally, there are regional discrepancies in waiting times for treatments. For example, the waiting time for a CT scan ranges from 53 days in Kujawsko-Pomorskie to 74 days in Pomorskie; for material collection, from 37 days in Kujawsko-Pomorskie to 57 days in Pomorskie; and for PET scans, from 36 days in Łódzkie to 53 days in Mazowieckie (Manxhuka and Hofmarcher, 2024).

The NSO has set out plans to reorganise provision of oncological care to shorten waiting times for treatment and solve other problems. One of the solutions is the National Oncology Network, which aims to improve prevention, early diagnosis and quality of treatment for all patients, regardless of their place of residence, and deliver standardisation of care pathways and quality monitoring.

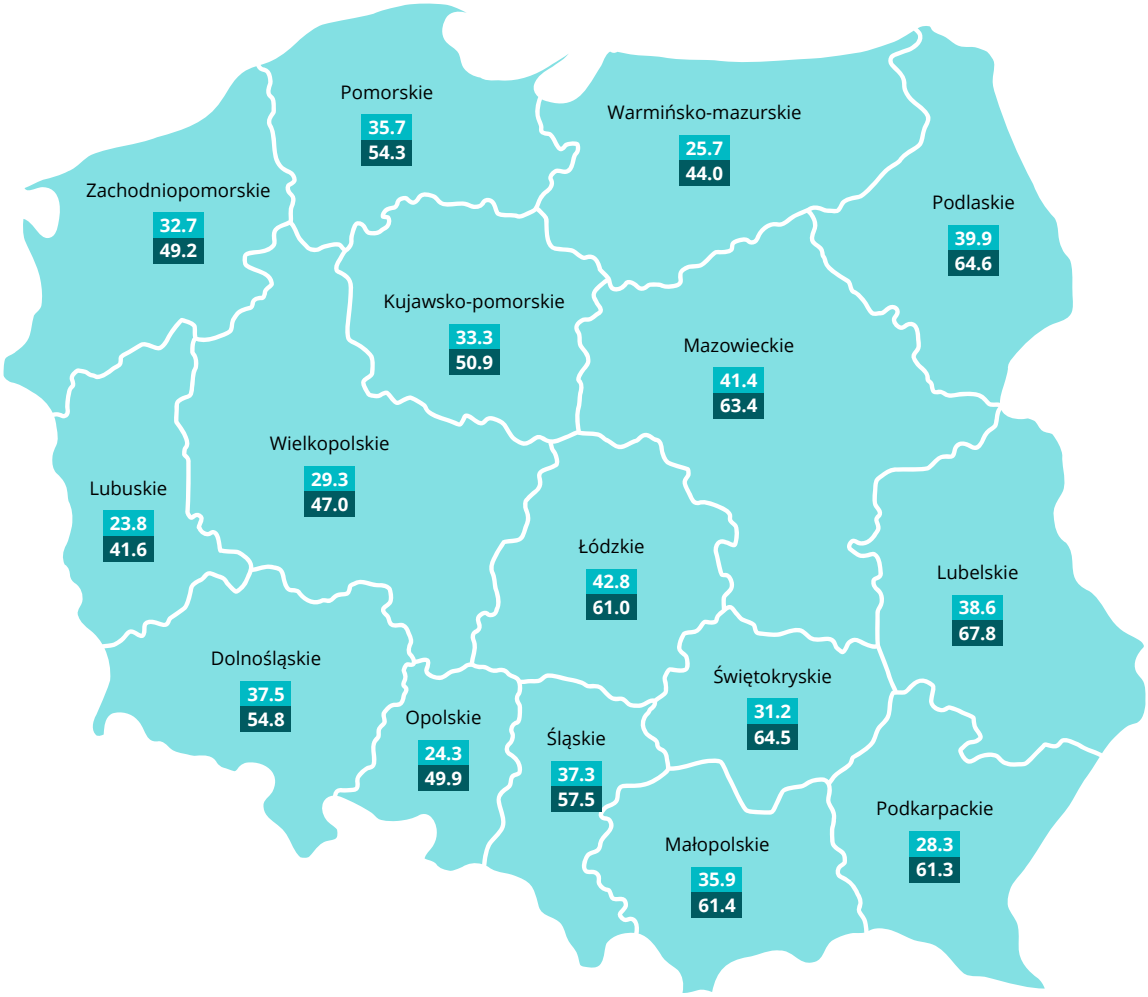
Poland reports shortages of professionals engaging in cancer care

Over the last 10 years, the number of practising physicians in Poland has increased from 2.5 physicians per 1 000 inhabitants to 3.5 per 1 000 in 2022. However, density of physicians is still lower than in most EU countries, where the average is 4 physicians per 1 000 inhabitants. The same trend can be observed in the number of practising nurses, which in Poland is 5.7 per 1 000 inhabitants in 2022 – among the lowest across the EU, where the average is 8.6 per 1 000.

There are also noticeable geographical differences (Figure 12). The lowest numbers of physicians per 10 000 inhabitants in 2022 were in Lubuskie (24),

Opolskie (24) and Warmińsko-Mazurskie (26), and the highest were in Łódzkie (43) and Mazowieckie (41) voivodeships. The lowest numbers of nurses per 10 000 in 2022 were in Lubuskie (42), Warmińsko-Mazurskie (44) and Wielkopolskie (47), and the highest were in Lubelskie (68 nurses), Podlaskie (65) and Świętokrzyskie (65) voivodeships (GUS, 2023).

