12. SUBJECTIVE ASSESSMENT OF HEALTH AND THE LEVEL OF SATISFACTION OF HEALTH NEEDS

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The National Institute of Public Health NIH – National Research Institute conducts cyclical studies on the subjective and unmet health needs of the Polish population.

The purpose of the data analysis is to assess the subjective evaluation of health status and the level of satisfaction of health needs, based on social surveys carried out on representative samples of adult residents of Poland.

The data presented below come from a study conducted by the NIPH–NIH in 2025. In selected areas, comparisons are made with the results of an analogous study conducted in 2018, i.e., before the COVID-19 pandemic.

The study was carried out using the Computer Assisted Personal Interview (CAPI) method on a representative, random–quota sample of the Polish population aged 20 years and older.

In 2025, the survey included 3,000 respondents. The sample was divided into five age groups: 20–39 years (N=800), 40–59 years (N=800), 60–74 years (N=800), 75–84 years (N=400), 85 years and older (N=200). The sample was representative in terms of demographic variables (age, sex, place of residence – region and size of locality).

In 2018, 3,000 respondents also participated. The sample was stratified according to the size of the locality, proportionally to the number of inhabitants. Within each voivodeship, proportions by sex and age (20–39, 40–59, 60+) were maintained. At the national level, the proportions of urban and rural residents by sex and age were also preserved.

During the data analysis phase, the results were weighted according to the age structure of the adult population of Poland. Comparisons with the previous study take into account changes in the structure of sex, age, and place of residence between 2018 and 2025.

Between consecutive study editions, efforts were made to maintain maximum consistency of the questionnaire, to allow for analysis of changes over time in perceived health status, health behaviors, and health needs. The questionnaire is updated only to the extent necessary and relevant to current research needs.

The tool includes both proprietary questions and standardized items used in European health surveys such as EHIS and EU-SILC (e.g., regarding self-assessed health, chronic diseases, pain, physical activity, social support, and exclusion). It also incorporates validated instruments for assessing:anxiety symptoms (GAD-2),depression (PHQ-9),sleep quality (Single-Item Sleep Quality Scale), attitudes toward vaccination.

This chapter discusses the following selected topics included in the survey questionnaires:

- general self-assessment of health status,
- assessment of unmet health needs,
- use of health services financed publicly by the National Health Fund (NFZ) and privately – through direct out-of-pocket payments or via medical subscriptions and health insurance.

Subjective health status assessment

As explained in the previous edition of the "Report on the health status of the Polish population and its determinants",[1] one of the most important measures describing quality of life in terms of health is its subjective assessment. Respondents perform a self-assessment using a five-point scale ranging from "very good" to "very poor". This assessment is not based on any reference (e.g. other populations of the same age or expectations) and is not objective; it is based on the respondent's impressions and is made in relation to their opinions and attitudes. By default, it covers various dimensions of health – physical, emotional and social – and refers to the status at the time of assessment, but in the long term (it is not affected by short-term deterioration in health, e.g. due to an active infection). It

[1] Sytuacja zdrowotna ludności Polski i jej uwarunkowania, National Institute of Public Health NIH – National Research Institute, Warsaw 2022. https://www.pzh.gov.pl/raport-sytuacja-zdrowotna-ludnosci-polski-i-jej-uwarunkowania/

is recognised that subjective health status assessment is an accurate predictor of current or future health needs and mortality (in the elderly).[2]

The results of the 2025 survey indicate a decrease in the average self-assessed health status of women and men in Poland aged over 20 compared to 2018. The deterioration of this important indicator may suggest an increase in future pressure on the healthcare system, beyond the observed trends.

Compared to 2018, the number of respondents declaring very good health in all socio-demographic groups analysed decreased significantly, with an increase in the number of respondents rating their health as "good". Currently, only 19% of men and 14% of women say their health is "very good", compared to 38.2% and 28.5% six years ago. The percentage of people describing their health as "poor" increased significantly (Fig. 12.1 and Fig. 12.2).

Subjective assessment of health status depends on socio-demographic factors such as age and education.

The younger the subgroup, the higher the proportion of individuals who rate their health as good. Similarly, higher health ratings are more frequently observed among respondents with secondary or higher education (72.1% and 75.0% among men, and 64.8% and 77.4% among women in 2025, respectively), compared to approximately 60.0% among men with primary or vocational education and 42.0% and 55.4% among women in these groups. As for income level, no clear relationship is observed between respondents' income and their self-assessed health status.

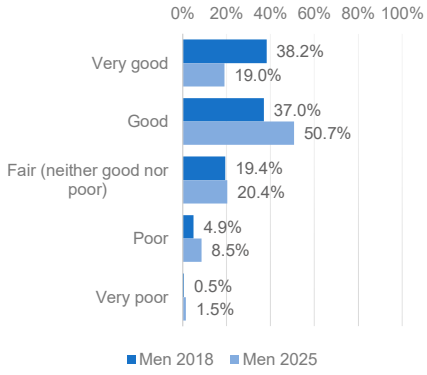


Fig. 12.1. Subjective health status assessment, men (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

[2] Palladino, R. et al. (2016), "Associations between multimorbidity, healthcare utilisation and health status: Evidence from 16 European countries", Age and Ageing, Vol. 45/3, http://dx.doi.org/10.1093/ageing/afw044

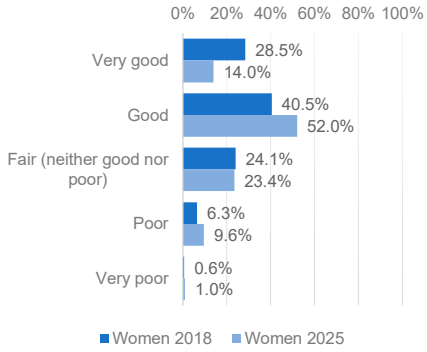


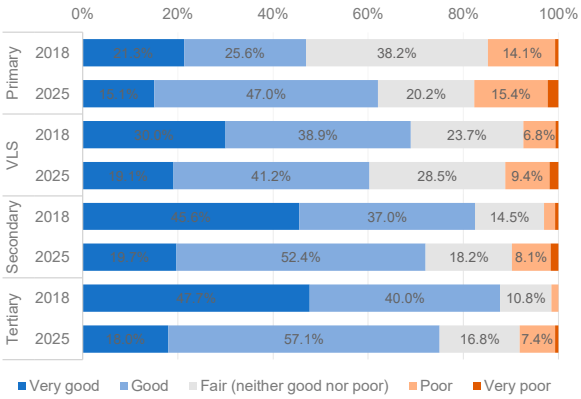
Fig. 12.2. Subjective health status assessment, women (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

Subjective health status assessment is lowest among the oldest respondents and those with lower levels of education. Poor or very poor health is reported by 36.0% of men and 31.8% of women aged 75 or over, and by 17.7% of men and 27.7% of women with primary education (Tab. 12.1 and 12.2).