Figure 12. The highest numbers of physicians per 10 000 inhabitants are in Mazowieckie and Łódzkie voivodeships

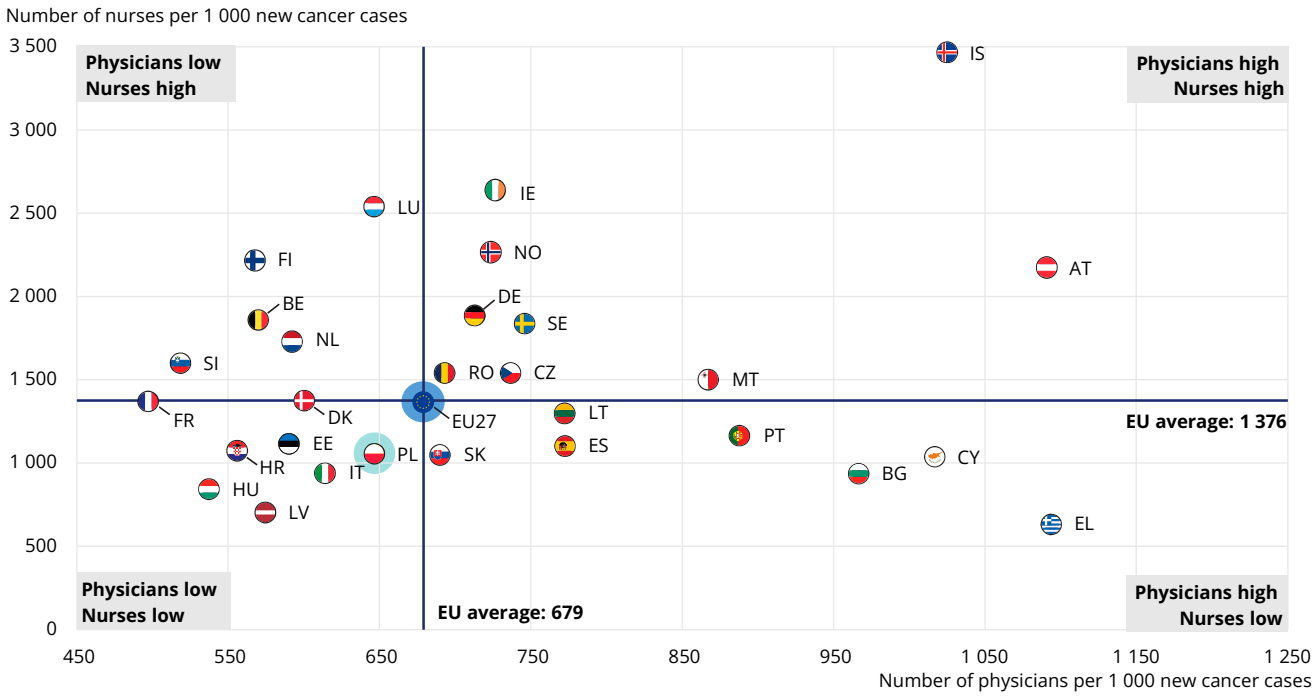


Note: Light green values show numbers of physicians per 10 000 inhabitants in 2022; dark green values show numbers of nurses per 10 000 inhabitants in 2022.
Source: Adapted from GUS (2023).

Poland is also among the EU countries with low numbers of both physicians and nurses relative to new cancer cases (Figure 13). The number of nurses in Poland in 2022 (1 057 per 1 000 new cancer cases) was among the lowest in the EU, where the average was 1 376 per 1 000. Similarly, the number of physicians (647 per 1 000 new cancer cases) was lower than the EU average (679 per 1 000). Availability of general practitioners, who play a crucial role in cancer care and follow-up care in Poland, is the lowest among EU countries, at fewer than 0.4 per 1 000 population.

Several actions are being implemented to overcome workforce shortages in oncology, such as introduction of changes to training pathways, changes in task allocation among healthcare professionals, introduction of financial incentives, and recognition of qualifications of foreign-trained doctors and nurses residing in the country. Most of these policies are conducted as part of the NSO.

Figure 13. Poland has low numbers of both nurses and physicians per 1 000 new cancer cases



Notes: The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). Data refer to practising nurses except in Portugal and the Slovak Republic, where they refer to professionally active nurses. In Greece, the number of nurses is underestimated as it only includes those working in hospitals. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors. The EU average is unweighted.
Source: OECD Health Statistics 2024. Data refer to 2022 or latest available year.

According to the European Oncology Nursing Society (EONS) Cancer Nursing Index, there is room for improvement in Poland with regards to cancer specialisation and occupational safety (EONS, 2020). Although university-level education is available for nurses, there is no master's programme on cancer nursing, and no specialisation is available in this field. There is also room for improvement in the field of patient and occupational safety. Safety guidelines are in place for cytotoxic drugs, and nurses do not prepare the drugs, but access to spillage kits and personal protective equipment is limited, and there is no mandatory formal training before administering cytotoxic drugs.

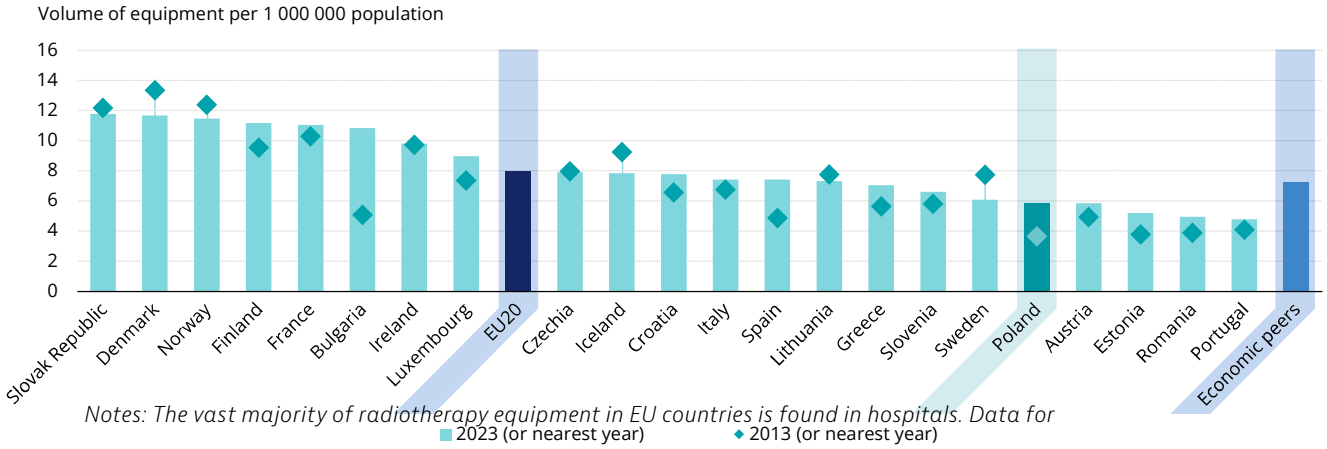
Medical equipment supply in Poland is lower than the EU average

In Poland, the volume of radiation therapy equipment was 6 per 1 000 000 population in 2022, which is 26% lower than the EU average (8 per 1 000 000) and 19% lower than the average among the country's economic peers (7 per 1 000 000). The volume has increased by 60% since 2012 (Figure 14).

In 2024, around 50% of the radiotherapy equipment used in Poland was 10 years old or less, of which only 9% was less than 5 years old. Numbers of magnetic resonance imaging (MRI) units (13 per 1 000 000 population in Poland compared to 18 per 1 000 000 across the EU), mammographs (10 per 1 000 000 in Poland compared to 21 per 1 000 000 across the EU), CT scanners (23 per 1 000 000 in Poland compared to 26 per 1 000 000 across the EU) and positron emission tomography (PET) scanners (1 per 1 000 000 compared to 2 per 1 000 000 across the EU) are lower than the EU averages. Additionally, increases in equipment supply do not always mean expansion of numbers of specialised medical personnel capable of performing, for example, radiotherapy.

According to the Directory of Radiotherapy Centres, in 2023 there were 47 radiotherapy centres in Poland, which was about 6 machines per 1 000 000 population – below the EU average of 8 per 1 000 000. Most of the units are located in Śląskie, Mazowieckie and Małopolskie voivodeships. In Poland, there are 170 photon and electron beam radiotherapy equipment, 2 proton radiotherapy equipment, and 25 brachytherapy equipment.

Figure 14. Volume of radiation equipment is lower than the averages across the EU and Poland's economic peers



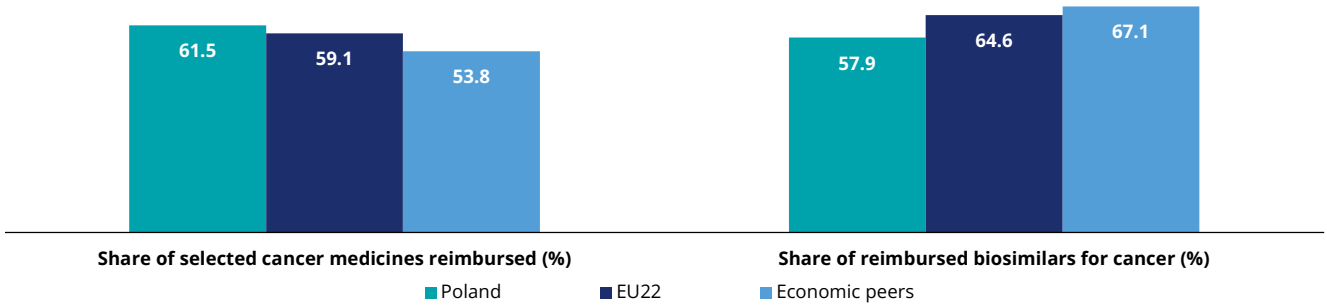
Notes: The vast majority of radiotherapy equipment in EU countries is found in hospitals. Data for Portugal and France includes equipment in hospitals only while data for other countries refer to all equipment. Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for PL are BG, EE, EL, HR, PT, RO and SK. The EU average is unweighted.
Source: OECD Health Statistics 2024.

Time to availability of new oncology drugs is much longer in Poland than in other EU countries

The share of indications of a sample of cancer medicines (for breast and lung cancer) with a high clinical benefit with public coverage is 62% in Poland – higher than both the EU average (59%) and the average among its economic peers (54%) (Figure 15). The proportion of biosimilars for cancer medicines with public coverage in Poland is 58%, which is lower than the EU average (65%) and the average among its economic peers (67%).

Reimbursement decisions regarding new therapies are made in Poland with a delay of at least three years from the date of registration of the therapy by the European Medicines Agency (EMA). Time from marketing authorisation to coverage decision in Poland is more than 900 days, which is much longer than in other EU countries (where the average is about 500 days). Median time to availability in Poland is among the longest among EU countries, at over 800 days.