Compared to 2018, the percentage of respondents declaring poor or very poor health increased, especially among people with tertiary and secondary education and those with a relatively good economic situation. A significant deterioration in self-assessed health status in the period described was also observed among people aged 60–74 and 75 or over. The percentage of poor and very poor health ratings is highest among people with primary education. A similar situation can be observed among individuals whose households are in a difficult economic situation.

The data indicate social groups with potential below-average health status, requiring increased public health and restorative medicine interventions specifically targeted at these groups.

A negative trend can be observed in the overall analysis of positive health assessments: good and very good. Since 2018, particularly marked declines have been observed among persons in a relatively good economic situation (a decline of approx. 11 percentage points among men and 8 percentage points among women), in the group of men with tertiary education (-13 percentage points), and among women aged up to 39 (6 percentage points). The declines persist after applying weights to adjust for changes in the socio-demographic structure of the population between the surveys (Fig. 12.3 to Fig. 12.6).



*VLS: Vocational lower secondary

Fig. 12.3. Overall health status assessment by education group, men (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

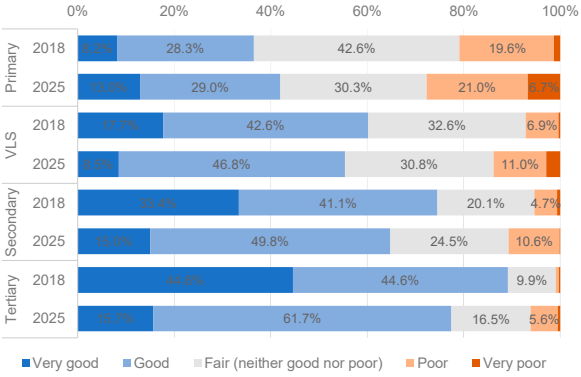


Fig. 12.4. Overall health status assessment by education group, women (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

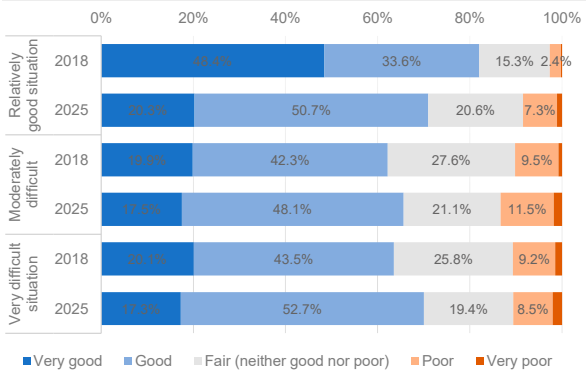


Fig. 12.5. Overall health status assessment in relation to economic situation, men (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

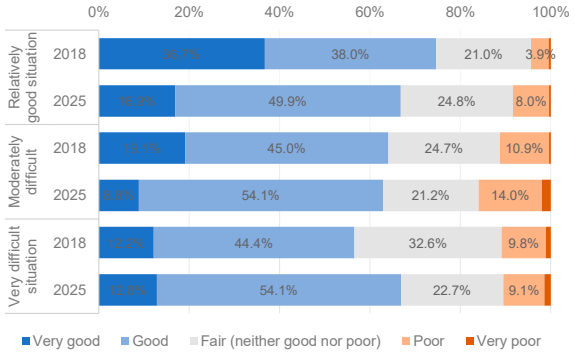


Fig. 12.6. Overall health status assessment in relation to economic situation, women (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

The economic situation is assessed based on three questions about the household's difficulties paying bills, and buying food and clothing. Respondents who indicated that they experienced at least one of these difficulties "always", "often" or "sometimes" were classified as having a very difficult economic situation, while those who never experienced such difficulties were classified as enjoying the best economic conditions.

Table 12.1. Overall health status assessment in relation to socio-demographic characteristics, men (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

		Men			
		2018		2025	
		Very good/ Good	Very poor/ Poor	Very good/ Good	Very poor/ Poor
Age (years)	20–39	94.7%	1.2%	92.5%	2.8%
	40–59	80.6%	3.0%	77.1%	4.2%
	60–74	46.5%	9.1%	41.5%	21.6%
	75 and over	13.8%	33.2%	16.0%	36.0%
Education	Primary	46.9%	14.8%	62.1%	17.7%
	VLS	68.9%	7.4%	60.3%	11.2%
	Secondary	82.5%	3.0%	72.1%	9.7%
	Tertiary	87.7%	1.4%	75.0%	8.1%
Place of residence size	Rural area	76.9%	4.7%	71.9%	8.8%
	Up to 10,000	79.8%	2.4%	65.8%	10.6%
	10,000–20,000	76.4%	5.7%	64.3%	10.7%

		Men			
		2018		2025	
		Very good/ Good	Very poor/ Poor	Very good/ Good	Very poor/ Poor
Place of residence size	20,000–50,000	74.1%	4.6%	64.8%	8.5%
	50,000–100,000	76.4%	8.0%	55.0%	14.2%
	100,000–200,000	73.9%	6.9%	69.9%	12.6%
	200,000 or more	70.6%	6.7%	73.5%	10.8%
Economic situation of the household	Very difficult	63.5%	10.7%	70.0%	10.6%
	Moderately difficult	62.2%	10.2%	65.6%	13.3%
	Relatively good	82.0%	2.6%	71.0%	8.5%

Table 12.2. Overall assessment of health status in relation to socio-demographic characteristics, women (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

		Women			
		2018		2025	
		Very good/ Good	Very poor/ Poor	Very good/ Good	Very poor/ Poor
Age (years)	20–39	93.1%	0.7%	86.8%	3.4%
	40–59	75.2%	4.2%	80.6%	5.5%
	60–74	45.2%	10.3%	41.2%	16.6%
	75 and over	22.3%	28.8%	23.3%	31.8%
Education	Primary	36.5%	20.9%	42.0%	27.7%
	VLS	60.3%	7.2%	55.4%	13.8%
	Secondary	74.6%	5.3%	64.8%	10.7%
	Tertiary	89.2%	0.9%	77.4%	6.1%
Place of residence size	Rural area	71.3%	5.8%	66.0%	10.0%
	Up to 10,000	68.4%	8.7%	71.8%	10.2%
	10,000–20,000	71.0%	4.6%	70.8%	5.8%
	20,000–50,000	66.4%	10.6%	65.1%	9.9%
	50,000–100,000	74.8%	4.0%	71.3%	11.6%
	100,000–200,000	60.4%	12.3%	60.7%	12.5%
	200,000 or more	67.4%	6.0%	62.9%	12.6%
Economic situation of the household	Very difficult	56.6%	10.9%	66.9%	10.5%
	Moderately difficult	64.1%	11.3%	62.9%	15.9%
	Relatively good	74.7%	4.4%	66.8%	8.4%

It is worth noting that the health assessment structure observed in the National Institute of Public Health NIH – National Research Institute survey is broadly consistent with the results of the European Union statistics on income and living conditions (EU-SILC), which cover the population aged 16 and over. In 2023, 66.1% of men and 60.0% of women described their health as good or very good.