Figure 15. Public coverage for new cancer medicines is slightly higher in Poland than the EU average



Notes: The analysis includes a sample of 13 indications of 10 new cancer medicines for breast and lung cancer with a high clinical benefit and 19 biosimilars of three cancer medicines (bevacizumab, rituximab, trastuzumab), with active marketing authorisation by the European Medicines Agency as of 26 March 2023. The data represent the share of the indications or biosimilars that were on the public reimbursement list on 1 April 2023. Economic peers are defined as tercile clusters based on 2022 GDP per capita in purchasing power standard terms. Economic peers for PL are BG, EE, EL, HR, HU, LV and PT. The EU average is unweighted.
Source: Hofmarcher, Berchet and Dedet (2024), "Access to oncology medicines in EU and OECD countries", OECD Health Working Papers, No. 170, OECD Publishing, Paris, https://doi.org/10.1787/c263c014-en.

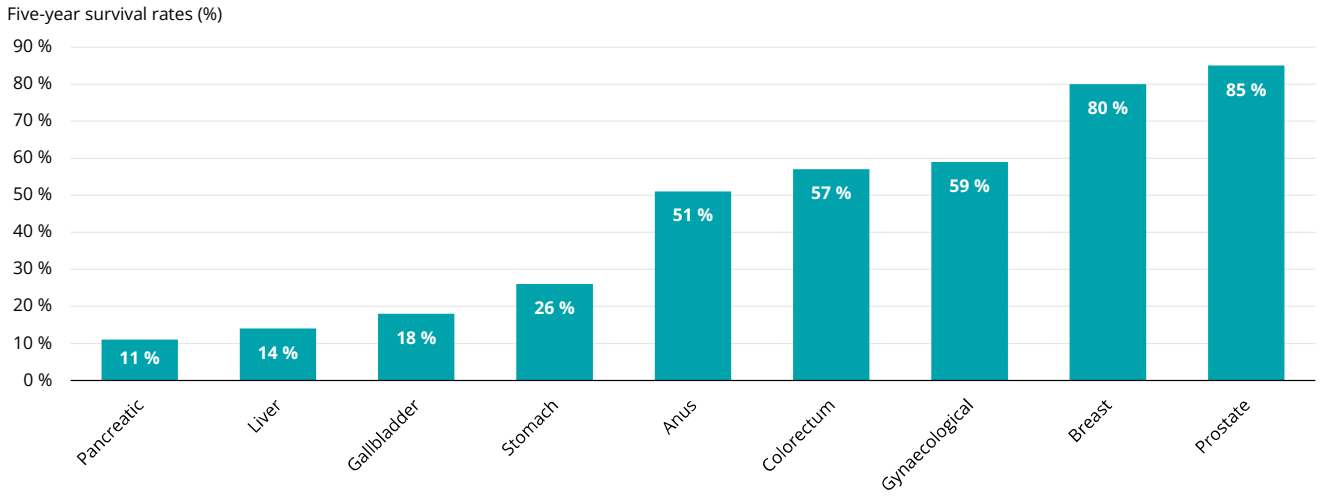
Among 46 oncological drugs approved by the EMA in 2018-21, 11% are on the reimbursed list, 35% have limited availability, 11% are only available privately and 43% are not available in Poland (Newton et al., 2023).

5.2 Quality

There are geographical disparities in five-year cancer survival rates

Five-year survival rates in Poland for patients with cancer diagnosed between 2015-19 are 52% for men and 59% for women. Disparities in survival rates exist according to cancer type (Figure 16). The net survival rate for gynaecological cancers in 2019 was 59% – including cancers of the cervix uteri (57%) and corpus uteri (76%). For gastric cancers the net survival rate was 11% – including cancers of the stomach (26%) and colorectum (57%). The highest survival rates were for prostate (85%) and breast (80%) cancers. The lowest survival rates were for pancreatic cancer (10% among men and 13% among women).

Figure 16. The highest five-year survival rates in Poland are for prostate and breast cancers



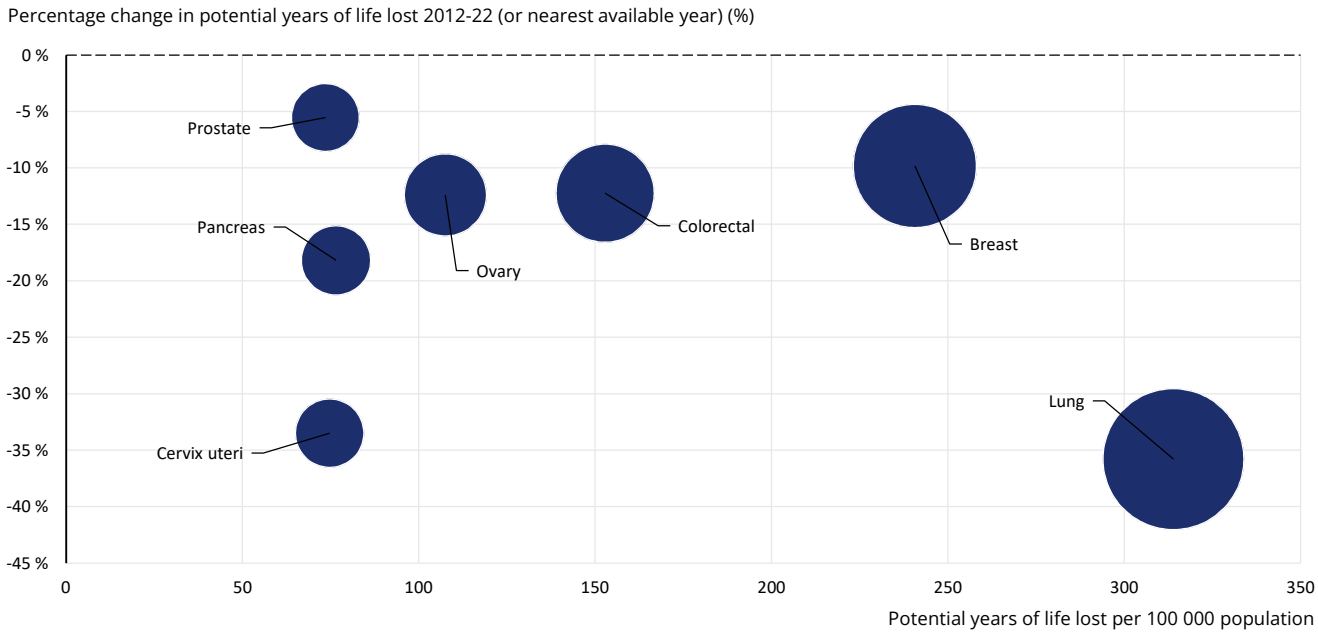
Source: Data sent by National Experts.

Differences in five-year net cancer survival rates occur between voivodeships. Among those diagnosed in 2015-19, women have higher survival rates in all voivodeships compared to men. The highest values among women were in Łódzkie, Mazowieckie, Podkarpackie and Pomorskie (all at 62%), and the lowest in Kujawsko-Pomorskie (55%) and Śląskie (56%) voivodeships. Among men, the highest were also in Mazowieckie (55%), Podkarpackie (55%) and Pomorskie (57%) and the lowest in Warmińsko-Mazurskie(47%) and Dolnośląskie (49%) voivodeships (Wojciechowska et al., 2023).

Potential years of life lost in Poland are decreasing for all cancer types

Potential years of life lost (PYLL) is a complementary measure of the impact of different cancers on society, putting a higher weight on cancer deaths among younger individuals. Examining the change in PYLL over time across various cancer sites can point to improvements in cancer care systems via reductions in premature mortality. In Poland, the overall number of PYLL due to cancer across all sites in 2021 was 1 508 per 100 000 population, which is 11% higher than the EU average (1 355 per 100 000) (Figure 17). The number of potential years of life lost has decreased by 23% since 2012. The number of potential years of life lost in Poland decreased for all cancers. Although the rate has fallen by 36% since 2012, however, lung cancer was responsible for most potential years of life lost in 2021, at 314 years per 100 000 population.

Figure 17. Poland saw a reduction in the number of potential years of life lost between 2012 and 2022 for all main cancer types



Notes: The rate of PYLL from breast, cervical and ovarian cancer is calculated in women only, while the rate of PYLL from prostate cancer refers to men. Pink bubbles signal an increase in the percentage change in PYLL during 2012-22 (or latest available year); blue bubbles signal a decrease. The size of the bubbles is proportional to the PYLL rates in 2022.
Source: OECD Health Statistics 2024.

The National Oncological Network aims to improve the quality of cancer care

As part of the National Oncology Network, three levels of SOLO have been defined (see Section 5.1). The tasks of SOLO I and SOLO II are to implement patients' oncological treatment plans established by a multidisciplinary board, to forward information on its implementation to SOLO III, to appoint a co-ordinator and to conduct systematic satisfaction assessments. In addition to the tasks of SOLO I and SOLO II, SOLO III provides lower-level centres with the opportunity to benefit from advice and consultations – including online provision – and supervises implementation of oncological treatment plans.

Each patient is assigned a co-ordinator who guides them throughout the treatment process. The co-ordinator acts as a link between the patient and doctors. Their task is to arrange medical appointments and necessary investigations, and to prepare the patient's documentation for multidisciplinary boards. Multidisciplinary boards may establish an oncological treatment plan online, provided it is carried out in real time, via audio-visual transmission.

The National Oncological Network also introduces unified documentation through information systems for both patient data and the results of their pathological and radiological examinations. This will facilitate exchange of patient information between centres (which is currently often difficult), and will enable its use in multidisciplinary boards.

The National Oncology Network has introduced a new quality monitoring system

The National Oncology Network has also introduced an obligation to assess patient satisfaction systematically. The assessments are to be used to introduce any necessary corrections to the system. The quality of oncological care will be monitored by the National Institute of Oncology and the provincial monitoring centres (at the voivodeship level). So far, monitoring is conducted in parallel by a number of stakeholders, including the Association of Polish Oncologists, the Cancer Society, the Ministry of Health and the Patients' Association.

Additionally, an oncology hotline will be established at the national level in 2025. It will provide information on the organisation of oncological care within the National Oncological Network. The hotline will also enable patients to sign up for first-time medical visits.

Maintaining the National Cancer Registry (set up in 2010-13) has been designated as a task of the National Institute of Oncology. The Registry is a comprehensive tool for monitoring the cancer health situation of the Polish population. Data are both entered into the register by doctors and downloaded from the hospital information system. They are then verified and integrated.

The organisational structure of the cancer data collection system consists of the National Cancer Registry and 16 provincial registration offices. The data are collected in one common database; the provincial offices supervise the quality and completeness of data in each voivodeship. In 2022, the publicly available database of the Central Register of Clinical Trials was also created.