Prevalence of long-term health problems and chronic diseases

Compared to 2018, the number of persons reporting long-term health problems or chronic diseases increased, particularly problems that cause serious limitations in activities of daily living.

The trend of worsening self-assessed health compared to 2018 is consistent with a very significant increase in the percentage of people reporting long-term health problems or chronic diseases, particularly problems that cause serious limitations in activities of daily living. This trend affects both sexes to a similar extent.

In 2025, 39.8% of men and 46.5% of women report health problems lasting at least 6 months (an increase of approximately 16 and 13 percentage points compared to 2018). The difference between the sexes is related to the different age structure in these groups. It decreases after appropriate data standardisation (44.9% of men and 41.9% of women after standardisation by age) (Fig. 12.7).

In turn, approximately 9% of men and women struggle with conditions that seriously limit their activities of daily living, which is 4 and 3 percentage points more than in 2018, respectively. The increases persist after standardisation of the socio-demographic structure of the data compared to the previous edition of the survey.

A demographic analysis of the data revealed a significant increase in the percentage of people experiencing long-term health problems among those aged 40–59 (from 25.6% to 45.8% for women and from 17.2% to 38.8% for men) and among people in a relatively good financial situation (from 18.3% to 35.6% for men and from 28.9% to 43.9% for women). These percentages are even higher among older and less affluent groups, but the increase was not as significant.

When it comes to the prevalence of health problems that seriously limit activites of daily living, the group that has seen the most significant change is men with primary education, with a twofold increase from 14.1% to 28.2%, and young women (aged 20–39), with a surge from 1.1% to 8.6%.

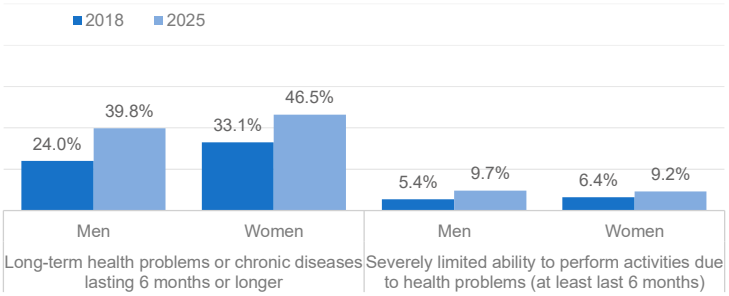


Fig. 12.7. Burden of health problems, as reported in a survey, by sex (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025)

A significant proportion of the Polish population reports symptoms of moderate to severe depression. This is especially true for people struggling financially and those with lower levels of education. This problem is more common in women than in men.

It should be noted that the survey was conducted in September 2018 and February 2025, respectively, which may affect the percentage of people reporting symptoms of depression. However, the observed increases are worrying and require further close monitoring.

The 2025 survey included questions about mental well-being, including depressive symptoms in the last 2 weeks (Patient Health Questionnaire-9, PHQ-9), generalised anxiety symptoms (Generalised Anxiety Disorder 2-item, GAD-2) and sleep quality in the past 7 days, using the 11-item Sleep Quality Scale (SQS).

Symptoms of moderate to severe depression are currently reported by 16.2% of men and 19.9% of women, compared to 8.4% and 10.7% in 2018 (Fig. 12.8).

A significant increase in the prevalence of depressive symptoms was observed in working-age groups, i.e. those aged up to 59, and among people with primary/lower secondary education. However, it should be noted that the age group with the highest incidence of depressive symptoms is still the elderly, aged 75 and over (25.2–26.9% of men and women), and when considering the economic status of households, people in a very difficult financial situation (approximately 36% of men and women in this group).

In the 20–39 age group, the problem affects 13.0% of men and 23.1% of women (an increase of 8 and 17 percentage points, respectively), while in the 40–59 age group, it affects 17.7% of men and 20.8% of women (an increase of 10 and 13 percentage points, respectively). In turn, among people with primary education, moderate to severe depressive symptoms were reported by 36.2% of men

and 42.8% of women (an increase of approximately 18 percentage points), which is significantly higher than among people with higher levels of education. After standardising the results by age and sex in different groups of educational attainment, the prevalence of depressive symptoms increases further (to 50.5%) among women with primary education.

A large proportion of respondents declare symptoms of generalised anxiety. Women report anxiety significantly more often than men.

The question about generalised anxiety was included for the first time in the survey. The results indicate high levels of anxiety, especially among younger people. This is worrying and requires further in-depth investigation.

As with depression, symptoms of generalised anxiety are reported more frequently by women (20.7% vs 17.8% of men), especially those of working age [Fig. 12.8]. An estimated 25.0% and 23.1% of women aged 20–39 and 40–59 experienced anxiety symptoms in the past two weeks, compared to 17.3–19.5% of men in the same age groups.

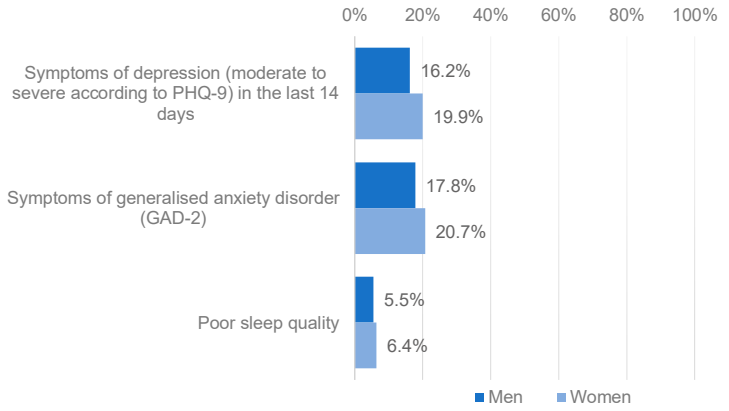


Fig. 12.8. Burden of mental health problems, by sex (National Institute of Public Health NIH – National Research Institute survey, 2025)

Anxiety symptoms are reported by a very high percentage of people in difficult economic situations and with primary education; in particular, this applies to 37.8% of men and 33.3% of women in very difficult economic situations and 31.9% of men and 37.7% of women with primary education. In other groups defined by economic status or education, this proportion does not exceed 20%. These proportions do not change significantly after standardisation by sex and age in the analysed subgroups.

A relatively small percentage of respondents report poor sleep quality. Poor sleep quality (scores ranging from 0 to 3 on a scale of 0 to 10) is more often

reported by people with vocational education (7.9% of men) or primary education (12.8% of women), as well as by less affluent men (9.3%) and women (8.5%).

A large percentage of respondents report severe pain. Once again, women declare such symptoms significantly more often than men. Almost 20% of people experiencing pain claim that it interferes with their usual activities, which still represents a high percentage: 13% of men and 17% of women in the general population aged 20 and over in Poland.

The high level of reported pain in the surveyed population, which hinders normal daily activities, requires further investigation. Pain causes increased demand for medical services and reduces economic efficiency, resulting in presenteeism and absenteeism. At the same time, many of these conditions can be prevented by modifying lifestyle and reducing risk factors such as overweight and obesity, or insufficient physical activity.

In the current edition of the survey, respondents were asked about any physical pain they had experienced in the last four weeks, including its intensity and any impact on their everyday work, daily activities such as studying, professional duties and household chores.

Severe or very severe pain was reported by 13.3% of men and 15.6% of women (Fig. 12.9). Among people experiencing any level of pain, as many as 16.9% of men and 20.5% of women reported that the pain interfered with their everyday activities (including studying, professional duties or household chores) (Fig. 12.10). After standardising the age structure, the differences between the sexes disappear, approaching 14% of severe/very severe pain in both groups and 18.0%–19.7% (men and women experiencing pain, respectively) reporting difficulties in performing work.

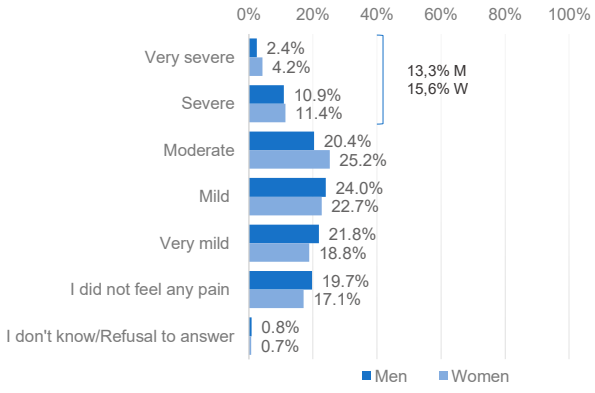


Fig. 12.9. Pain experienced in the last 4 weeks, by sex (National Institute of Public Health NIH – National Research Institute survey, 2025)

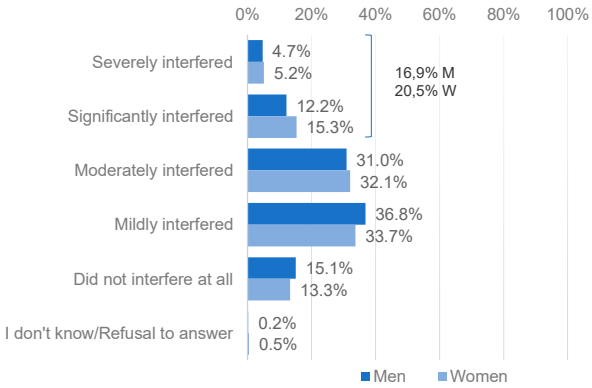


Fig. 12.10. Assessment of pain interfering with everyday work in the last 4 weeks, by sex, n=1,256 men, 1,260 women reporting pain (National Institute of Public Health NIH – National Research Institute, 2025)

No significant differences in the prevalence of pain were observed in subgroups defined by demographic factors, except for women with primary education, among whom severe or very severe physical pain was significantly more common (29.6%) compared to individuals in groups with higher levels of education (below 20%). When considering pain that interferes with daily activities, it is clearly more common not only among women but also among men with primary education (23.6% of men and 28.0% of women in this group reported any pain).

Use of health services within the National Health Fund and private health care providers

The share of those largely or exclusively using privately financed services is significant, ranging from 24.6% in men to 22.5% in women.

Such individuals relieve the burden on the publicly financed system, but are potentially exposed to inefficient health expenditure due to, e.g., the lack of comprehensive and coordinated care.

In order to determine the extent to which respondents use private health services, the survey asked them to select one statement from a predefined list that best describes how they usually use health care in typical everyday situations (i.e. excluding hospital stays or emergencies).

Some 36.8% of men and 36.3% of women stated they only use public healthcare services. A similar percentage – 38.0% of men and 41.0% of women – sometimes

use private healthcare, but the National Health Fund remains their primary provider of health services. Some 22.5% of men and 24.9% of women rely more on private healthcare, with 9.5% of men and 7.1% of women claiming it is their only provider of health services (Fig. 12.11).

The highest percentage of people using non-publicly financed services is observed in the younger population, with secondary and higher education, living in large cities (over 200,000 residents) and rural areas. However, almost a third of the population who exclusively or to a large extent use non-publicly financed services struggle to finance their health expenditure. This is indirect evidence of significant difficulties in accessing publicly financed services.

The survey results permit an analysis of the socio-demographic profile of individuals based on their use of publicly and privately funded services.

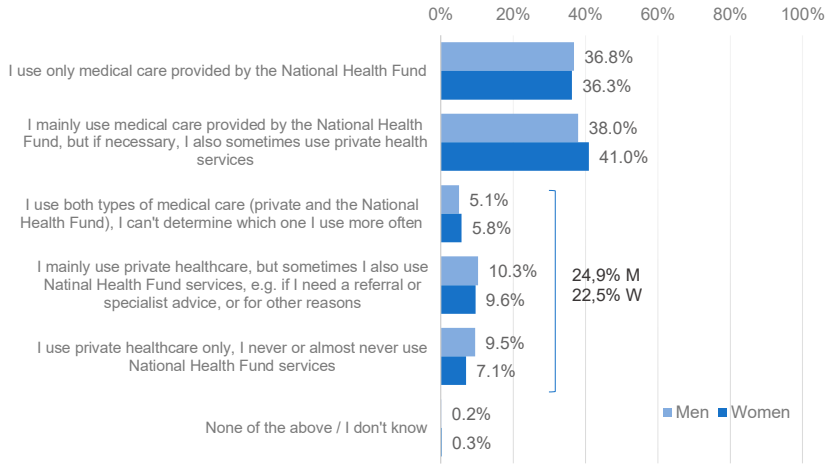


Fig. 12.11. Profile of medical services usage – private and within the National Health Fund, by sex (National Institute of Public Health NIH – National Research Institute survey, 2025)

Three subgroups were analysed: 1. persons declaring that they use only health services provided by the National Health Fund; 2. persons who occasionally use private services when necessary, but still rely mainly on care financed by the National Health Fund; 3. a group that uses non-publicly financed health services to an extent comparable to or greater than that provided by the National Health Fund.

People who use non-publicly financed healthcare more intensively (or exclusively) are often young (people aged 20–39 account for about 43% of the total, while in other subgroups this figure is no higher than 32%) and women with tertiary education (43% of women vs 18.6%–33.3% in other subgroups by type of

service use), as well as women in large cities (26.3% vs 16.3–17% of women who use services financed by the National Health Fund more often) (Tab. 12.3).