5.3 Costs and value for money

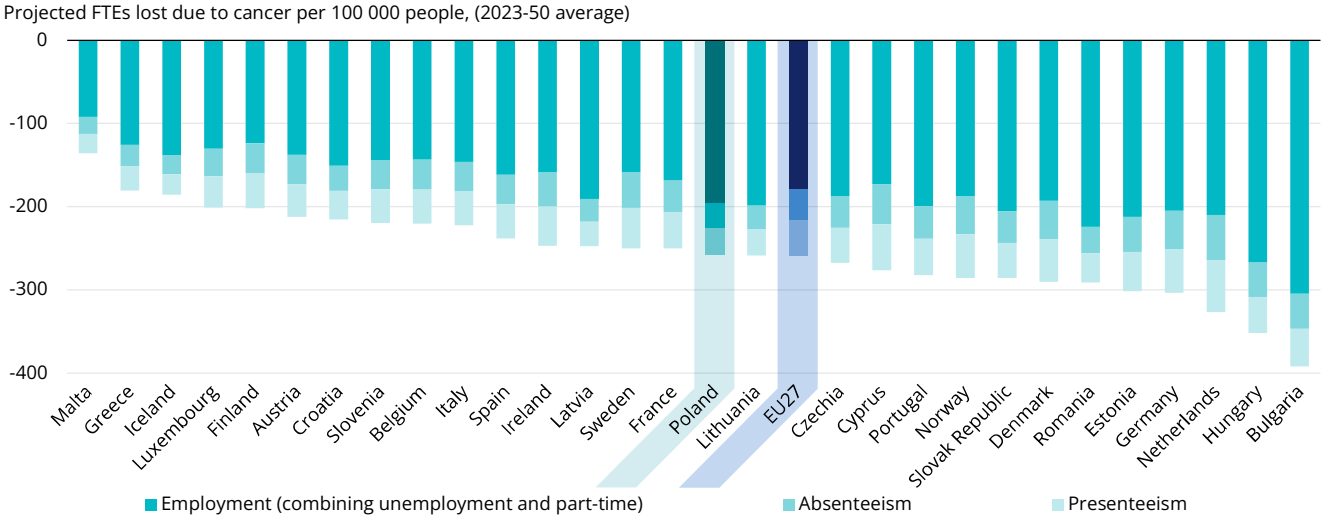
Poland is investing in cancer care

As part of the NSO, PLN 11 billion (EUR 2.5 billion) of spending is planned. These funds are covered by the Ministry of Health, the National Health Fund and the Medical Research Agency. Expenditure of PLN 500 million (EUR 116 million) was also planned for 2024 under the NSO. Additionally, the government predicts that expenditure on oncology will amount to 0.6% of GDP. In 2023, the Medical Fund in Poland announced a call for co-financing of oncology hospitals. Strategic projects were selected consisting of construction, reconstruction or modernisation of medical facilities providing oncological healthcare services. In October 2023, PLN 4.2 billion (EUR 0.9 billion) was transferred to 19 centres.

According to OECD SPHeP modelling work, the per capita health expenditure on cancer care is expected to grow by 89% in Poland between 2023 and 2050, compared to 59% in the EU27 (OECD, 2024b).

Cancer is also expected to have large societal costs. According to OECD SPHeP modelling work, it is estimated that cancer will have a large impact on the workforce in Poland. Between 2023 and 2050 on average, cancer is expected to lead to a loss of 194 full-time equivalent workers (FTEs) per 100 000 people due to the need to reduce employment because of cancer, as well as a loss of 31 FTEs per 100 000 due to absenteeism and 34 FTEs per 100 000 due to presenteeism[7] (Figure 18).

Figure 18. The impact of cancer on Poland's workforce is close to the EU average



Note: The EU average is unweighted.
Source: OECD (2024b), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

More than half of the expenditure on drug programmes in Poland concerns oncology programmes

The National Health Fund financed 38 cancer drug programmes in 2022. Each programme has an application from the Ministry of Health and must be approved by the Agency for Health Technology Assessment and Tariff System, which is the national health technology assessment institution. Expenditure on the cancer drug programmes in 2022 was PLN 4 billion, which accounted for more than half of the expenses on all drug programmes. These amounts increase from year to year. The largest expenditure was incurred on drug programmes for lung cancer (about PLN 750 million), breast cancer (about PLN 790 million) and melanoma (about PLN 420 million). In total, over 54 000 patients participated in oncological drug programmes in 2022 (Ministry of Health, 2024).

7 *Presenteeism refers to lost productivity that occurs when employees are not fully functioning in the workplace because of an illness, injury or other condition.*