Table 12.3. Characteristics of persons by profile of use of publicly and non-publicly financed healthcare (National Institute of Public Health NIH – National Research Institute survey, 2025)

		Men			Women		
		National Health Fund only	Mainly National Health Fund	Private health services*	National Health Fund only	Mainly National Health Fund	Private health services*
Age (years)	20–39	31.8%	27.9%	42.6%	24.8%	24.9%	43.3%
	40–59	37.8%	35.1%	36.5%	34.8%	33.6%	33.5%
	60–74	24.7%	28.9%	15.8%	31.0%	29.0%	14.9%
	75 and over	5.7%	8.2%	5.2%	9.5%	12.6%	8.3%
Education	Primary	3.8%	2.2%	6.7%	6.4%	2.6%	3.6%
	VLS	23.4%	23.1%	23.5%	24.6%	13.4%	13.3%
	Secondary	51.6%	50.%	43.9%	50.%	50.7%	40.1%
	Tertiary	21.2%	24.2%	25.9%	18.6%	33.3%	43.0%
Place of residence size	Rural area	46.0%	45.2%	47.5%	46.1%	43.0%	42.1%
	Up to 10,000	7.9%	9.6%	6.5%	7.6%	8.8%	8.2%
	10,000–20,000	4.9%	4.8%	6.4%	5.6%	6.1%	5.1%
	20,000–50,000	8.8%	6.5%	8.3%	8.2%	8.8%	9.8%
	50,000–100,000	5.1%	6.2%	5.3%	6.9%	7.3%	4.4%
	100,000–200,000	8.3%	8.0%	6.8%	9.2%	9.0%	4.0%
	200,000 or more	18.9%	19.7%	19.2%	16.3%	17.0%	26.3%
Economic situation of the household	Very difficult	26.8%	15.2%	41.2%	35.4%	20.3%	31.9%
	Moderately difficult	20.6%	22.7%	16.8%	21.8%	21.8%	19.9%
	Relatively good	52.7%	62.2%	42.0%	42.8%	57.9%	48.2%
Assessment of financial capacity in relation to health expenditure	Very good	5.1%	3.5%	5.7%	3.5%	4.6%	8.2%
	Good	22.3%	21.6%	27.9%	14.2%	19.1%	21.8%
	Average	41.9%	44.7%	37.0%	45.9%	42.5%	40.2%
	Barely sufficient	18.7%	23.3%	20.0%	20.1%	25.2%	22.1%
	Insufficient	12.0%	7.0%	9.4%	16.3%	8.6%	7.6%

*persons using non-publicly financed health services equally often or more frequently than those financed by the National Health Fund

It is worth noting that a relatively large percentage, i.e. 41.2% of men and 31.9% of women, who use non-publicly funded health services, were classified,

based on their responses, into the subgroup with the very difficult economic situation of the household. Among individuals who use only the National Health Fund services, this figure is 26.8% for men and 35.4% for women.

The population of those who find it difficult to cover their health expenditures, a very large percentage (significantly over 50%), reports a high burden of health problems. It can be assumed that such individuals (in their perception) require medical services, but do not have sufficient access to free services, hence they make use of the non-publicly financed sector. As a result, their health expenditure exceeds their financial capacity.

When discussing the way and possibilities of meeting health needs, it is necessary to look at those experiencing an average worse situation due to socio-economic conditions. For the analysis, individuals in a bad financial situation in a household were selected, who constituted 25.9% of men and 28.5% of women in the entire population under study, as well as the group who assessed their financial status as not good enough to cover health-related expenses, i.e. 9.4% of men and 11.2%.

In addition, attention was given to those with a low level of education, i.e. with basic vocational education or lower. This is 27.2% of men and 21.7% of women in the adult population of Poland.

In the economically disadvantaged group, the structure of responses related to health assessment was similar to the surveyed general population of men and women. Nonetheless, this group is much more likely to have a health burden – 21.7% of men and 17.5% of women report having a severely limited ability to perform daily activities due to chronic health problems, compared with 9.7% and 9.2% of men and women in the general population. [Tab. 12.4].

Similarly, those who cannot afford to cover their health expenses are much more likely to indicate serious limitations resulting from chronic conditions (27.8% of men and 20.8% of women) (Fig. 12.12).

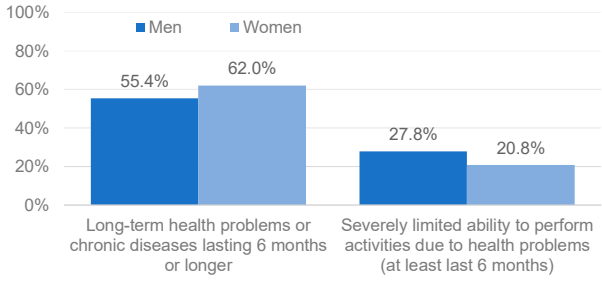


Fig. 12.12. Burden with health problems declared by the group of respondents with insufficient financial resources to cover health expenses, n=150 men and n=160 women (National Institute of Public Health NIH – National Research Institute surveys, 2025)

Table 12.4. Characteristics of persons whose financial capabilities are insufficient (according to declarations) to cover health expenses, n=150 men and n=160 women, and n=1,500 men and n=1,500 women in the general adult population under study (National Institute of Public Health NIH – National Research Institute survey, 2025)

		Selected subgroup		Total population	
		Men	Women	Men	Women
	Share in population	9.4%	11.2%	100.0%	100.0%
Age (years)	20–39	33.1%	30.9%	33.0%	29.1%
	40–59	30.1%	34.8%	36.5%	33.9%
	60–74	30.5%	26.8%	24.0%	26.5%
	75 and over	6.4%	7.5%	6.5%	10.4%
Education	Primary	4.9%	6.7%	3.9%	4.2%
	VLS	26.9%	20.3%	23.3%	17.5%
	Secondary	39.4%	45.8%	49.3%	48.3%
	Tertiary	28.9%	27.2%	23.6%	30.1%
Place of residence size	Rural area	32.8%	36.4%	46.1%	44.0%
	Up to 10,000	10.2%	8.9%	8.2%	8.3%
	10,000–20,000	5.5%	3.8%	5.3%	5.7%
	20,000–50,000	11.5%	11.4%	7.8%	8.8%
	50,000–100,000	9.2%	8.5%	5.6%	6.5%
	100,000–200,000	13.8%	9.6%	7.8%	7.9%
	200,000 or more	17.0%	21.5%	19.2%	18.8%
Economic situation of the household	Very difficult	49.1%	60.0%	25.9%	28.5%
	Moderately difficult	21.4%	14.1%	20.4%	21.3%
	Relatively good	29.5%	25.9%	53.6%	50.2%
Use of health care services	National Health Fund only	46.7%	52.8%	36.8%	36.3%
	Mainly National Health Fund	28.0%	31.5%	38.0%	41.0%
	Private care (as often as or more often than under the National Health Fund)	24.8%	15.3%	24.9%	22.5%
	Other	0.5%	0.4%	0.2%	0.3%

Those with a low level of education are more likely than average to report a poor health condition and are more likely to indicate severe limitations due to chronic health problems. This phenomenon requires in-depth research into health inequalities.

Lower education does not seem to be strongly correlated with health inequalities, which is the case with a worse economic status, although this phenomenon is also observed. People with lower education stand out from the general population due to

their lower health assessment (60.6% of men and 52.8% of women assess their health condition as good or very good, while it is 69.7% of men and 66% of women in the general population) and are more likely to indicate serious limitations resulting from chronic health problems – 13.1% of men and 16.9% of women, while it is 9.7% and 9.2% of men and women in the general population (Tab. 12.6).

Those declaring problems with financing health care expenses are much more likely to use publicly financed services. Those reporting a difficult financial situation are also more likely to use only services financed by the National Health Fund; this applies particularly to women. The remaining respondents from these groups declare using non-publicly financed services to some extent, which means an additional burden on their household budgets.

Based on the presented data, a significant group of people who are in an unfavourable financial position or are burdened by the costs of services (due to poor economic status and/or poor health condition) believe that they do not have satisfactory access to publicly financed services.

Individuals who find it difficult to finance their health expenses, compared to the rest of the population, use only publicly financed services: 46.7% of men and 52.8 % of women use only such services. For comparison, in the general population, this is 36.8% and 36.3% of men and women. In the group of those in a difficult financial situation (based on 3 questions regarding household expenses), this phenomenon is not observed to a large extent and is noticeable mainly in women: 45% of women use exclusively services under the National Health Fund (8.7 pp more than in the entire population under study) (Tab. 12.4).

A large share of those using only the services available under the National Health Fund is also noticeable among women with vocational education or lower, it is 51.7%, i.e., 15.4 pp more than in the general population (for men, it remains at a level similar to the general population) (Tab. 12.6).

To sum up the situation from the perspective of using non-publicly financed services, it can be assumed that a very large part of the society, including those with a worse economic status, choose medical care services outside the National Health Fund. In the adult population under study, 63.5% of men and 63.0% of women use private medical care to some extent (at least occasionally or more often). In the groups considered vulnerable due to socio-economic status, the percentage is also high:

- 52.8% of men and 46.8% of women, among those assessing their financial capacity as insufficient to cover health expenses
- 61.9% of men and 54.3% of women in the group of people who are in the most difficult economic situation
- 63.1% of men and 47.7% of women with vocational or primary education.

Table 12.5. Characteristics of the economically disadvantaged in the household, in terms of health status and use of services, n=345 men and 395 women (National Institute of Public Health NIH – National Research Institute survey, 2025)

		Men	Women
	N	345	395
Health status assessment	Very good	17.3%	12.8%
	Good	52.7%	54.1%
	Fair (neither good nor poor)	19.4%	22.7%
	Poor	8.5%	9.1%
	Very poor	2.1%	1.4%
Long-term health problems/chronic diseases lasting six months or longer		47.8%	51.0%
Severely limited ability to perform usual activities due to health problems lasting at least 6 months		21.7%	17.5%
Use of private and public healthcare	National Health Fund only	38.0%	45.0%
	Mainly National Health Fund	22.2%	29.2%
	Private care (as often as or more often than under the National Health Fund)	39.7%	25.1%
	I don't know	0.1%	0.7%
Assessment of financial capacity in relation to health expenditure	Very good	1.5%	1.9%
	Good	12.0%	9.2%
	Average	46.4%	33.9%
	Barely sufficient	22.2%	31.5%
	Insufficient	17.9%	23.6%

Table 12.6. Characteristics of people with vocational education or lower, in terms of health status and use of services, 437 men and 343 women (National Institute of Public Health NIH – National Research Institute survey, 2025)

		Men	Women
	N	437	343
Health status assessment	Very good	18.5%	9.4%
	Good	42.1%	43.4%
	Fair (neither good nor poor)	27.3%	30.7%
	Poor	10.2%	12.9%
	Very poor	1.9%	3.6%
Long-term health problems/chronic diseases lasting six months or longer		43.9%	55.8%
Severely limited ability to perform usual activities due to health problems lasting at least 6 months		13.1%	16.,9%
Use of private and public healthcare	National Health Fund only	36.9%	51.7%
	Mainly National Health Fund	35.4%	30.2%
	Private care (as often as or more often than under the National Health Fund)	27.7%	17.6%

		Men	Women
Use of private and public healthcare	I don't know	0.1%	0.5%
Assessment of financial capacity in relation to health expenditure	Very good	3.0%	4.0%
	Good	16.3%	13.4%
	Average	43.9%	41.7%
	Barely sufficient	25.8%	26.8%
	Insufficient	11.0%	14.0%

A relatively large share of the surveyed population (15.7% of men and 18.2% of women) declare that they use the services of specialists only in the publicly financed sector.

The above observation may indicate difficulties in accessing services financed by the National Health Fund and/or the prevalence of specialist services in the form of subscriptions or extra insurance. It can be assumed that those declaring the use of services provided by primary care physicians outside the National Health Fund (7.8% of men and 10.2% of women) are covered by subscriptions or additional health insurance.

Almost all respondents (97.5% of men and 98.1% of women) visited a GP or a primary care physician in the last 12 months. Specialist services were used by 72.5% of men and 76.1% of women and 70.6% of the respondents in both groups underwent diagnostic tests (Fig. 12.13).

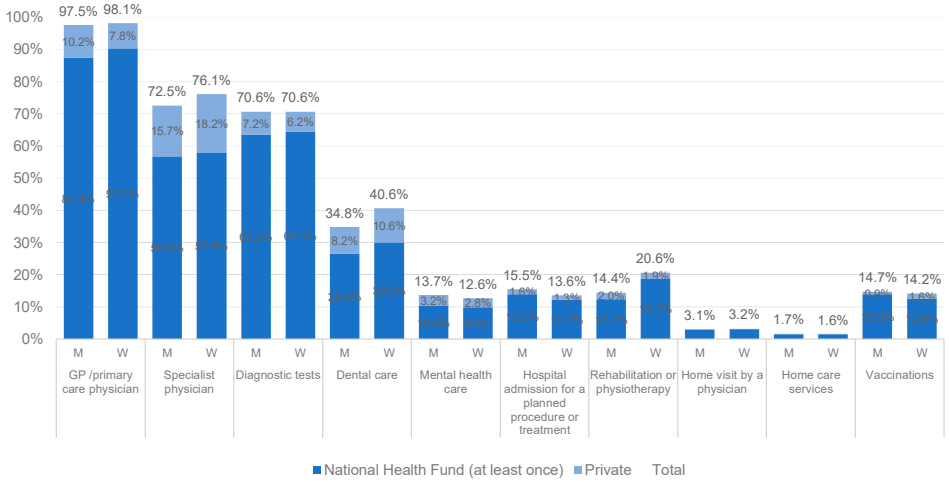


Fig. 12.13. Use of different types of services in the last 12 months. At least once under the National Health Fund vs privately (National Institute of Public Health NIH – National Research Institute survey, 2025)

Women benefited from dental care and rehabilitation/physiotherapy significantly more often than men – 40.6% and 20.6%, respectively (men: 34.8% and 14.4%). The differences are not due to different age-sex structures and are still noticed after considering age standardisation.

The services most often financed exclusively privately were specialist consultations: 15.7% of men and 18.2% of women visited a specialist in the private health care system in the last 12 months. A relatively high percentage of people used GP services outside the National Health Fund (10.2% of men and 7.8% of women) (Fig. 12.13).