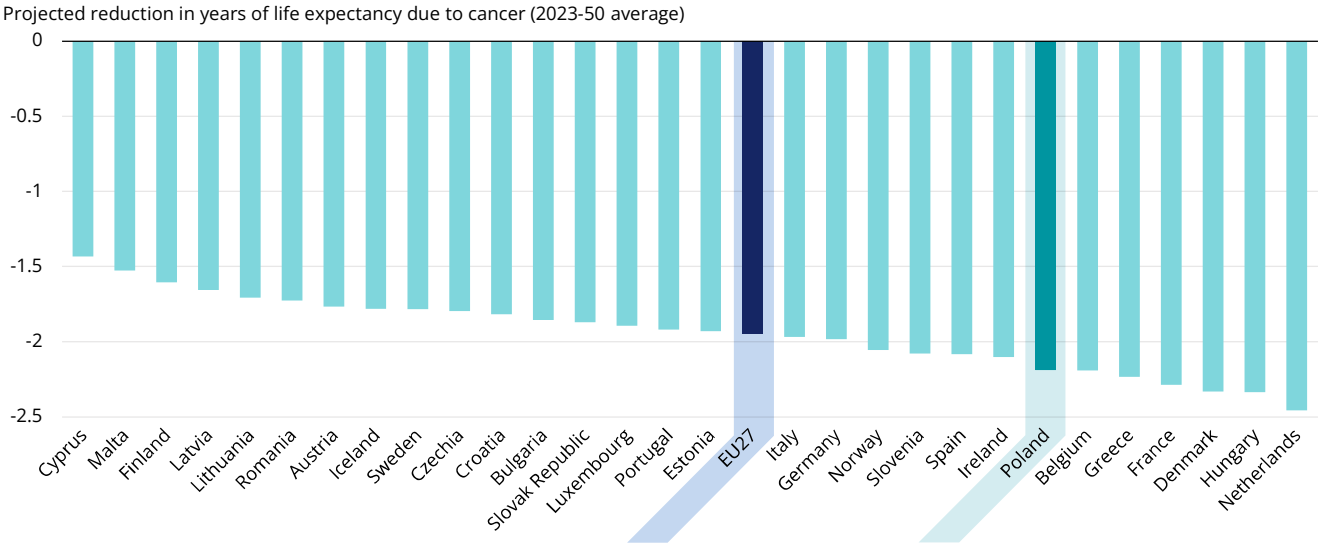
5.4 Well-being and quality of life

Cancer is anticipated to have an impact on the mental health and life expectancy of Poland's population

According to OECD SPHeP modelling work, in Poland cancer is expected to reduce life expectancy by an average of 2.2 years between 2023 and 2050 compared to a scenario without cancer (Figure 19). This is higher than the 1.9 years average reduction across the EU. For context, it took Poland from 2007 to 2019 to increase its life expectancy by 2 years.

In addition, cancer takes a substantial toll on the mental health of the population through its associated symptoms and treatment side effects, and impact on daily life, social roles and work. According to the OECD's SPHeP model, Poland is expected to have higher depression rates because of cancer, at an additional age-standardised rate of 5 cases per 100 000 per year. This is, however, well below the EU average of 17 cases per 100 000 per year.

Figure 19. The number of years of life expectancy lost due to cancer is estimated to be higher in Poland than the EU average



Note: The EU average is unweighted.
Source: OECD (2024b), Tackling the Impact of Cancer on Health, the Economy and Society, https://doi.org/10.1787/85e7c3ba-en.

One of the goals of the National Strategy for Oncology 2020-30 is to provide every cancer patient with access to psycho-oncology

Cancer patients can benefit from psychological help covered by social health insurance. In large cancer centres, psychological clinics employing psycho-oncologists are being established. Many medical centres do not have a psycho-oncologist, which means that patients do not have any opportunity to benefit from this form of help. Online help may be the solution, and one initiative is the online psycho-oncological support platform in Poland. The NSO is responsible for developing psychological care for people suffering from cancer. By 2028, coverage of psychological care is to be extended. Additionally, in 2023, a postgraduate education programme was developed for psycho-oncologists.

While the palliative care network in Poland is large, availability of end-of-life care in palliative wards remains limited

The National Health Fund finances three types of palliative care in Poland: palliative medicine clinics, inpatient hospices and palliative care at home in "home hospices". People living with cancer are entitled to use these types of palliative care.

In an inpatient hospice, the patient receives care from a doctor, nurses, a physiotherapist and a psychologist. This can include respite care for up to 10 days when caregivers are unable to attend to the patient or need rest. The home hospice scheme provides at least two nurse visits per week and at least two doctor visits per month, with the frequency increasing if necessary. Additionally, patients in home hospices can rent medical or rehabilitation equipment free of charge, such as glucometers, oxygen concentrators and hospital beds.

More than half of people receiving palliative care in Poland are in home hospices; as a result, the palliative care network is large. However, availability of end-of-life care in palliative wards remains limited. In November 2023, the number of people waiting for a home hospice was 2 866. Access to palliative care varies both between voivodeships and between rural and urban areas. The situation is worse in rural areas than cities, with the most significant limitations observed in the Mazowieckie, Podlaskie and Lubelskie voivodeships. Additionally, Poland has pain treatment clinics, but waiting times are very long. In 2023, a regulation on pain treatment was introduced, allowing it to be provided in primary healthcare clinics. The overarching objective is to reduce queues and provide pain relief to more patients.

One of the goals of the NSO is to improve the quality of palliative care for cancer patients. Prior to April 2024, the palliative care financial contract covered the full amount specified for all care services and after reaching the limit, only life-savings procedures. Since then, it has been extended to enable financing of any procedures or services required by cancer patients (in the palliative stage of their care).

Informal caregivers in Poland receive formal support

In Poland, end-of-life care for people with cancer is often provided by family members and non-governmental organisations. There is growing commitment to support informal carers who combine work and care. In Poland, there is no direct cash benefits for carers, but there are indirect cash benefits, which rank the country among those with the most generous compensation packages for carers. For example Poland offers paid leave to take care of an older dependent equivalent to 80% of the carer's wage for up to 60 days per year.