Unmet health needs

A very high percentage of the surveyed population (over half of those using a given service) declare delays in access to various types of services financed by the National Health Fund due to long waiting times. This is most often the case of access to specialists, diagnostic tests, hospital care and mental health care. A significantly smaller percentage (several per cent) declares such delays due to transport issues or long distances.

Delays in accessing services due to long waiting times are a very common issue among the Polish population.

People who used various types of services in the last 12 months were asked whether they had experienced a delay in accessing a given service provided under the National Health Fund at least once during that time. Separate questions concerned the issue of long waiting times for the appointment and delays due to long distances or transport.

For a large percentage of the respondents, using health care services financed by the National Health Fund involved long waiting times for the appointments. Most often, this concerned visits to specialists (experienced at least once by 79.6% of men and 82.7% of women using such services). The problem of long waiting times was also reported by a very high proportion of those receiving mental health care (72.6% of men and 65.7% of women), the respondents scheduled for a planned procedure or hospital treatment (69.1% of men and 76.4% of women), diagnostic tests (68.3% of men and 74.2% of women in this group) or vaccinations (65.3% of men and 70.2% of women) (Fig. 12.14).

Delays related to transport or long distances were no longer as common as long waiting times. It is noteworthy that this issue is more often indicated by

women than men, and this is clearly the case for rehabilitation or physiotherapy and visits to specialists (26.0%–26.6% of women using the service in question). Men, in turn, are more likely to declare problems with transport/long distance when it comes to visiting a psychologist or psychiatrist (26.0% of men vs 18.9% of women). The differences remain clear after standardising the data based on different age structures for women and men (Fig. 12.15).

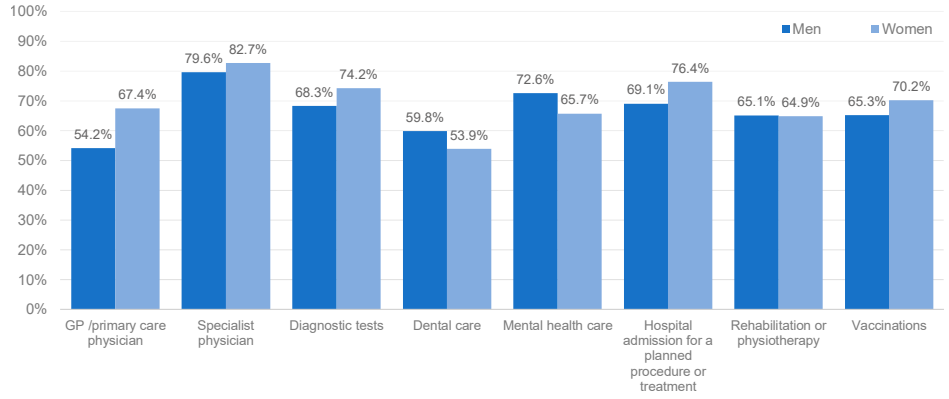


Fig. 12.14. Delays in access to particular types of health services offered under the National Health Fund in the last 12 months due to LONG WAITING TIMES. 100% – persons using a given service (National Institute of Public Health NIH – National Research Institute survey, 2025). Services indicated by n<50 persons were excluded

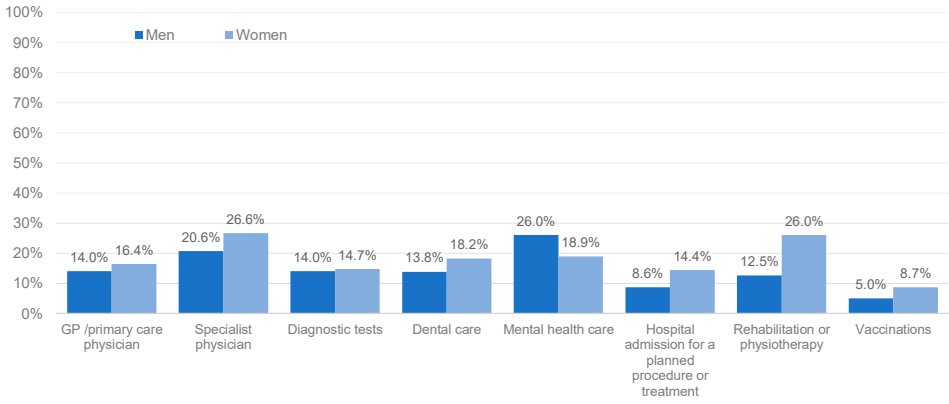


Fig. 12.15. Delays in access to particular types of health services offered under the National Health Fund in the last 12 months due to long waiting times. 100% – persons using a given service (National Institute of Public Health NIH – National Research Institute survey, 2025). Services indicated by n<50 persons were excluded

A relatively small percentage of the surveyed population indicated that delays in obtaining medical services contributed to a deterioration in their health condition.

Although the largest number of people reported delays concerning specialist appointments, hospital admissions and mental health care, a small proportion reported that the delay caused a significant deterioration in their health condition. Health deterioration was more often experienced by the group of those who reported problems with access to primary care physicians and, which is probably more difficult to explain, vaccinations. 6.2% of men and 7.2% of women who had a delayed primary care physician visit, and 11.9% of men and 6.0% of women who waited a long time for vaccination, assessed that this contributed to a significant deterioration in their health condition (Fig. 12.16).

A significant share of the respondents who declared a need for medical services decided not to obtain them. The most frequent reasons were queues/impossibility to make the appointment, difficulties in reaching the health care facility via the phone, but also a potentially high cost of the paid services and lack of time.

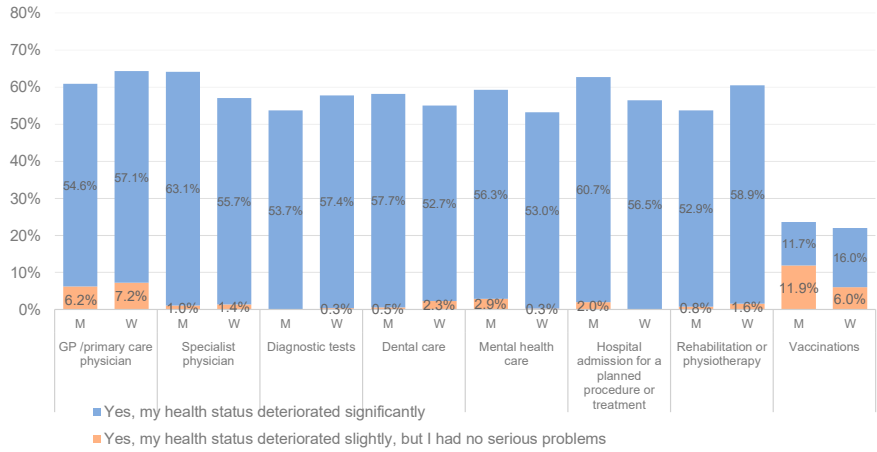


Fig. 12.16. Experienced deterioration in health due to delay in accessing a particular service as a result of long waiting times for the appointments or transport problems, long distances. 100% – people who experienced a delay (National Institute of Public Health NIH – National Research Institute survey, 2025). Services indicated by n<50 persons were excluded