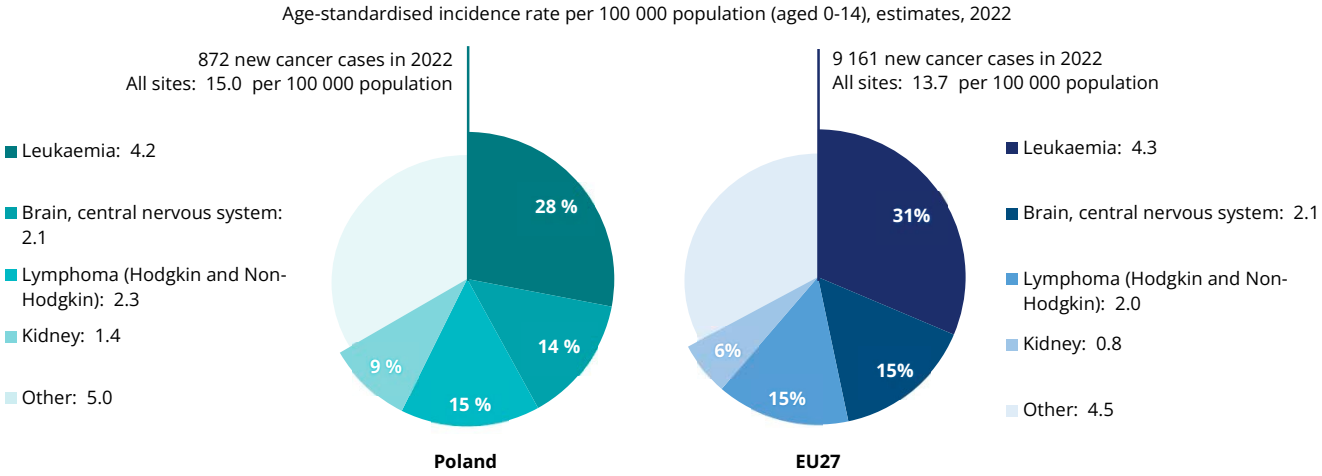
From 2024, there are two types of benefits in Poland: care allowance and support benefit. Care allowance is granted to those who take care of people with disabilities aged up to 18. Support benefit is provided to people with disabilities aged over 18, who must first obtain a decision from the disability assessment team regarding the level of support needed; there is an opportunity for this benefit to be used more often to care for people with cancer. The amount of the benefit depends on the degree of disability. Carers of people receiving support benefits have the option of retirement, disability and health insurance from the Social Insurance Institution. Additionally, a respite care programme is organised to provide 24-hour care for up to 14 days, if caring for a cancer patient is so intensive that the carer requires rest.

6. Spotlight on paediatric cancer

According to ECIS, it is estimated that 872 children and adolescents up to age 15 were diagnosed with cancer in 2022 in Poland. Incidence rates for children aged 0-14 in 2022 were estimated at 15 per 100 000 in Poland compared to 14 per 100 000 across the EU. In Poland, incidence rates among boys are higher than among girls, mirroring the EU pattern. The most common cancer types are leukaemia with 4.2 cases per 100 000 children (28%), brain and central nervous system cancers with 2.1 cases per 100 000 (14%), lymphoma with 2.3 cases per 100 000 (15%), and kidney cancer, with 1.4 cases per 100 000 (9%). The incidence of kidney cancer among children in Poland was 75% higher in Poland than in the EU (Figure 20).

Eurostat data shows that the cancer mortality rate is higher in Poland at 2.4 per 100 000 children as compared to the EU average of 2.1. According to the Polish National Cancer Registry, since the early 1980s, there has been a downward trend in mortality, but increasing incidence of cancer among children in Poland (Didkowska et al., 2023).

Figure 20. Cancer incidence rates among children are higher in Poland than the EU average



Notes: 2022 estimates are based on incidence trends from previous years, and may differ from observed rates in more recent years. "All sites" includes all cancer sites except non-melanoma skin cancer.
Source: European Cancer Information System (ECIS) for cancer incidence. From https://ecis.jrc.ec.europa.eu, accessed on 10 March 2024. © European Union, 2024.

The European Society of Paediatric Oncology (SIOPE)'s Organisation of Care & Research for Children with Cancer in Europe (OCEAN) Project identified that the country has 18 institutions treating children with cancer (SIOPE, 2024). None of these is considered a cancer centre. In Krakow, the Children's Oncology and Haematology Clinic, is the Innovative Therapies for Children and Adolescents with Cancer (ITCC) Consortium Centre in the country, providing access to innovative therapies for children and young people with relapsed or refractory cancer.

All 13 infrastructural and treatment modalities are provided from centres within the country, including chemotherapy, surgery solid tumours stem cell transplant, radiation therapy, proton and photon radiation therapy, brachytherapy and palliative care. In 2018, 78% of the 68 medicines identified as essential for treating cancer in patients aged 0 to 18 were available in Poland, compared to 76% in the EU on average (Vassal et al., 2021).

However, of the 436 clinical trials involving paediatric and adolescent cancer patients in Europe between 2010 and 2022, 14% were running in Poland. This is a similar rate to that in Czechia (13%).

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovak Republic	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Cancer Inequalities Registry

Country Cancer Profile 2025

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Registry contains a website and data tool developed by the Joint Research Centre of the European Commission (https://cancer-inequalities.jrc.ec.europa.eu/), as well as an alternating series of biennial Country Cancer Profiles and an overarching Report on Cancer Inequalities in Europe.

The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by national experts, the OECD Health Committee and the EU Thematic Working Group on Cancer Inequality Registry.

Each Country Cancer Profile provides a short synthesis of:

- the national cancer burden
- risk factors for cancer, focusing on behavioural and environment risk factors
- early detection programmes
- cancer care performance, focusing on accessibility, care quality, costs and quality of life.

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