Table 12.7. Reasons for opting out of a particular type of medical care, 100% – persons who opted out of the health service in the last 12 months. Men (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025). Services indicated by n<50 persons were excluded

	Men				
	GP/ primary care physician	Specialist physician	Diagnostic tests	Dental care	Prescription drugs
No appointments available/too long waiting list/queue	24.4%	33.5%	18.7%	14.0%	22.3%
Difficulties to reach the facility via the phone to book the visit	20.7%	14.9%	21.5%	10.1%	16.0%
Could not afford (the visit was too expensive or not covered by health insurance)	16.7%	12.0%	10.6%	36.5%	19.7%
Did not have time due to work, childcare or other reasons	15.9%	17.6%	9.8%	16.,9%	8.8%
Too large distance/no means of transport	8.1%	6.4%	9.8%	2.5%	10.9%
I don't know any good doctors	6.8%	5.9%	2.7%		1.8%
Fear of physicians/hospitals/tests/treatment	4.2%	3.1%	15.4%	4.0%	8.8%
Waited for the problem to go away	3.3%	6.6%	11.5%	16.1%	11.6%

Table 12.8. Reasons for opting out of a particular type of medical care, 100% – persons who opted out of the health service in the last 12 months. Women (National Institute of Public Health NIH – National Research Institute surveys, 2018, 2025). Services indicated by n<50 persons were excluded

	Women				
	GP/ primary care physician	Specialist physician	Diagnostic tests	Dental care	Prescription drugs
No appointments available/too long waiting list/ queue	31.6%	28.8%	30.9%	32.7%	15.0%
Difficulties to reach the facility via the phone to book the visit	20.1%	15.7%	5.6%	4.1%	5.4%
Could not afford (the visit was too expensive or not covered by health insurance)	28.7%	35.1%	40.3%	36.7%	39.8%
Did not have time due to work, childcare or other reasons	7.6%	6.9%	8.1%	11.7%	7.9%
Too large distance/no means of transport	1.6%	3.8%	5.8%	6.3%	11.5%
I don't know any good doctors	4.0%	2.3%	1.9%		6.8%
Fear of physicians/hospitals/tests/treatment	2.9%	4.7%	5.2%	5.9%	6.1%
Waited for the problem to go away	3.6%	2.7%	2.2%	2.6%	7.6%

A significant number of the respondents declared resignation from various types of medical services. The most common resignations concerned mental health care and dental services.

This phenomenon requires in-depth research. Access to mental health care, even non-publicly financed services, may be difficult due to limited availability of specialists, but also other factors, such as the feeling of shame. The resignation from dental services is probably due to the low availability of public financing and high costs for the patient or the limited availability of medicinal products for self-medication.

The fact of resignation from various types of medical services was declared by approximately 10% and 24% of men and women, among those who claimed that they needed a particular service. It should be noted that 24.5% of men and 20.0% of women declared that they refrained from visiting a psychologist or psychiatrist in the last 12 months, despite the fact that they needed mental health care. Women were more likely than men to resign from rehabilitation/physiotherapy (17.0% vs 11.3%), while men were more likely to resign from dental care (18.5% vs 15.4%) (Fig. 12.17).

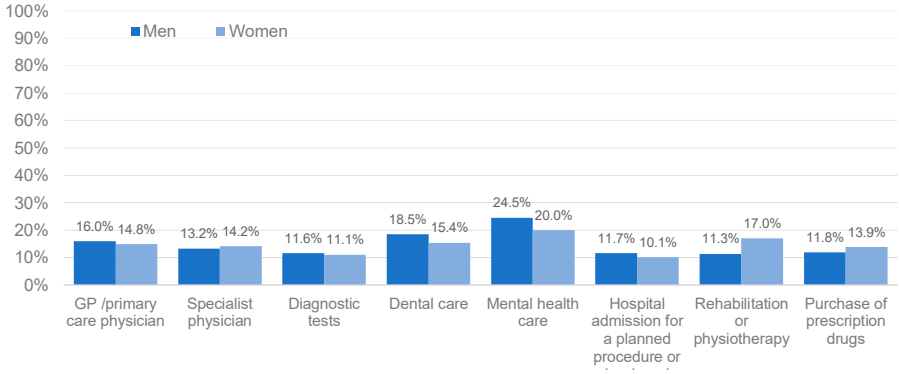


Fig. 12.17. Resignation from particular types of services (despite the need to use the service) in the last 12 months. 100% – persons declaring that they needed a particular service. (National Institute of Public Health NIH – National Research Institute survey, 2025). Services indicated by n<50 persons were excluded

A relatively large proportion of respondents resigned from visits to specialists or did not purchase prescribed medicines, and some of those experienced a deterioration in their health condition as a result of the lack of diagnosis or treatment. This observation indicates the need for thorough research to identify the populations and services most correlated with resignations resulting in deterioration in health. The services often resigned from, which is usually associated

with health consequences, include visiting a specialist and purchasing prescribed drugs: 13.2–14.2% of men and women decided not to visit a specialist despite the need. Of these, 15.9% of men and 23.6% of women experienced a clear deterioration in their health condition as a result (Fig. 12.18).

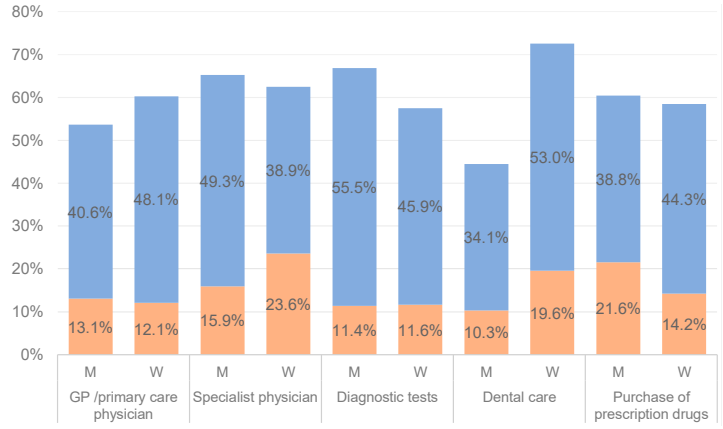


Fig. 12.18. Experienced deterioration in health due to resignation from a given service in the last 12 months. 100% – persons who decided not to use a given service (National Institute of Public Health NIH – National Research Institute survey, 2025). Services indicated by n<50 persons were excluded

Similarly, approximately 11.8–13.9% of men and women did not always purchase prescribed medication. In this group, 21.6% of men and 14.2% of women claim that their health condition has deteriorated as a result.

The most frequently given reasons for the resignation were queues, lack of available dates, difficulties in getting through to the facility to make an appointment and financial issues – more often mentioned by women than men. Men, in turn, are more likely to explain their resignation from a visit to a physician or diagnostic tests by lack of time due to work, childcare or looking after other persons (Tab. 12.7 and 12.8).